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The National Centre of Excellence in Youth Mental Health

Clinical practice in depression and suicide

Managing ongoing suicidality in young people diagnosed with Major Depressive Disorder (MDD)

Introduction

Around 25% of those who develop a depressive disorder do so by the age of 20 (Thapar, Collishaw, Potter, & Thapar, 2010). Around 40 to 80% of young people diagnosed with Major Depressive Disorder (MDD) are thought to experience suicidal ideation, or engage in self-harm, including suicide attempt (hereafter together termed suicidality), at some point during their experience of mental ill-health (Cash & Bridge, 2009). Furthermore, around 60% of young people who die by suicide are thought to have a diagnosable episode of MDD at the time of their death (Fleischmann, Bertolote, Belfer, & Beautrais, 2005).

Assessing and managing ongoing suicidality can be a particularly daunting task for clinicians. There is the need to balance issues regarding confidentiality and duty of care, while maintaining engagement and rapport, as well as undertaking ongoing self-management planning to manage suicidality (hereafter termed self-management planning) and providing appropriate psychosocial interventions. The lack of predictive validity of standardised tools means that risk assessment for the purpose of a) risk stratification, and b) as a basis for the allocation of treatments, should not be done (Mulder, Newton-Howes, & Coid, 2016). Rather, clinicians need to engage in psychosocial assessments focused on identifying modifiable risk factors that are contributing to suicidality, in order to guide decisions about the evidence based treatments that should be allocated, on the basis of this assessment.

This clinical practice point is designed to help clinicians who work with young people diagnosed with MDD and may be at risk of suicide to:

- engage young people who are suicidal
- assess suicidality in young people
- develop a self-management plan to manage suicidality
- gain an understanding of the role of Cognitive Behavioural Therapy (CBT) in the treatment of suicidality
- manage ongoing suicidality
- understand the importance of self-care in clinicians.

Assessing and managing ongoing suicidality can be a particularly daunting task for clinicians.

Engaging young people who are suicidal

Early engagement and establishing a trusting therapeutic alliance is critical when working with suicidal young people. Rice et al (2014) have identified the following as being important in this engagement and consistency of care*:

- building therapeutic alliance and trust early in treatment and practice in a collaborative manner (e.g. by negotiating engagement and encouraging the young person to express their opinions, preferences and concerns in treatment planning)
- attending to any engagement barriers (e.g. past negative experiences of treatment or low expectation of treatment) and considering assertive outreach via home and school visits
- being flexible in engagement, for example through text messages or phone contact, or through trusted third parties (e.g. family, General Practitioner (GP), school counsellor)
- offering therapeutic consistency through clinical predictability and dependability (e.g. the young person's awareness of the clinician commitment to longer term treatment especially where initial treatment was unsuccessful).

*Adapted from Rice, SM, Simmons, MB, Bailey, AP, Parker, AG, Hetrick, SE, Davey, CG, Phelan, M, Blaikie, S and Edwards, J 2014, 'Development of practice principles for the management of ongoing suicidal ideation in young people diagnosed with major depressive disorder', *SAGE Open Medicine*, vol. 2, doi: 2050312114559574.

Assessment of suicidality in young people with MDD

Clinicians working with young people experiencing a MDD should regularly assess and monitor for the presence of suicidality, particularly in the context of new and ongoing antidepressant medication. When antidepressant medication is started, suicidality should be monitored once a week for four weeks, and then every two weeks thereafter ((NICE), 2015). If the prescribing professional is not able to do this, then they should collaborate with other treating professionals (e.g. case manager, psychologist) to ensure that this monitoring is put in place.

A psychosocial approach to the assessment of suicidality focuses on assessing the young person's situations and needs in order to inform treatment planning

Historically, if the presence of suicidality is detected, the risk of future suicidality has then been assessed using standardised suicide risk scales. These tend to lead a clinician through various risk factors associated with suicidality and subsequently categorise risk as high, medium or low. However, in clinical practice such assessment measures have shown to be poor at predicting risk, and can also detract from forming a therapeutic relationship (Large et al., 2016; Mulder et al., 2016; Quinlivan et al., 2016; Smith et al., 2015).

A psychosocial approach to the assessment of suicidality focuses on assessing the young person's situations and needs in order to inform treatment planning (Hawgood & De Leo, 2016). It is done in collaboration with the young person, and allows for more of a focus on the therapeutic relationship.

Engaging young people in a psychosocial risk assessment

A collaborative approach, whereby the young person is seen as the expert in understanding their own experience and the clinician strives to see the experience through that young person's eyes, is essential when undertaking a psychosocial risk assessment. Alongside engaging with the young person, strategies for undertaking a psychosocial risk assessment include*:

- taking an interested, curious and non-judgmental stance
- asking open-ended questions
- ensuring that you put the young person at ease
- creating an atmosphere in which the young person feels comfortable to disclose their thoughts
- normalising suicidal or self-harm cognitions as a common consequence of depression to assist in open discussion, assessment and self-management planning.

*Adapted from Hetrick, S, Parker, A, Bailey, A, Cahill, S, Rice, S, Garvin, T, Phelan, M and Davey, C 2015, *Cognitive-behavioural therapy for depression in young people: a modular treatment manual*, Orygen, The National Centre of Excellence in Youth Mental Health, Melbourne.

Risk and protective factors for suicide

Knowledge of distal and proximal risk factors, as well as protective factors is critical and must be assessed as part of a psychosocial assessment (see Table 1 on page 3).

Table 1: Distal and proximal risk factors alongside protective factors for suicide in young people.

Distal risk factors	Proximal risk factors
Psychiatric • Depression • Substance use • Conduct disorder • Schizophrenia • Anxiety disorders • Personality disorders • Eating disorders Behavioural • Previous self-harm, suicidal ideation or suicide attempt Social & familial • Family history of self-harm, suicidal ideation, suicide attempt or death by suicide • Childhood adversity/trauma • Cultural background • Living in a rural/remote location • Living in statutory care • Interpersonal difficulties • Poor peer relationships • LGBT and gender diverse young people Psychological • Impulsivity • Poor problem solving • Hopelessness • Self-hatred Other • Poor physical health or disability	Adverse life events • Relationship difficulties • Interpersonal losses • Conflict (parents; peers; boy/girlfriends) • Ongoing exposure to bullying • Legal problems • Financial problems • Recent death of a family member or close friend • Suicide-related behaviour in others, especially in school settings Intoxication Availability of means Certain types of media reporting
	Protective factors
	• Awareness of and access to clinical and health services • Positive relationships and social support from family and friends • Connections to other non-parental adults • Effective problem solving skills • Overall resilience • A sense of safety at school and in the community. • A feeling of belonging (e.g. to community, culture, religion) • Academic achievement

Factors to consider when assessing suicide risk include*:

- mental state
- withdrawal and isolation
- recent significant stressors
- suicidal thoughts, suicidal behaviours or exposure to the death of another person by suicide
- access to means of suicide
- coping skills
- supports and help-seeking capacity
- reasons for living and barriers to self-harm.

*Adapted from Cognitive-behavioural therapy for depression in young people: A modular treatment manual, Orygen.

Questions to help understand suicide related behaviour:

- Have you thought about ending your own life?
- What has happened that makes life not worth living?
- What specifically have you thought about doing to yourself?
- Have you taken any steps towards doing this?
- Have you thought about how/when/where you might do this?
- Have you thought about how your death would affect your family and friends?
- Have you spoken to your friends/family about how you feel?
- Have you ever tried to end your life before?
- Have you ever made a plan to end your life in the past?

- What has stopped you from acting on your thoughts so far?
- What makes it more likely that you will act on your suicidal feelings?

Careful assessment of previous suicidality is particularly important as overall seriousness of ideation, extent of preparatory planning, access to means and impulsivity are thought to play a role in the transition from suicidal ideation to suicide attempt (O'Connor, 2011). In addition, clinicians should also seek to obtain corroborative information from others, and integrate this into their psychosocial assessment, including of suicide related behaviours.

Developing a self-management plan

A self-management plan, which has more commonly been called a safety plan, aims to help a young person manage distressing and painful emotions and to prevent an escalation in their thoughts of suicide (Stanley & Brown, 2012). Clinicians should collaborate with the young person to develop a self-management plan which aims to a) identify their warning signs of suicidality, and b) develop coping strategies and supports to use in order to prevent an escalation in their suicidality. Young people with depression who present with some suicidality, but without any particular plan or intent, may still benefit from a self-management plan.

When developing a self-management plan, clinicians should:

- Provide a rationale to the young person as to why it is important to have a self-management plan (e.g. it aims to prevent distressing and painful emotions escalating, can help to ensure their safety during times of crisis, and highlights the seriousness of suicidal behaviour as well as the understanding that such behaviour is manageable).
- Identify warning signs and vulnerability factors (e.g. thoughts, behaviours and emotions that may precede suicidal behaviours, lack of sleep, substance use).
- Assist the young person to identify and develop internal and external coping strategies. Internal coping strategies are those that the young person can engage in alone (e.g. self-soothing, pleasant activities) and external ones are those that require the assistance of another person (e.g. talking to a friend). The self-management plan should also include contact details for professional services available to the young person, such as their clinician, after-hours support services, suicide helplines and local emergency services.
- Identify potential obstacles around each coping strategy and how to overcome these.
- Involve others in the development of the self-management plan, such as immediate family or those in their social network and provide them with a copy of it. Respecting confidentiality is important, however if there are significant concerns about suicide risk, there are usually sufficient grounds for breaching it.
- Ensure that the environment is made safe for a young people who has clear suicidal intent and a plan. Discuss the availability of potentially lethal means (such as paracetamol, other medications, sharp objects or rope), and ask the young person to remove these items from their environment.
- Integrate the self-management plan into ongoing therapy. It should be reviewed during future sessions, especially if the young person has needed to use the self-management plan. Reviewing the plan provides an opportunity to identify coping strategies that might be ineffective, or to discuss barriers to their use. Strategies in the plan can be updated as the young person learns and develops new coping skills, such as relaxation techniques and problem-solving skills.

Discuss with the young person whether they would like an online self-management plan. As young people are frequent users of technology, online planning apps offer the opportunity for them to access them anytime, anywhere (https://www.beyondblue.org.au/get-support/beyondnow-suicide-safety-planning).

Box 1: Responding to acute risk of suicide

If on the basis of a psychosocial risk assessment, a clinician is not confident that the young person is able to keep themselves safe, clinicians should consult senior members of their team. An inpatient admission or intensive after-hours follow-up may be required. Ideally, parents or other responsible adults should be involved in this process.

Effective treatment for suicidality in MDD: CBT for Suicide Prevention (CBT-SP)

CBT is the most thoroughly researched psychotherapy for young people with MDD (Callahan, Liu, Purcell, Parker, & Hetrick, 2012) , and one of the most effective treatments (Weisz et al., 2017; Weisz, McCarty, & Valeri, 2006). Although the evidence base is still evolving, CBT is one of the few treatment interventions shown to reduce suicidality among young people (Cox & Hetrick, 2017; Hetrick, Robinson, Spittal, & Carter, 2016). In addition, interventions that have a specific focus on suicidal thoughts and behaviours are more effective in both the short and long term, compared

with treatments that address symptoms associated with suicidal behaviours only, such as depression and anxiety (Meerwijk et al., 2016).

Components of CBT designed to specifically address suicidality include*:

- chain analysis
- psychoeducation
- addressing reasons for living and building hope
- case conceptualization in order to inform skill building (within this, standard CBT techniques can be used such as behavioural activation, mood monitoring, emotion regulation and distress tolerance, cognitive restructuring, problem solving, goal setting, building social support and assertiveness skills)
- family sessions
- relapse prevention.

*Adapted from Stanley, B et al. 2009), "Cognitive behavior therapy for suicide prevention (CBT-SP): treatment model, feasibility and acceptability', *Journal of the American Academy of Child and Adolescent Psychiatry*, vol. 48, no. 10, pp. 1005–1013.

Management of ongoing suicidality in young people with MDD

Ongoing suicidal ideation reflects a fluctuating pattern of unremitting, or partially remitting, sub-acute suicidality (Rice et al., 2015), which although requires ongoing monitoring and intervention, but does not meet the threshold for referral to an inpatient unit. Clinicians need to work out ways to manage a particular individuals chronic suicidality, given that it tends to be less responsive to initial psychosocial or pharmacological treatment (Bryan & Rudd, 2006). This might mean longer term management including ongoing monitoring and self-management planning in the longer term, potentially augmented with family support.

Ongoing suicidality, as well as the modifiable risk factors that are related to this suicidality, and clear documentation of this is needed with such young people, including maintaining a clear chronology of changes to presentation. Clinicians should be mindful that repeated assessments of suicidality can be frustrating for young people, however they are important in the context of ongoing treatment, and when antidepressant medication has been started. Clinicians may use an 'abbreviated' form of psychosocial risk assessment, whereby they reflect back the young person's previous experience of suicidality back to them, and then enquire about any changes to this (Rice et al., 2015). Clinicians may also choose to use the PHQ-9 or an online monitoring tool (Hetrick et al., 2017) in order to address fluctuations in suicidality. However, such tools should be used as an opportunity to prompt further conversation with the young person, rather than a stand-alone risk assessment measure.

Clinician self-care

Outpatient treatment of young people who report ongoing suicidality is often anxiety provoking and emotionally demanding for mental health clinicians (Wortzel, Matarazzo, & Homaifar, 2013). The assessment, management and treatment of suicidal young people rates among the most stressful tasks of a clinician (Berk et al., 2014). This is largely due to the need to balance and attend to competing, and at times opposing, issues of client confidentiality, therapeutic rapport, duty of care, self-management planning and intervention, direct involvement of caregivers and disclosure of risk to crisis or emergency services. Appropriate clinician support (i.e. consultation and supervision), and maintenance of clinician self-care and wellbeing is essential for those treating suicidal young people.

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