Latest evidence concerning youth suicide risk, youth depression, the challenges of prevention and clinical management

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*Our Vision is*

“a community that values people and the quality of life; a nation where no one believes suicide or self-harm is the only option for them.”

www.suicidepreventionaust.org
Epidemiology

- Suicide is a tragic, largely preventable global health problem.
- In Australia and many Western countries, leads causes of death by injury, significantly exceeding fatalities from motor vehicle accidents and homicides. In 2007 there were 1,884 suicide deaths, approximately 75% involving males (Australian Bureau of Statistics (ABS), 2009).
- For complex reasons, Australian suicide rates from 2002 to 2007 were 30-40% under-reported.
Epidemiology

- Suicide rates rise through the teen years and into the 20s. Suicides under age 14 are not reported in Australia, despite such deaths not being infrequent, especially in indigenous communities.

- For youth aged 15-24 years, suicide accounts for 20% of deaths. From 1964 to 1997, suicide rates for 15-24-year-old Australian males rose from 6.8 to 30.6 per 100 000. Reported rates then declined to 2007. Suicide rates for 15-24 year females have been fairly stable at around 6 per 100 000.
• Non-fatal self-harm behavior leads causes of morbidity for young women. Medically serious suicide attempts however are as common or more common among males.

• In Australia, common younger male suicide methods are hanging, firearms, and car exhaust. Firearm rates declined in recent years, but hangings rose for both sexes. Poisoning (fatal and non-fatal) predominates among young women. It is generally less lethal except in countries where the ingestant is untreatable, such as herbicide poisoning and/or treatment resources are unavailable.
Self-harm (cutting, burning etc)

- Purpose: Relief from unbearable pain/managing unmanageable emotions, calming oneself or feeling alive again
- Secondary problems in relation to contagion, stigma, secrecy, parents’ and schools’ responses (overlap and confusion with suicidality), habit formation
- Associated with various psychiatric problems (e.g. anxiety and depression, eating disorders, personality-related issues etc)
- Distinguish from cultural practices, initiation rites
- May be impossible for patient or parents/friends to prevent short-term. Emotion regulation is key task, & continuing assessment of suicidal risk is vital.
Experimentation and risk-taking deaths (NSW Child Deaths Review Committee)

- Engaging in behaviours while under the influence of alcohol and drugs
- Overdose of illicit substances in social/group context
- Risky driving behaviour
- Mainly male
Costs

• Suicide and self-harm entail massive human, social and economic costs: the last alone runs to billions of dollars. Estimates indicate each suicide impacts directly on at least six other people (Corso et al, 2007).
Overview of session

- Epidemiology and risk (briefly!?)
- Clinical assessment and management of adolescent depression
- The possibility of suicide prevention
- Clinical management of suicidal behaviour
Origins of suicidal behaviour

• What makes people suicidal?
• Unbearable psychological pain in intolerable situations, inability to think of alternatives, & the wish to die (Schneidman, 1993).
Origins of suicidal behaviour

• The wish to die involves failed belongingness and perceived burdensomeness (the misperception one’s death will relieve others).

• Suicidal behaviour also involves acquiring the capacity to lethally self-injure - habituating to pain and fear of self-injury, using it to achieve the opposite emotion of calmness. This may require progressively extreme measures, including intentional self-harm but also accidents, violence, child abuse, severe substance abuse and daredevil behaviours (Joiner, 2005, 2009).
Risk factors

- Multifarious.
- Psychiatric and gender-specific profiles for those who attempt and complete suicide are similar.
- In the West females attempt and males complete suicide. Lethality of respective methods may largely account for this.
- Risk factors and processes often extend back to early childhood.
Risk factors

- For individuals, psychological, biological, and illness-related factors interact with situations and with family, school and wider socio-cultural environments.
- Protective factors and resilience-promoting processes are also important, though much less understood. Risk and resilience are not static.
- Risk management is more than exercising individual lifestyle choices, since environments can thwart capacities for choice.
Motivations

- Interpersonal motivations include a cry for help, the wish to make reparation, or punishing oneself or others.
- The wish to die strongly predicts re-attempts and completed suicide, as does courage and competence about self-harm and previous worst-point resolved plans and preparations.
- Rehearsal, prevention of discovery, and communication beforehand are also important suicide predictors. Expecting repetition also predicts recurrent suicide attempts.
Precipitants

- Common precipitants include relational conflict, loss and legal or disciplinary action, and being bullied.
- Suicidal behaviour may also induce life stresses and worsen psychological difficulties, as well as arising from them.
Risk factors - overview

- Past attempts
- Psychiatric
- Personality
- Familial, and developmental transmission
- Neglect/abuse
- Motivations and precipitants
- Health risks and physical disorders
- Genetics
Risk factors - overview

- Social trends
- Availability of services
- Rural/remote
- Indigenous
- GLBTI
- Contagion, imitations, media and internet
- Exposure to suicide
- Suicide bereavement
- Access to methods
- Services (engagement, continuing care, stigma)
Past suicidal ideation & attempts

- Risk highest in months post-attempt and post-discharge from psychiatric care.
- High medical lethality attempts (e.g., hanging, shooting, or jumping) are associated with high suicide risk. Low lethality attempts may conceal high intent where knowledge of method lethality is limited e.g. in children. Low intent attempts can become lethal with a lethal method.
- Impulsivity and substance misuse combine to increase dangerousness.
Psychiatric risks for suicide & suicide attempts

- Risks for suicide & suicide attempts overlap
- Psychological autopsies identify psychiatric disorders in about 90% of adolescent suicide victims & 80% of attempts. This may not be so in non-Western or indigenous cultures.
- The number of co-morbid disorders increases suicidal risk (e.g. substance abuse, mood and/or conduct disorders in older adolescent males).
- Many suffering mental disorders are not suicidal: hence these factors while sensitive are very non-specific.
Psychiatric risks for suicide & suicide attempts

- Mood disorders (including bipolar disorders)
- Substance abuse (predisposing, precipitating and facilitating) (includes cigarette smoking)
- Conduct disorders and antisocial behaviour
- Psychoses
- Eating disorders
- PTSD (direct assoc with attempts only)
- Anxiety disorders (assoc with attempts only)
- Lifetime and/or recent outpatient and esp inpatient psychiatric care (esp in last month)
Personality disorders and traits

- Cluster B personality
- Neuroticism (negative view of self, world, future)
- Hopelessness
- Impulsivity
- Impulsive aggression
- Problem-solving deficits, cognitive distortions
- Maladaptive coping styles e.g. rumination, self-blame, hopelessness, rather than trait emotional intelligence
- Tendency to retrieve only generalised memories, rather than specific autobiographical memories.
Health risk behaviours & Physical disorders

- Suicidal behaviour may be associated with high-risk activities such as binge drinking, tobacco use, carrying weapons, and having unprotected sex. These behaviours share common risk factors with suicidal behaviour and frequently coexist.

- Poor physical health, chronic physical illness and disability may be associated with increased risk for suicidal ideation.
Sexual orientation and gender identity

• Reliable data regarding suicide among gay, lesbian, bisexual and transgender young people is lacking, because at death, information may not be known or recorded.

• Suicide attempt, ideation and self-harm rates are considerably elevated in GLBT young people. Attempts may occur while still coming to terms with one’s sexuality and/or gender identity, prior to disclosure to others, or, for transgender individuals, engaging in gender related treatment.
Familial contributions to suicidal behaviour

• Parental separation, divorce
• Troubled parent-child relationships, attachment problems, poor communication, discord, low parental care and high parental control
• Parental psychopathology
• Physical and sexual abuse
• Tendency to suicidal behaviour is transmitted independently from psychiatric disorder per se
Developmental transmission

- Suicidal behaviours are rare before puberty.
- Parental risk factors may include mood disorder, suicide attempts, impulsive aggression.
- Child precursors may include impulsive aggression, anxiety and neuroticism.
- After puberty, onset of mood disorders and substance exposure sometimes co-occur with impulsive aggression. Overwhelming life events and disadvantages, exposure to suicidal behaviour, access to means and opportunity are also crucial. Protective factors mitigate risk.
Genetics/neurobiology of suicide

- Impulsive aggression and suicidality are in evidence in adolescents and are associated with:
  - Reduced serotonin and 5HIAA in CSF
  - Reduced serotonin transporter binding receptors in ventral prefrontal cortex and brainstem
  - Short form or ‘allele’ of serotonin transporter gene on chromosome 17, particularly the s/s genotype
• Impulsive aggression is implicated in the neurobiology and familial transmission of suicidal behaviour: early onset mood disorders and impulsive aggression have precursors in parental depression, suicide attempts and sexual abuse histories (Melhem et al, 2008).
Social trends and youth suicide

- Socioeconomic and educational disadvantage
- Social exclusion and social connection are closely related to health outcomes
- Shifts in moral concepts and values may contribute to increased psychosocial disorder through mechanisms such as family breakdown, individualism, rising substance misuse, changing life transitions, rituals and declining organised religion
- Communal structural instability, anomie and imitation are also important
Rural/remote

Higher rates in rural areas and among aboriginal people

- Rural/remote: economic trends, financial hardship, drought, unemployment, communication difficulties and isolation, dearth of services and avoidance of help-seeking, alcohol usage, and firearms
Indigenous suicides

- Indigenous suicides occur at earlier ages, often involve hanging and alcohol, occur in clusters and with complicated communal grief, and is intimately related to the complexity and comprehensive nature of indigenous disadvantage.
Contagion, imitation, the media and internet

- A small number of suicides and attempted suicides (1-5%), especially among adolescents and young adults, occur in time and space clusters.
- Inappropriate media reporting of individual suicides promotes suicides and suicide attempts.
- The exposure of young people to suicide-related materials and discussions on the internet has been associated with suicide, though little empirical research is available.
Exposure to peer suicide, peer suicidal behaviour and violence

• Some studies note no increase of suicidal behaviour after adolescent suicide, others find peers of suicide attempters and completers have higher rates of suicidal behaviour. Assortative friendships may also contribute to this.
Suicide bereavement

- Often diminishes sense of self-worth, accentuates shame and silences people, who may experience rejection, guilt and self-blame, including feeling they failed to recognise mental illness or its severity.
- This has profound effects, including the frequent concealment or denial of suicide among bereaved individuals and families.
- The likelihood of help seeking is reduced. Coronial procedures or media exposure may also be harrowing (Hawton and Simkin, 2003).
Suicide bereavement

- Those bereaved by suicide may not be clinically unwell, but are at high risk of becoming so.
- While the death of a parent can be a traumatic experience for most people, it may be especially intensified for young children. Children bereaved by parental suicide are more likely than children not so bereaved to experience social maladjustment and increased psychological symptoms and problems, including anxiety, depression, anger and shame.
Schools

- Learning difficulties, and dropping out of school and college are associated with suicide and suicide attempt.
- Bullying and peer victimisation are common problems for children and adolescents. Both victims and bullies are at risk for suicide and those at highest risk may be both.
Access to methods

- Choice of suicide method may be influenced by accessibility; knowledge, experience, and familiarity; meaning and cultural significance; and state of mind.
- Restricting access to particular means of suicide may reduce suicide rates by those methods, and sometimes overall suicides.
- Method substitution may occur, but may be less important among youth, whose attempts are more impulsive and may involve drugs and alcohol.
Stigma

- Stigma associated with mental health and substance misuse problems affects health care and quality of life for mental illness sufferers, their families, communities and mental health services. It comprises
  - Ignorance
  - Prejudice
  - Discrimination
  - These affect resourcing, marginalisation, help-seeking
Availability of services

• There is some evidence of a relationship between psychiatrist availability, social disintegration and suicide rates (Kposowa, 2009).
Services, engagement, continuing care, stigma

• The challenge: 1) young people’s low service attendance and treatment participation rates, and 2) effectively identifying, assessing and managing their risks when they do.
• Stigma prevents help-seeking.
• Most adolescent suicide attempters (esp older boys) do not receive continuing treatment.
• Lack of staff knowledge about self-harm, poor patient-staff communication, sub-optimal post-discharge follow-up, and knowledge of and access to services, all contribute to this.
Services, engagement, continuing care, stigma

- Poor service provider communication with each other and family/carers is a frequent theme in stories of suicide.
- One Australian study found treatment satisfaction for suicide attempt survivors as mixed for 1/3 and poor/very poor for 1/5; 28% reported attitudes of hospital health professionals as mixed and 33.5% as poor or very poor (De Leo et al., 2005)
- Doctors in EDs may focus solely on the physical at the expense of the emotional.
Protective factors

- Much less is known than for risk
- A close confiding relationship with at least one parent; supervision and expectations
- School connection
- Life-affirming values against suicide
- Strong social support systems
- Good social skills, coping and problem-solving
- Family cohesion
- Youth religiosity or spirituality may be protective, independent of confounders such as cohesion, low rates of substance abuse
Talk about it
Depression in young people: disabling, common, potentially dangerous

- Major depression affects 3.7% of 6-17 yr olds, and 4.9% 13-17 olds (C&A NSMHWB). Lifetime prevalence: 15-20%. Almost 100,000 young Australians affected each year.
- Pre-adolescent boys and girls are affected equally, but in adolescents, twice as many girls as boys present with MDD.
- Often chronic, carries significant social, emotional, work-related and physical morbidity, the burden of stigma and suicide risk.
Depression in young people

- Suicide = second most common cause of death for 15-24 year Australian males. Many suicides are depression related.
- Depression is a cardinal risk factor for suicide (OR 11-27), yet depression is under-recognised and under-treated.
- Over sixty percent of depressed youth do not seek help from a health professional.
- Most talk to family and friends who are often not equipped to deal with the problem.
Why is adolescent depression not recognised more often?

- Depressive disorder confused with moods (think: severity, pervasiveness, persistence)
- Comorbidities, multiple manifestations
- Lack of treatment facilities, continuity of care
- Issues with help-seeking, engagement
- Non-disclosure
Assessment considerations

- Severity (including psychosis, melancholia)
- Suicide risk
- School, family, social, m/health problems
- Strengths, interests, supports
- Seek corroborative history
- Identify possible bipolar depression: previous short-lived manic or hypomanic episodes, or family history of bipolar illness.
Common Presentations of Depression in Adolescents

- depressed mood
- lack of interest and pleasure in activities/life
- persistent boredom, cynicism
- increased activity or irritability
- somatic symptoms (e.g. fatigue, headache)
- poor school performance
- low self-esteem
- acting out, increased risk taking
- substance abuse
Protective factors for depression

- Good peer relationships
- A good relationship with at least one parent
- Being employed
- Exercise, sport
- Spirituality
Management issues with C&A depression

- Mild to moderate depression without serious risk warrants support and regular review.
- This includes modifying adverse environments, reducing stress, encouraging exercise and sleep routines, undertaking pleasant events, educating re depression and its treatment, supporting families
- Melancholic features, psychotic features or risks of self harm or suicide should prompt urgent referral to mental health services or a child and adolescent psychiatrist.
Psychological Therapies

- All management in context of supportive therapeutic relationship
- Antidepressants should always be given in the context of psychological therapy
  
  Some evidence for: CBT, IPT

- Family therapy
- School-based group programs
- Web-based programs (e.g. MoodGym).
- Psychological treatments accelerate resolution of depression (the control group catch up)
Dangers of SSRIs? or no SSRI’s?

- In FDA analyses in 2003, more than 4400 children and adolescents showed a higher incidence of suicidality (suicidal thoughts, attempts) in those receiving antidepressants, mostly SSRIs, compared with placebo (4% vs. 2%).
- BUT Epidemiological data links higher SSRI use with lower suicide rates across many countries and over time (this is association, not causation) &
- In moderate-severe depression, benefits for fluoxetine and possibly other SSRIs demonstrably outweigh risks.
- SSRIs are found in only 1.7% of child and adolescent suicide victims (Dudley et al, 2010)
SSRIs Do Not Uniformly Increase Suicidal Thoughts or Self-harm

- Perturbation may relate to starting or stopping them.
- Starting SSRIs induces akathisia, agitation, and irritability more often than placebo. (NB Activation effect with depressed people. Risk of suicide attempt highest in the month before a suicide attempt, decreasing progressively after beginning of treatment)
- Non-compliance may also play a part, setting off withdrawal symptoms.
- SSRIs, TCAs etc may trigger manic switches, often with unstable mood and higher suicide risk.
SSRIs

- Individual RCTs have shown benefits for a number of this class (e.g. fluoxetine, sertraline and citalopram)
- Meta analyses support that fluoxetine has best evidence of effectiveness in depression in adolescents

NOTE
- Placebo effect is marked
Treatment of Adolescent Depression Study (TADS)

- Methodology has some flaws
- Participants similar to clinical practice
  (severe depression, clear impairment, co-morbidities, suicidal thinking not excluded)
- 4 arms - fluoxetine, CBT, CBT + fluoxetine, placebo
TADS Results

- All active treatment arms showed statistically significant benefit over placebo
- Fluoxetine better than combined for marked or severe depression
- Combined better then fluoxetine alone in mild depression

In relation to risk benefit...

- Fluoxetine: NNT 4, NNH 25
- Fluoxetine+CBT: NNT 3, NNH 50
A recent meta-analysis (Bridge et al, 2007)

- Assessed clinical response & risk for reported suicidal ideation and suicide attempts in 27 RCTs.
- Used a different form of statistical analysis to the FDA
- 13 MDD trials showed a pooled difference in response rates between antidepressant and placebo of 11% (95% CI, 7 to 15) and an NNT of 10, compared with a difference of 1% (95% CI, -0.1 to 2%) and NNH of 112 for harm-related events. Rates of response for MDD were higher for adolescents than children, for shorter rather than longer episodes, and in trials where the number of sites was less. For children < 12 years with MDD, only fluoxetine (3 trials) showed benefit over placebo.
Efficacy/Effectiveness of Antidepressants in Other Disorders (2)

- Bridge et al showed a pooled difference in rates of response between antidepressant and placebo for MDD of 11% (95% CI, 7 to 15), for OCD of 19.8% (CI, 13.0 to 26.6%), and for non-OCD anxiety disorders of 37.1% (95% CI, 22.5% to 51.7%). Thus, there was a gradient in the strength of effect for these conditions.
• Based on these clinical trials, fluoxetine does appear to have efficacy in paediatric depression
• Recent RCT evidence suggests higher doses (60 mg) may be needed in some patients.
• Also, there is a differential effect for adolescents versus children in MDD: for example, in two pooled studies of sertraline, NNTs ranged from 2 to 10, and were greater for adolescents than children (March et al, 2006).
• Full remission rates however are only between 30 and 40%.
Antidepressants: more developments

- The debate about antidepressants has continued in learned journals (e.g. Isacsson et al, 2010).
- However it has been complemented and arguably overtaken by research that illuminates the practicalities of using of antidepressants in clinically depressed and suicidal young people and those with other co-morbidities (e.g. The TORDIA study - Brent et al, 2008; Brent et al, 2009).
- Also, from an initial database of 656 studies, Dudley et al (2010) identified and examined six population-based observational studies. In the latter, nine of 574 young people (1.6%) who died by suicide had had recent exposure to SSRIs.
Conclusions from recent debate

• Doing nothing not an option

• Always use in conjunction with therapeutic relationship: best augmented with psychotherapy

• Mild depression – questionable value?

• In moderate to severe cases of depression, the extra risk of self-harm with SSRIs may be less than that of suicide if they are not used when indicated.

• Co-morbidity needs to be addressed
SSRIs in clinical management of C&A depression

- If mild to moderate depression persists, consider medication concurrently with psychological treatments (e.g. CBT or IPT), where available. Try fluoxetine or another SSRI e.g. citalopram, sertraline). Not paroxetine.
- All trials should be done slowly
SSRIs in clinical management of C&A depression

- Regular monitoring for response and side effects, including suicidal thoughts, especially in the early stages. Treat for adequate time.
- Watch for ‘activation’, withdrawal, serotonin syndromes
- Warn patients of possible suicidal thoughts and behaviour: daily scoring of mood and suicidality
SSRIs in clinical management of C&A depression

• Rationale: assists neurovegetative symptoms, improves mood, calms, and enables people to solve problems more easily. Tolerated, but not thought to induce tolerance (cf. withdrawal)

• Treat co-morbid conditions

• Any patient not responding to watchful waiting or an initial SSRI trial or with complicated depression or suicidality, or a seriously compromised social situation should be referred to specialist mental health services.
Management of C&A depression

• Where appropriate, physicians should help parents to understand their child's depression and its treatments by talking with them about their questions or concerns, reinforcing that child and adolescent depression is not uncommon, and reassuring that psychotherapy and/or medication can lead to improved functioning.

• Hospitalisation and physical treatments such as ECT are rarely needed. Long-term follow-up is important to minimise relapse and chronicity.
‘Prevention denial’?: can we prevent suicide?

- In November 2009, Lifeline Australia commissioned a national *Newspoll* Omnibus Survey to ascertain public attitudes towards suicide and strategies for prevention.

- 1,203 respondents aged 18 years and over, from across Australia were surveyed.

- 64% indicated that suicide in Australia is ‘mostly preventable’. More alarmingly, one quarter (26%) indicated that suicide is ‘mostly not preventable’, with 10% undecided.
It is hard to show suicide prevention works

- suicide has a very low base rate
- the absence of a suicide generates no data
- the sample sizes needed to demonstrate efficacy for interventions are dauntingly large.
- Ethical (can’t easily do randomised control trials with suicidal people)
- Absence of a suicide generates no data
- BUT some suggestions of positive results from Australia and overseas
- Stigma remains a huge obstacle
Misconceptions

1) “Once an individual decides to complete suicide, intervention is fruitless because the individual will simply attempt or complete suicide at another time”.
Misconceptions

• However, suicidal intent fluctuates, and suicidal attempts are often only recently conceived (although they may have long trajectories.
• This is particularly so with youth, where impulsivity and substance abuse co-occur with suicidal behaviour.
• Various strategies can work: for example, restricting means of suicide is highly effective, frequently deterring suicide by that method but also overall suicide rates.
Misconceptions

2) “Asking questions or talking about suicide with children and adolescents will increase its probability”. Unsanitised media reporting of suicide undeniably increases (youth) suicide rates, while school awareness programs about suicide are controversial. However, avoiding direct questioning of youth about suicidal ideas or behaviour has no empirical basis.
Misconceptions

- 3) those who talk about it don’t or won’t do it’. Communication beforehand distinguishes those who attempt or complete suicide. This is likely to be with friends and peers first, rather than professionals. Parents or caregivers in particular often do not know about their child’s suicidal behavior.
Is suicide preventable?

- We know that suicide can be prevented, but also sometimes it can’t (despite the best precautions)
- Warning signs (e.g. agitation, hopelessness, anxiety, active suicidal planning) can often be detected, but in some cases, there apparently is no warning
- There is nevertheless much that services can do
School based programs

- Education system is an ideal site for programs

- Universal and selected interventions can reach those in need, while indicated strategies must be planned to address the needs of those at critical risk

- Currently there is no consistent approach to school based suicide prevention in Australia.
Mindmatters

• Key resource in 1/5 of secondary schools and used in some way in 2/3 of secondary schools. (Ainley et al 2006)

• Aims to:
  ▫ embed promotion, prevention and early intervention activities for mental health and wellbeing in Australian secondary schools
  ▫ enhance the development of school environments where young people feel safe, valued, engaged and purposeful
  ▫ develop the social and emotional skills required to meet life’s challenges
  ▫ help school communities create a climate of positive mental health and wellbeing
  ▫ develop strategies to enable a continuum of support for students with additional needs in relation to mental health and wellbeing
  ▫ enable schools to better collaborate with families and the health sector.
Evidence

- Whole school approach is innovative and empirically based (schools affect MH outcomes - Rutter et al’s ’15,000 hrs’)
- Avoidance of talk about suicide (awareness-raising alone = potentially harmful (Shaffer et al’s work), but talking about suicide doesn’t put it in people’s heads
- Evaluations of Mindmatters have found that schools that implement it consider it effective
- However no evaluations of impact on students or their wellbeing have been published.
Kidsmatters

- Primary school version of MindMatters

- Positive school community, social and emotional learning, parenting support, early intervention

- Developed in response to the (up to) 14% of primary age children with mental health difficulties
Evidence

- Evaluation focused on teacher and parent satisfaction with the program

- There was an increase in teachers confidence to respond to the mental health needs of their students

- Pilot to be expanded ($19.6 million to role it out 1700 more primary schools in Labor policy)
Resourceful Adolescent Program

- 5000 people have been trained to implement the program from 2000 schools in Australia

- 11 classroom session

- Integrates cognitive behavioural and interpersonal approaches to improve coping skills and build resilience in teenagers.
Evidence

- RCTs have showed reduced depressive symptoms in participants immediately and at 10 months post intervention

- NHMRC research found that twice as many participants were considered healthy immediately and at follow up than the control group
Signs of Suicide (SOS)

- USA based program (Aseltine et al).
- Designated as an effective program by SAMHSA
- Educational video for youth addressing suicide and depression warning signs and encouraging help seeking
- Accompanied by Suicide Screening questionnaire (which is backed up by referral plans)
Evidence

- 40% reduction in self reported suicide attempts in 3 months following intervention

- Greater knowledge and more adaptive attitudes about suicide and depression observed in the intervention group
Miami Dade Youth Suicide Prevention and Intervention Program

- Serves over 350,000 students in Florida school district. Began in 1988
  a) focus on developing district wide school policy
  b) educate school professionals about warning signs and risk factors
  c) encourage collaboration between teachers, nurses and counsellors
  d) suicide prevention education in the curriculum
  e) peer assistance programs
  f) activities aimed at school connectedness also establish school crisis teams and support school/family partnerships
Evidence

- Reduction in suicide deaths from 5.5 per 100,000 to 1.5 per 100,000

- Reduction in suicide attempts from 45.5 per 100,000 to 9 per 100,000

- (Zenere and Lazarus 2009)
Other school programs

- Various anti-bullying programs work (but impact on suicide/suicidal behaviours has yet to be studied)
- Postvention programs in schools – also require further evaluation
ALL YOU EVER NEED TO KNOW TO RUN A SUCCESSFUL SCHOOL

MORE OF WHAT YOU NEED TO KNOW TO RUN A SUCCESSFUL SCHOOL
School based programs

Whole school approach shows promise
Need to evaluate outcomes of programs and roll out those with evidence to EVERY school
Introduce suicide awareness (and screening and referral) in Australian schools (along with the rest)
MYTH - talking about suicide with youths will put the idea in their heads.... Evidence shows the opposite, discussions are an effective way to encourage youth to open up and seek appropriate help for themselves and their peers. (Kalafat 2003, Gould 2005, Joiner 2009, Miller and Eckert 2009, Poland 2010)
Gatekeeper training

- Training teachers and school counsellors to recognise suicide risk and warning signs.
- Currently many teachers feel unconfident and undertrained to take on this role
- Must extend beyond teachers to include GPs, social workers, sports coaches, youth workers etc
- Suicide awareness training is not a compulsory component of any professional roles, should it be?
Evidence

- Gatekeeper training reduces suicidal behaviour in contact populations (Mann et al 2005)

- Gatekeeper training contributed to reduced suicide rates in Nuremberg (Hegerl et al 2009)

- 60% reduction of suicide in island of Gotland following comprehensive GP training of suicide warning signs and treatment (Rutz 2001)

- 33% reduction in suicides in the military and additional improvements in other behaviours (Knox et al 2003)
Internet and New Media

- Risks of new media: cyber bullying, isolation and disengagement from surroundings
- Benefits: access to information, stigma free, anonymous, cost effective, online communication and connections, online counselling, used ++ by young people
- Inspire - Reachout offers online information, support and resources to youth
- Kids Helpline offer web and email counselling for youth at risk of suicide
Evidence

- Kidshelpline receive approx 20,000 online contacts a year
- Reachout received 2.6 million visits in 2007
- 30% of young people seeking help and info for mental health problem use the internet (Burns et al 2010)
- Shows huge demand for services
- More research is needed on the impact of new media on suicide prevention and the possible risks
I've searched every book, also the Internet, so in desperation... I've come to you, doctor!

GP RECORD

It's the only way I can get some of my patients to listen to me!
Media

- Strong evidence that inappropriate media reporting of individual suicides can cause a risk of copycat suicides

- Media guidelines can reduce suicide rates (Etzersdorfer and Sonneck, 1998)

- However lack of awareness across all levels of community may contribute to lack of prevention

- Research must be done to establish how to safely increase awareness without putting youth at risk
Evidence

- Risks of glamorising suicide and reporting on method, location or characteristics of deceased. (Pirkis and Blood 2010)

- Mindframe guidelines outline what not to do

- Some examples of how to do it eg Kurt Cobain
Clinical interventions

- Systematic review and meta-analysis of RCTs testing psychological interventions for youth presenting clinically with suicide attempt, ideation or self-harm (Hetrick et al, 2010)
- 16 trials were included, with 6 more ongoing
- Overall conduct was poor, outcome data reporting inconsistent.
- 3 studies involving CBT, IPT and ‘attachment based family therapy’ (derived from interpersonal theories about suicide) showed significant differences between interventions and standard treatment on some outcomes.
- DBT is useful for borderline traits, emotion regulation
Access to means

Restricting means of suicide is highly effective, frequently deterring suicide by that method (e.g. jumping (Beautrais et al, 2009)) but also overall suicide rates. The long term effect of legislation limiting the size of packs of analgesics (paracetamol and salicylates) sold over the counter. Suicide deaths, liver transplants, large overdoses all reduced in 3 years after the legislation (Hawton et al, 2004). Lack of good information about the Australian situation.

Restrictions on pesticides
Senate Inquiry

- Data reform
- Hospital-based assessment, follow-up, and accommodation services
- A guideline-adherent, sustained national SP & awareness campaign with regular reports
- Mindframe review
- Hotspots
- Support for telephone crisis services
- High risk groups (indigenous, CALD, GLBT)
- Postvention
- Evaluation/research
- National coordinating agency and resource centre
Senate Inquiry: youth

- Recommends **Gatekeeper training**

- **Recommendation 28:**
  The Committee recommends that the Australian Bureau of Statistics and other public agencies which collect health data record and track completed suicides and attempted suicides of those under 15 years of age.

Need to review evidence re SP campaigns (Nuremberg, Scottish campaign) and how to do guideline-adherent reporting of individual suicides
Recommendations

- Increased funding
- Greater focus on upstream determinants
- Early Intervention
- Encourage help seeking and non-traditional pathways to care
- Coordination
- Involvement of young people
- National awareness raising and stigma reduction
- Gatekeeper training
- Evaluation
- Curriculum content
- Training of teachers
Suicide attempts: the challenge to services

• Suicide risk increases with outpatient status, and esp in the month after psychiatric admission
• Failure to undertake mental health and risk assessment increases risk of repetition and suicide
• Failure of service providers to communicate with each other and community contacts is a frequent theme in stories of suicide.
Suicide prevention: organisational supports

- Mental health and risk assessment reduces risk of repetition and suicide
- Hospitals using comprehensive assessment approach can demonstrate its cost-effectiveness.
- Trained mental health nurses perform assessments as effectively as registrars and psychiatrists (and potentially, GPs or other professionals etc).
- Members of the public can be learn suicide prevention and effectively prevent suicide
Hospital policies and procedures

- All services should have accessible policies and procedures, governing the acute phase, ongoing treatment, rehabilitation & discharge
- Improved integration of inpatient and community-based care reduces risk at these critical transitions
- Pathways need to be accepted and endorsed by local clinical community
- Regular training, audits and case reviews
- Key themes are systems of safety, continuity of care, positive staff attitudes/ reducing stigma
Triage in DSH cases (ACEM & RANZCP guidelines)

• I. Immediate risk (medically serious attempt e.g. requiring ICU or surgery, or major psychiatric illness, or evidence of serious continuing suicide intent)

• II. Serious risk (current or past history of psychiatric illness and treatment, substance abuse, previous suicide attempt, firearm access, chronic physical illness, evidence of continuing suicidal ideation or intent).
Triage in DSH cases (ACEM & RANZCP guidelines)

• III. Lesser risk i.e.
  • first episode of DSH with no evidence of major psychiatric disorder, no evidence of continuing suicidal ideation or intent, no history of drug or alcohol abuse, and evidence that the crisis has passed.
Between life and death: defining concerns

- Empathic stance, connect with patient and those round him/her (‘System of Safety’)
  - What is it that makes life unbearable?
  - Treat the patient as a subject not an object (self-harming patients often are not treated this way, so be mindful of your feelings and responses)
  - Remember the issue of stigma for mental health consumers, services
  - Balance privacy and safety. Offer privacy, but beware the confidentiality trap
  - Ensure continuity of care
Assessment: setting, and who?

• The young person is best interviewed alone wherever possible, in a quiet setting where basic needs have been or can be addressed.

• Adolescents generally are better reporters of their suicidal experiences than their parents, though parents may be more accurate where they have had a history of depression or where perceived parental support is higher.
Assessment: content and process

Both are important.

• Assessments, by inquiring about suicidal behaviour, risk and protective factors and precipitants, aim to minimise foreseeable risk, diagnose and treat underlying conditions, and mobilize strengths and supports.

• Assessment also initiates engagement, enabling shared understandings of the problem and treatment goals, while providing a sense of containment and hope.
Assessment impasses

- Patients are sometimes reluctant or unable to divulge concerns or what led to the presentation.
- Barriers to trust, such as
  - 1) mode of referral and consent for treatment,
  - 2) stigma regarding mental health problems and services, and
  - 3) concerns about confidentiality should be therefore addressed early
- Supplementary history-taking (e.g. from family, school, doctor) may be needed, preferably with the adolescent’s consent.
Assessment: Medico-legal

- Predicting suicide or suicidal attempts is not possible, but from a medico-legal viewpoint, evidence pertaining to risk should be collected, contemporaneously documented and evaluated, and standards of care must be reasonable and prudent (Berman, 2006).
Management Outline (RANZCP 2004)

- establish rapport/therapeutic alliance
- assessment of risk to self and others
- psychosocial assessment (+ collaborative Hx)
- conduct and record MSE
- identify, initiate treatment for mental disorders
- mobilise supports & coordinate treatment with patient, family and other health services
- ensure safety at care transitions and discharge
- address access to means (e.g. amount, lethality of drugs, firearms)
- enhance resilience and adaptive coping
Assessment post-attempt

- suicidal intent & lethality (may not = knowledge)
- the meaning or goal of the attempt (note specific behavioral incidents)
- degree of planning: preparations (will/insurance/obtaining means/letter), timing, isolation, final acts, notes, avoiding discovery
- awareness of chance of rescue/whether help was sought at the time
- aftermath: effects on self/friends/family & feelings after the attempt (remorseful vs disappointed)
Aftermath:

- effects on self/friends/family & feelings after the attempt (remorseful vs disappointed)
- expecting repetition
- Suicidal ideation should be assessed for intensity and pervasiveness pre-attempt, and persistence post-attempt. The latter, particularly with plan or intent, increases reattempt risk.
- A highly impulsive attempt may be nonetheless concerning as future attempts may be difficult to anticipate or predict.
Evaluation of MH and other risk factors in suicide ideation/attempt

- As noted above, and as per general psychiatric and risk assessment.
- Ask re details of sexual abuse in the confines of a therapeutic relationship. Clarifying the purpose of the inquiry and its connection to suicidality may help.
- Planning and access to means (firearms, rope, drugs (including over-counter), industrial chemicals).
Mental state examination

- This should include attention to continued intoxication or delirium, in which case the clinician should delay decisions until the sensorium is clear.
- Manifestations of impulsivity, aggression, agitation, hopelessness or active psychosis should be noted, as they are all relevant to suicide risk.
Psychosocial Assessment

- Is the social environment (e.g. family, school, peers) supportive, or is the adolescent returning to conflict or abusive situation(s) they were trying to escape?
- Has the family rallied, or responded punitively or with indifference?
- Family interviewing 1) allows history-gathering and observation of dynamics 2) gauges family’s capacity to understand and support 3) identifies further work (e.g. impact of suicide attempt on family relationships, adolescent limit-setting etc). It can also have a therapeutic effect.
Management (cont)

- Assess risk factors (as above)
- ‘System of safety’ involves family/friends, GP/mental health/therapist, school/work
- 24/24 access to clinical care
  - incl. written details
  - alternative strategies
- address stressors
- verbal/written contract? (appealing, but little supporting evidence)
Ensuring Continuity of Care: Desiderata

• Individualised care
• Accessible and available services
• Transition management guided by stakeholder collaboration and structural linkages
• Comprehensive services (including if required, housing, education, support, vocational assistance etc)
• Timely, accurate and ongoing communication to all parties
• Contract to attend at least 3 sessions
• Continuity of therapists (appealing, but no evidence)
Aftercare

• Definite, prompt follow-up appointment time at time of initial assessment (e.g. DSH clinics)
• Written communication to aftercare agency summarising circumstances of presentation, results of assessment and treatment
• Reminder phone calls or home visit if patient defaults
Non-medical treatments that work?

• Intensive follow-up improves adherence.
• ‘Green card’* improves adherence, reduces repeat DSH esp. for first time attempters, and regular postcards reduce repetition
• Psychological therapies:
  • Dialectical behaviour therapy is useful for multiple episodes in Borderline PD
  • (group and individual) CBT & problem-solving therapy, Brief Interpersonal Therapy, cognitive behavioural family therapy are all promising
• (*Wallet-size card with time and date of appointment with a named mental health professional, 24 hour crisis numbers, invitation to return to ED if in crisis)
Drug treatments that work?

- Antidepressant, antianxiety and antipsychotic medications may be required, but can be used for overdose.
- Need newer antidepressants (less toxic in overdose) with adequate dose and duration (1st episode 4-6/12, 2nd 18-24/12, 3rd = maintenance).
- Lithium and clozapine are also antisuicidal.
Evaluation of suicidal ideation and behaviour

- Recognition
- Respectfully eliciting the story
- Risk assessment
- Responding
Psychiatric hospitalization

- For Specific imminent suicide plans, esp. associated with impulsivity or profound hopelessness, nihilism
- Active psychotic illness
- Risk associated with alcohol or drug intoxication
- May need to be compulsory, but emphasise that this is not punishment
- Lack of social support also an indication
- NB acute vs. chronic, problems with regression, risk of reinforcing undesirable behavior
What to tell family and friends:

• taking suicidal behaviour seriously
• ‘warning signs’ form index of suspicion regarding likelihood of suicidal thoughts or behaviour. Family, friends and carers take note of changes in behaviour, talk, emotions and assess whether there is something to be concerned about.
• listening and being alert for calls for help (part of them wants to live, part wants to die)
• doing pleasant things, avoiding conflict
• keeping routines going where possible
• removing means of suicide where possible (guns)
• getting suicidal person to professional help, and
• seeking support and help for oneself.
What to tell family and friends:

- If this is so, it is important to ask if the young person is contemplating suicide – suicidal people already have the idea, so bringing it up will not ‘give them ideas’, but give them a chance to share what most distresses them, and connect to someone.
- If a recognised situation of imminent risk, clarify intentions, don’t leave them alone, and don’t keep suicidal plans secret.
- Let suicidal people know how much they mean to you (while also acknowledging that their depression may prevent them understanding or believing this), and how terrible it would be if they did commit suicide.
Look, listen and talk

• Look for behaviours that may indicate that a young person is not travelling well.
• Communicate with the person by listening and talking about their troubles.
• Take action by promoting the different places they can get help.
What to tell suicidal people:

- Suicidal thoughts will pass. They come and go.
- Connection is vital. Get support from loved ones, friends and professionals, even though it may be the last thing that you feel like doing.
- Treatment for the problems that make you feel like this is also critical. If you don’t immediately find someone to help you, don’t give up looking.
- Drugs and alcohol increase depression and impulsivity and impair personal judgement, so don’t use them; and
- Don’t think family or friends would be better off without you: your suicide would profoundly affect them for the worse.
What to tell suicidal people:

- Identify (possibly with the assistance of your parents or friends), a safe place or activity, so that you can cool down and not be harmed. This can be actual or imaginary. Also identify key people who could help you.
Services

- GP
- Community Health Centres
- Mental Health Services (in SE Sydney, Adolescent Service, Prince of Wales Hospital)
- crisis lines (Lifeline, Kids Helpline, Youthline)
- websites (usually not for counselling)
- hospital emergency departments
Websites

- E.g.
- Reachout (www.reachout.com.au)
- beyondblue (www.beyondblue.org.au)
- MoodGYM
- SANE
- Black Dog
- Mental Health Association NSW
- Suicide Prevention Australia (see Links on this site for help and for a comprehensive listing of mental health websites relevant to many different community groups)
Take away messages

• Mental health problems in adolescence can be serious
• Effective interventions are available
• It is best to ask for help early, since this gives a better chance for effective intervention
• Persist with attendance. If you have problems with the service, tell them
• .
References


Joiner, T. (2009) *Suicide Prevention in Schools as Viewed Through the Interpersonal - Psychological theory of Suicidal Behaviour*. School Psychology Review 38, 2, 244 -248


