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Webinar

Suicide ideation in primary school-aged children

Tuesday 12 February 2019

“Working together. Working better.”

Supported by The Royal Australian College of General Practitioners, the Australian Psychological Society, the Australian College of Mental Health Nurses and The Royal Australian and New Zealand College of Psychiatrists

Tonight's panel



Dr Andrew Leech
General Practitioner



Ms Ellen Sinclair
Mental Health Nurse



Dr Huu Kim Le
Psychiatrist

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at the bottom right of
your screen to chat with
other participants.

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Dr Lyn O'Grady
Community Psychologist



Facilitator: Mr Dan Moss
Workplace Development Manager –
Emerging Minds

Ground Rules

To ensure everyone has the opportunity to gain the most from this live event please:

- **Be respectful of other participants and panellists:** behave as you would in a face-to-face activity.
- Interact with each other via the **chat box**. As a courtesy to other participants and the panel, please keep your comments on topic. Please note that if you post your technical issues in the participant chat box you may not be responded to.
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- If there is a significant issue affecting all participants, you will be alerted via an announcement.

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dialling this phone number
1800 896 323
Passcode: 1264725328#

Learning outcomes

Through an exploration of suicide ideation in primary school-aged children this webinar will provide participants with the opportunity to:

- Identify factors that are likely to increase the risk of suicidal thoughts in primary school-aged children
- Implement a referral pathway that allows the development of a collaborative mental health plan for primary school-aged children who have suicidal ideation
- Describe protective factors within families, schools and communities that can assist prevention of suicide ideation in primary school-aged children

Supporting resources
are in the library tab at
the bottom right of your
screen.

Psychologist's perspective

Child suicide risk – initial thoughts

- The thought of child death by suicide is a confronting one.
- It challenges ideals we hold about how children grow and develop.
- Children's understandings of death and their capacity to have the intent to suicide can leave adults uncertain about children's risk of suicide.



Dr Lyn O'Grady

Psychologist's perspective

Statistics – what do we know – and don't know yet?

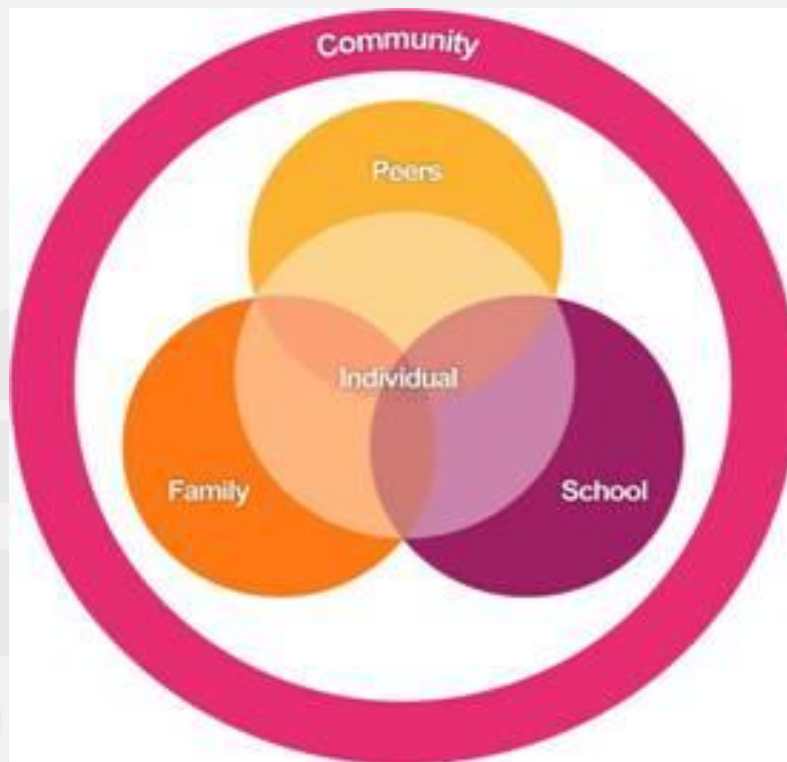
- 98 deaths by suicide occurred in Australia in 2017 in the age group 5 – 17 years.
- In 2017, suicide in Australia remained the leading cause of death of children between 5 and 17 years of age.
- This represents a 10.1% increase in deaths from 2016.
- In the period 2010 – 2014, 305 deaths of children aged 5 – 17, 88 deaths in children aged 5 – 14 (43 males, 45 females)
 - Underestimation?
 - Aboriginal and Torres Strait Islander children and young people much more likely to die by suicide (as in the adult population)
 - Statistically speaking this is a small number – difficult to make big claims or use it to fully understand what's happening
 - Suicidal ideation/thoughts/talk is reported to be very common



Dr Lyn O'Grady

Psychologist's perspective

Bronfenbrenner's socioecological model



Children develop within the context of relationships – the family is the most significant influence on children's mental health.

This is clear in the case study with Joshua appearing to be significantly impacted by his family circumstances. He feels “left out and unimportant” and believes that “no-one cares about him.”



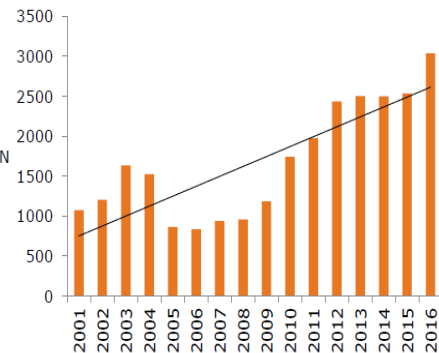
Dr Lyn O'Grady

Psychologist's perspective

Kids Helpline Data

Kids Helpline 2001-2016

Suicide contacts aged 14 years or younger



In 2016, 27.6% of all suicide-related contacts were with children aged 14 or younger

Many of these contacts are with children aged 14 or younger.

Suicidality amongst this young age group is a significant issue, but not a new issue – we have been responding to it for more than 15 years.



I thought the younger group may have received less help because they were experiencing less severe problems.

But from what they told us, that was not the case.

Children in the younger group were just as likely to have made a suicide plan or attempted suicide as those in the older group.

Have you ever made a suicide plan or attempted suicide?

		Made a suicide plan	Attempted suicide
Age	14 and younger (n=136)	82%	54%
	15 - 19 (n=185)	80%	56%

Did you receive help when you were thinking about suicide?

		Yes	No
Age	14 and younger (n=138)	26%	74%
	15 - 19 (n=191)	42%	58%

(χ^2 (1,329)=9.313, p=.002)

Less than half the respondents to our consultation survey had received any kind of help.

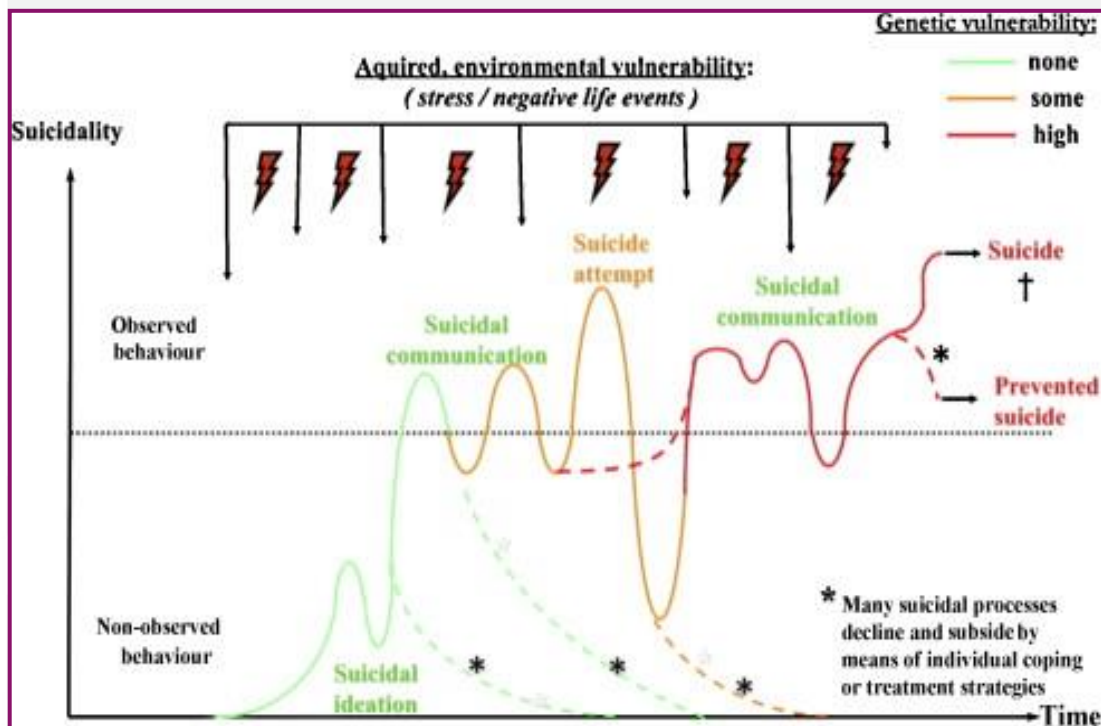
Younger children were significantly less likely to have received help than older teens – only 26% had received any kind of help.



Dr Lyn O'Grady

Psychologist's perspective

Opportunities to intervene (Wasserman & Wasserman, 2012)



Hearing the suicidal patient's emotional pain

1. Unspoken and unheard – invisible, alienated, wordless
2. Spoken but unheard – depersonalised, distracted
3. Spoken and heard – individualised, bolstered, co-bearing
4. Unspoken but heard – openness, impact, relief-seeking, connection

Dunkley, et al., 2017.

In the case study, it's clear that Joshua is feeling invisible and alienated. Finally, he has spoken the family doctor – it's now up to the adults to hear his distress and act to help and protect him.



Dr Lyn O'Grady

Psychologist's perspective

Suicide attempts - significant impact on families

- Lachal, Orri, Sibeoni, Moro, & Revah-Levy (2015) conducted a systematic review of qualitative studies of views of parents of suicidal young people.
- They found that “the family experiences their child’s first suicide attempt in a way resembling the youth’s experience:
 - loss of hope
 - blame
 - guilt
 - self-recrimination
 - a sense of total failure
 - Rejection
 - Isolation
 - incomprehension
 - powerlessness and helplessness, loss of control.” (2015, p. 13)

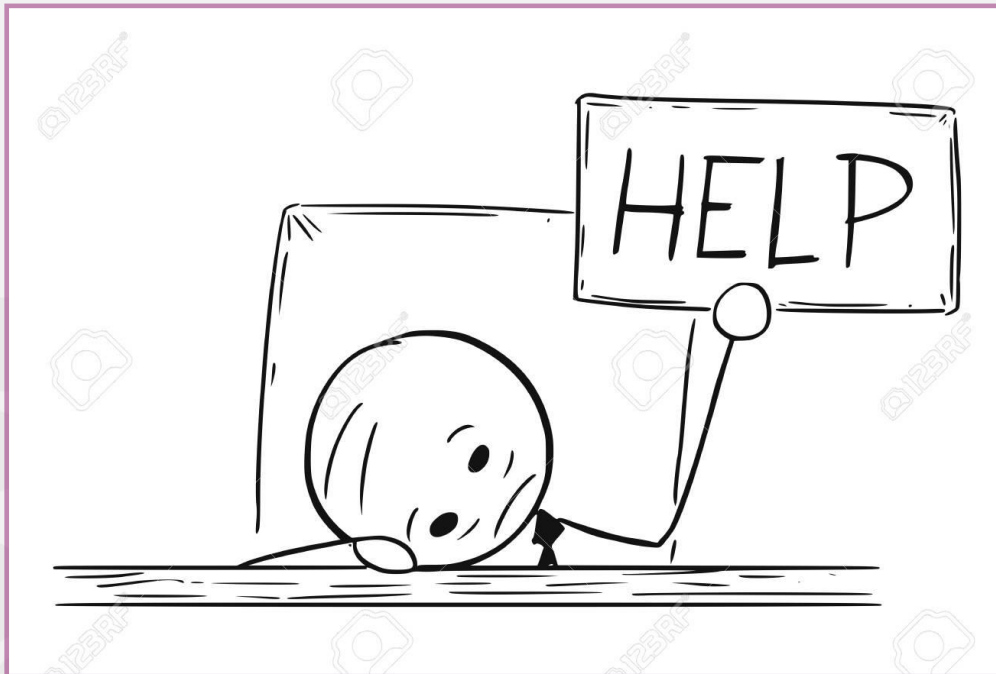
As Joshua’s family come to terms with the level of distress Joshua is feeling, it is likely that they may feel a range of feelings and responses. Parents (and teachers) will also need support to help them manage this and regain confidence in their ability to parent effectively.



Dr Lyn O’Grady

GP's perspective

The initial presentation of Joshua to his GP



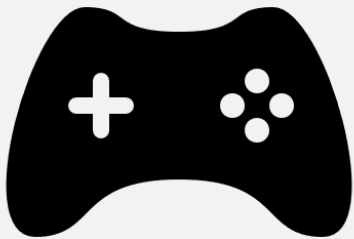
What is he trying to tell us?

How do we help Joshua to feel comfortable enough to open up about what is happening in his most vulnerable state?



Dr Andrew Leech

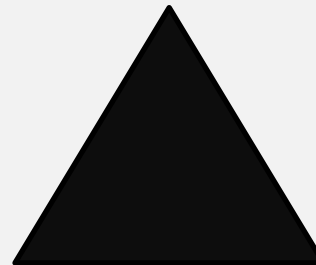
GP's perspective



Resilience

Negative
influences

Positive
influences



Dr Andrew Leech

GP's perspective

Assessing risk

- Ensuring a careful, non-intrusive, developmentally sensitive approach
- Being at the ready to mobilise interventions
- Working collaboratively and inclusively

Betteridge, C. (2016). Assessing suicidal risk in children and adolescents: Adopting a developmental lens. Retrieved from [read:https://www.psychology.org.au/inpsych/2016/feb/betteridge](https://www.psychology.org.au/inpsych/2016/feb/betteridge)



Dr Andrew Leech

GP's perspective

Medical screening

- Blood tests and consider imaging
- Diet and sleep
- Technology
- Developmental problems (?ADHD)



Dr Andrew Leech

GP's perspective

GP management of Joshua

- Safety netting with close / regular follow up
- CAMHS referral
- 24/7 contact numbers
- Support for Mum and family
- Mental health care plan



Dr Andrew Leech

Mental Health Nurse perspective

Mental Health Nurse in primary care

- Team Case Management: Patient (Joshua), Parent (Emily), GP, Mental Health Nurse
 - Therapeutic engagement
 - Safety
 - Biopsychosocial assessment
 - ✓ Collaborative goal setting
 - ✓ Monitoring
- New patient 50mins
- Review patient 30mins vs GP 6-15mins



Ms Ellen Sinclair

Mental Health Nurse perspective

Therapeutic engagement

- Significant clinical importance and the crux of the nurse - patient relationship

Peplau HE. Interpersonal relations: a theoretical framework for application in nursing practice. Nurs Sci Q. 1952;5:13–18.

- Boundaries/ transference/countertransference
- Expectations of my involvement
 - ✓ Assist with facilitating access to psychologist/social worker, psychiatrist, Child & Adolescent Mental Health Service, family assistance
 - ✓ Practical suggestions
- Validation and support of mother/stepfather



Ms Ellen Sinclair

Mental Health Nurse perspective

Safety

- Thoughts of self-harm
- Thoughts of suicide
 - direct questions
 - plan, means, strength of urge
 - protective factors/ relationships
 - ? abuse-physical/verbal/sexual/neglect
- Refer to Child & Adolescent Mental Health Service if in crisis



Ms Ellen Sinclair

Mental Health Nurse perspective

Biopsychosocial assessment

- General health - ? pain, discomfort, sleep, appetite
- Opportunity for Joshua to tell his story
 - Previous counselling
 - Gaming
 - Relationships – school/sister/mum/step dad
 - Loss – dad, contact with paternal grandparents, position in family
 - Powerlessness
 - Isolation – physical /emotional, any other extended family/mentor available?
 - Ask for permission to summarise at the end of session with his mother present.



Ms Ellen Sinclair

Mental Health Nurse perspective

Treatment plan

- Collaborative Goal Setting
- Referral to psychologist/ social worker/CAHMS
 - Individual vs Family Therapy
- Monitoring



Ms Ellen Sinclair

Psychiatrist's perspective

School of Ryan/Large et al.

Suicide risk assessments don't prevent suicide

18 October 2017

Categorising a patient's risk for suicide isn't working.

According to research published today in current system of categorising a patient's isn't effective.

ECTIVE
Suicide risk assessment: myth and reality

he or not to be, that is the question –

Suicide risk categorisation of psychiatric inpatients: what it might mean and why it is of no use



Suicide risk assessment: where are we now?

A definitive way to identify patients who will suicide remains elusive

Christopher J Ryan
MB BS, MHL, FRANZCP,
Senior Clinical Lecturer¹

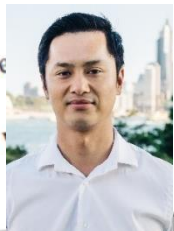
Matthew M Large
BSc(Med), MB BS,
FRANZCP,
Senior Clinical Lecturer²

Patients who present in psychological crisis or after a suicide attempt are more than 50 times more likely than the general population to die by suicide in the following year.^{1,2} They require careful assessment and management. Numerous publications suggest, and some health department policies insist, that such patients should

is at best unhelpful and at worst will be useful and needed psychiatric care. this is so and outline what we believe instead.

Although patients presenting after crisis have a greatly increased pr

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Christopher J Ryan Discipline of Psychiatry and the Centre for
Sydney, Australia



Dr Huu Kim Le

Psychiatrist's perspective

Clinical assessment in CAMHS setting

- Suicidal ideation a common presentation but completed suicide rare
- Did Joshua have any past history of suicide attempts?
- Does he meet the clinical criteria for a mental illness?
e.g. hopelessness, worthlessness, excessive guilt?
- Any current plans to end his life? Method? Suicide notes?
- What is keeping him alive?
- Does he want to die or want to disappear?
- Priority groups in CAMHS: Guardianship Minister + Aboriginal/Indigenous



Dr Huu Kim Le

Psychiatrist's perspective

Other questions family/development history

- Is there a family history of mental illness and suicide?
- Did his father suicide?
- Are there reports from the psychologist after 6 sessions? Did he find this useful?
- What happened developmentally? Did mother have post natal depression? Was he a planned pregnancy? Any complications? Milestones?
- What is his relationship like with Travis? Appears distant.
- Have they considered medication?



Dr Huu Kim Le

Psychiatrist's perspective

Working clinical formulation

- 10 year old male who has a past history of major depression. He is showing signs of a relapse of his depressive disorder, with poor concentration, more withdrawn and poor social connections. There has been a loss of activities.
- I suspect there is a biological predisposition to mental illness.
- In addition to the loss of his father, there have been multiple losses; loss of parentified role, loss of connection with mother, loss of connection with paternal grandparents.
- I do wonder if he is using online games as a means to escape/seek connection and would like to explore this further.

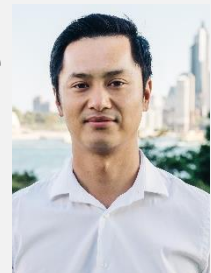


Dr Huu Kim Le

Psychiatrist's perspective

Discussing antidepressants

- Would I prescribe antidepressants for Joshua? (Unlikely, with the current information and without a current mental state examination)
- I would prefer psychological therapy first
- If no improvement, then combination with SSRI (usually fluoxetine)
- Start with low dose to minimise side effects and risk
- I am conservative for primary school-age children like Joshua (SSRI use more common in teens)
- CAMHS policy must be seen within 2 weeks of commencement to minimise “Black Box” concern around increased suicidality
- [Black Dog Institute guide for prescribing in teens is useful](#) – see resources for more details



Dr Huu Kim Le

Q&A



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