phn NORTH WESTERN MELBOURNE

An Australian Government Initiative

Child mental health CoP Session 3: Depression, Suicidality & Self-harm

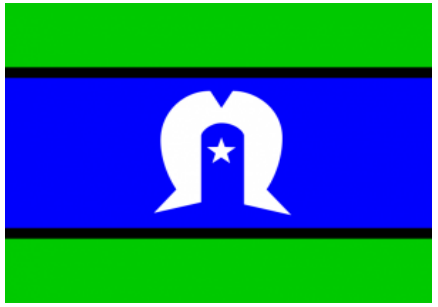
Tuesday 5 September 2023

The content in this session is valid at date of presentation

Acknowledgement of Country

North Western Melbourne Primary Health Network would like to acknowledge the Traditional Custodians of the land on which our work takes place, The Wurundjeri Woi Wurrung People, The Boon Wurrung People and The Wathaurong People.

We pay respects to Elders past, present and emerging as well as pay respects to any Aboriginal and Torres Strait Islander people in the session with us today.

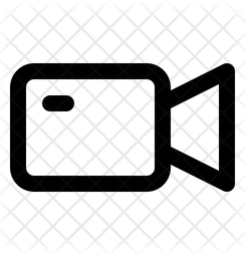


CoP guidelines
We agree to…

Stay on **mute** unless speaking

Raise your **hand** to speak

Keep conversations **confidential**



If possible, keep **camera on**

Introduce yourself and your role when speaking

Share **ideas** & promote everyone's **participation**

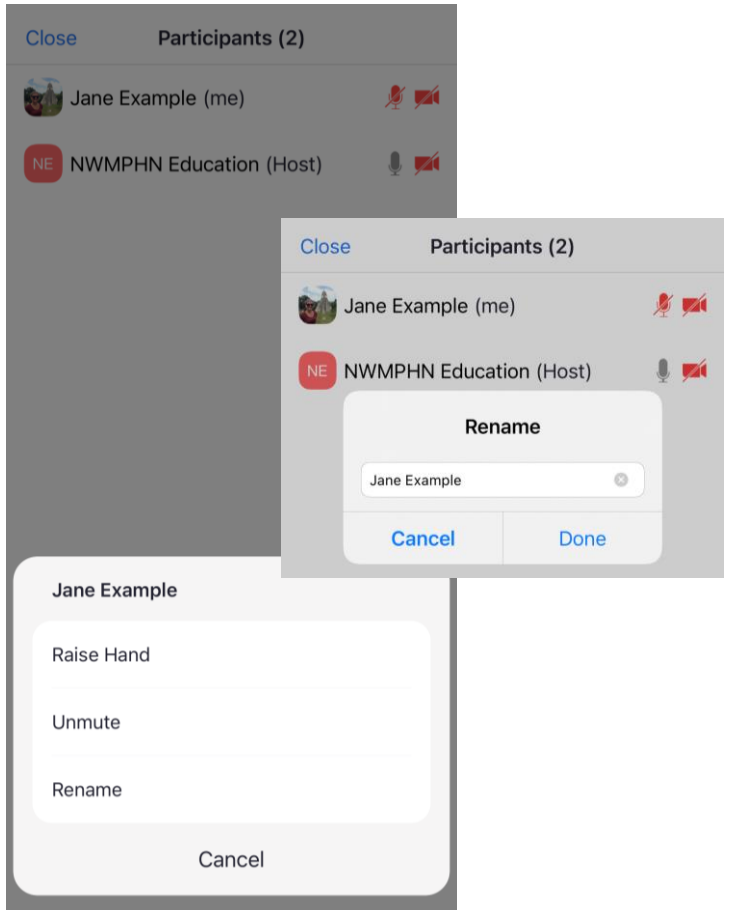
Acknowledge that we have **varied learning needs & interests**

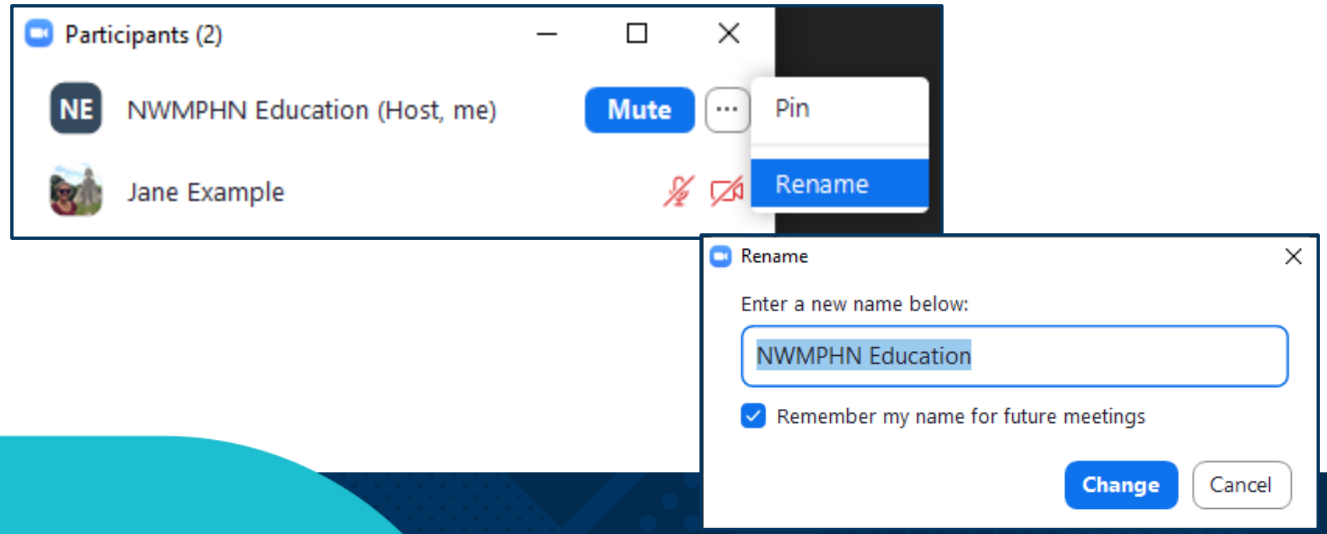
Ask **questions**

No question is silly

How to change your name in Zoom Meeting

1. Click on ***Participants***
2. **App:** click on your name
   Desktop: hover over your name and click the 3 dots
   Mac: hover over your name and click *More*
3. Click on ***Rename***
4. Enter the name you registered with and click
   Done / Change / Rename





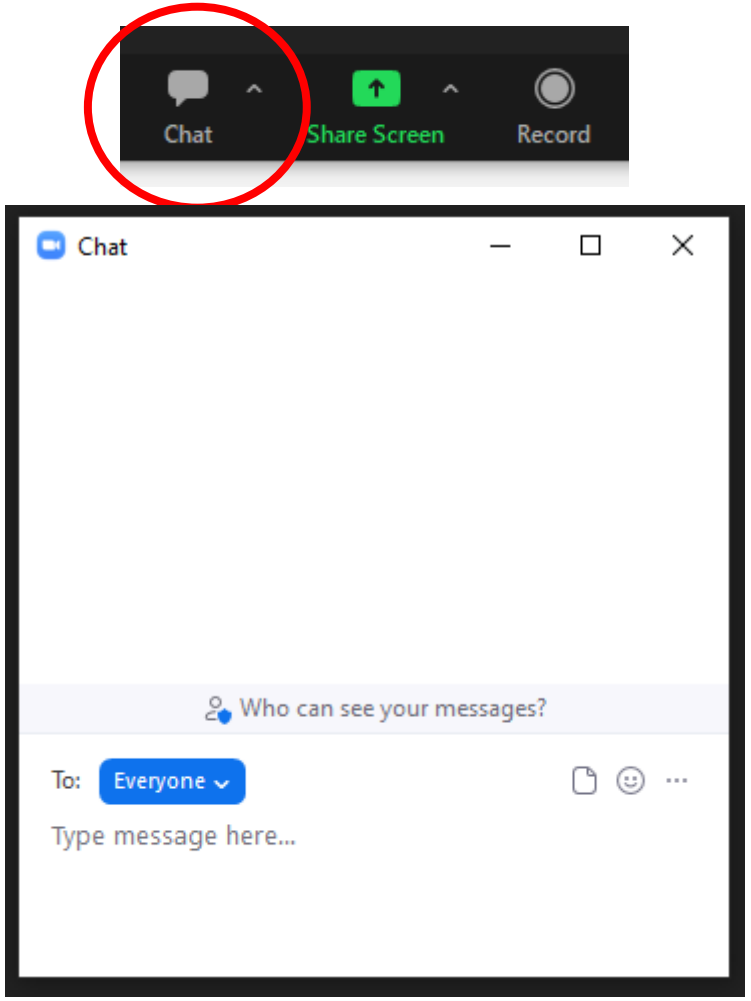
Housekeeping – Zoom Meeting

During the education component, please ask questions via the Chat box

This session is being recorded

Please ensure you join the session using the name you registered with so we can mark your attendance

Certificates and CPD will not be issued if we cannot confirm your attendance



Psychiatrist – Dr Chidambaram Prakash

- Dr Chidambaram Prakash is a senior consultant child and adolescent psychiatrist at the RCH with over 20 years' experience.
- Prakash has worked in, and managed, general and specialist clinics within child psychiatry in metropolitan and regional public mental health services.
- Prakash has worked with children and adolescents from 4 to 18 years of age assessing and managing a variety of mental health issues.

GP Facilitator - Dr Sahar Iqbal

- Practicing as a GP at Goonawarra Medical Centre for the past 9 years

- Sahar's areas of interest are child and adolescent mental health and chronic disease management

Agenda

Introduction and housekeeping	5 minutes
Education component: Depression, suicidality & self-harm *Psychiatrist Dr. Chidambaram Prakash*	30 minutes
Health Pathways	5 minutes
Case discussion Part 1 – Breakout room **Debrief**	12 minutes 10 minutes
Case discussion Part 2 – Breakout room **Debrief**	12 minutes 14 minutes
Conclusion	2 minutes

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Education component:

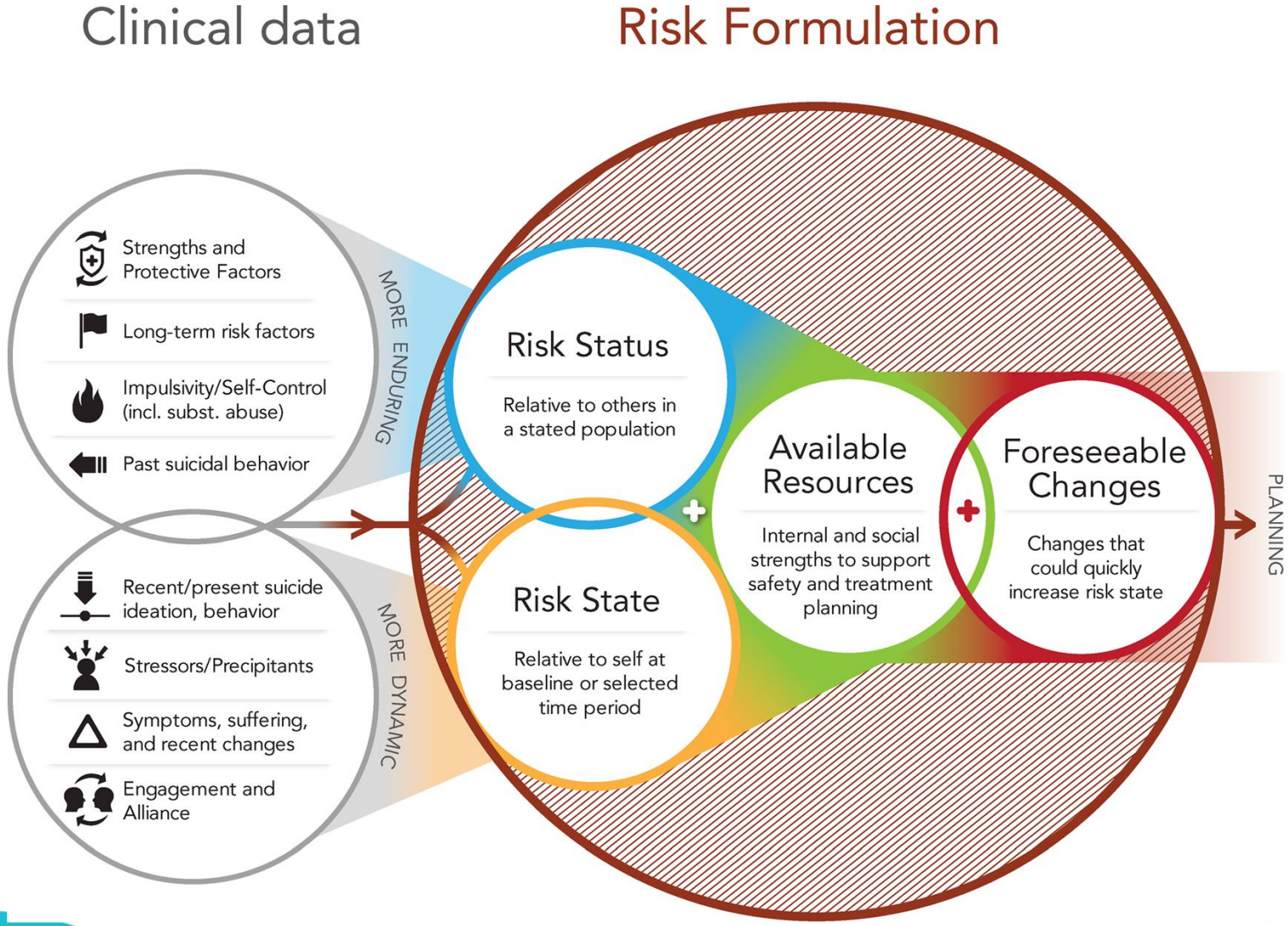
Management of Depression and Suicide

CHIDAMBARAM PRAKASH

Formulation and its importance

- The first step post assessment is to create a formulation.
- Formulation helps guide the focus of treatment especially the psychological therapy in depression.
- It helps choose the type of therapy that is most likely to be useful for the consumer
- Ratings of suicide risk based on a Likert type low, moderate and high prediction focused scale is not evidence based
- A more useful approach is the creation of a risk formulation that is based in the aim of prevention rather than prediction.

Risk formulation to prevent risk of suicide



Phases of treatment of depression

Acute phase

- Acute phase treatment aims at achieving response defined as at least 50% reduction in symptoms. This period may range from 2 weeks to 2 months.

Maintenance phase

- It is aimed at consolidation of gains achieved in acute phase and prevention of relapse.

Continuation phase

- It is defined as recovery phase where the aim is to prevent any recurrence of depressive symptoms.

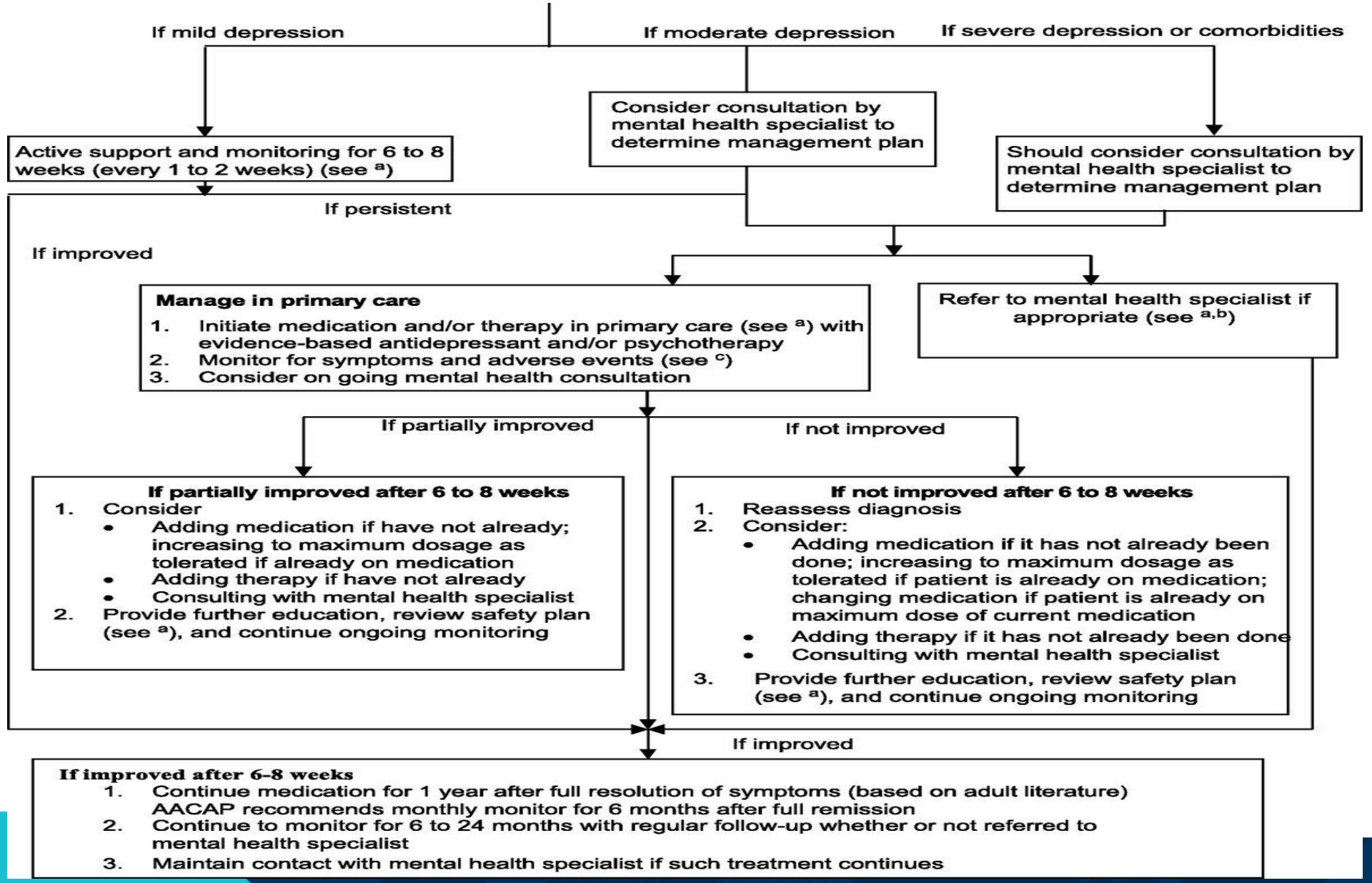
Improving insomnia and reducing suicidality

- Insomnia is significantly associated with increased suicide risk
- Studies show that sleep disturbances may be a marker of distress that leads to the suicide risk
- Multiple different types of sleep problems that are concurrent may confer greater risk for suicide than single sleep problems.
- Recommend focus on 1. Sleep disturbance screening 2. Suicide assessment and safety planning 3. Sleep treatment options in the suicidal patient
- CBT-Insomnia (CBT-I) has good evidence base but requires high levels of motivation and engagement from the consumer
- Melatonin effective in YPs with ASD and sleep problems.
- Use of Clonidine 50-200 mcgs, Zopiclone 7.5-15 mgs max.
- Use of Prazosin 1-3 mgs max in those with PTSD or trauma related nightmares

Cardiovascular exercise and depression treatment

- Physical activity is associated with decreased concurrent depressive symptoms; the association with future depressive symptoms is weak.
- This association found was stronger in cross-sectional studies than for longitudinal studies, in which the mean effect size was significant, but weak.
- PA of increased frequency and intensity was more strongly associated with decreased depressive symptoms compared with PA that was intense but not frequent

Clinical management flowchart



A brief overview of the Psychological therapies

What works in depression treatment?

- Promoting engagement in therapy through: Motivational Interviewing
- Therapeutic Assessment: a technique for crisis intervention and problem solving
- Psychoeducation is an essential part of promoting engagement in therapy
- Psychoeducation has been shown to be effective also as a stand alone intervention

What works in depression treatment?

- Routine specialist care that includes non specific individual, family and group work too has been found to be helpful.

CBT

- Numerous meta-analyses and reviews have been conducted on CBT in the treatment of adolescent depression and showed improved outcomes for subjects treated with CBT.
- Computerised (CCBT) may be a valid treatment option for young people with mild depression.

Individual Treatments

CBT-Suicide Prevention (CBT-SP):

- risk reduction, relapse prevention
- CBT, DBT and targeted therapies for suicidal, depressed youth.
- Consists of acute and continuation phases, each about 12 sessions,
- includes a chain analysis of the suicidal event, safety plan development, skill building, psychoeducation, family intervention, and relapse prevention.

Individual Treatments

- Dialectical Behaviour Therapy (DBT): teaches YPs to learn to accept life as a balance between the pleasant and unpleasant and teaches them to learn distress tolerance, mindfulness and interpersonal effectiveness skills

- Mentalization Based Therapy (MBT): Teaches young people to be aware of their own and others' mental states and learn to modulate their thoughts and actions through an improved understanding of the dissonance between their own assumptions of others and the reality.

Individual Treatments

Acceptance and Commitment Therapy teaches YPs to:

- accept automatic thoughts, sensations and urges
- defuse from thinking (ie. observe thoughts without believing them or following their directions)
- experience self as an observer of psychological experiences
- attend to the present moment with self awareness
- clearly articulate values (ie. self chosen, desirable ways of behaving)
- engage in committed action (ie. participating in values-consistent activities, even when psychologically challenging).

Individual Treatments

Interpersonal Therapy-Adolescents (IPT-A)

- IPT is a time-limited (acutely, 12-16 weeks) treatment with three phases: a beginning (1-3 sessions), middle, and end (3 sessions).
- The therapist uses specific strategies to deal with the interpersonal areas of focus and then prepares for ending the therapy by assisting the YP to gain confidence in themselves to manage their interpersonal relation ships more adaptively.

Cognitive Analytic Therapy

- CAT is a relational therapy, and focuses on the interaction between the client and therapist.
- It explores familiar roles and patterns, naming patterns in the way the person has been related to since childhood, postulating that these are replicated in current relationships and in the person's internal conversations.

Family based treatment

Attachment based family therapy

- Can be used concurrently with medication and individual therapy
- Reframes depression as occurring due to attachment rupture
- Teaches the YP and the parents over 5 tasks how to repair the attachment and enable the YP to go to their parents for comfort or assistance when feeling distressed and suicidal

Medications

SSRIs

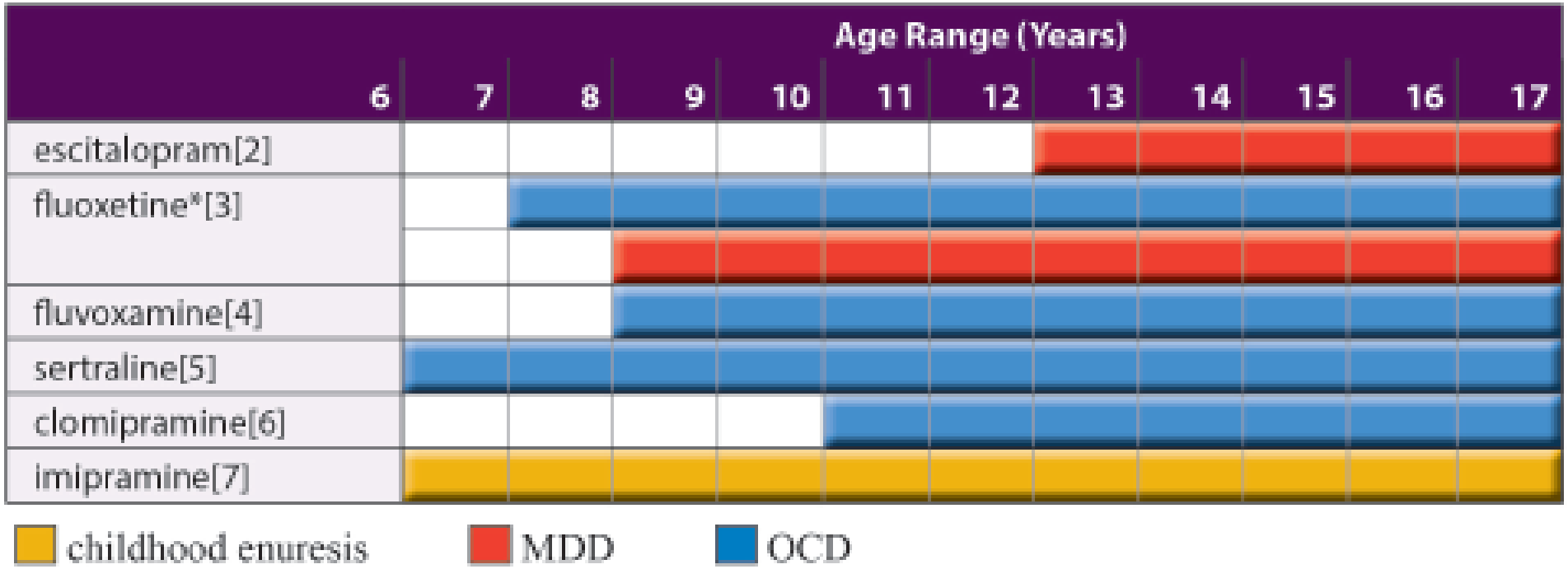
- Fluoxetine effectiveness (Emslie, Keller)
- Sertraline effectiveness (Wagner)
- Showed that adolescents can benefit from Fluoxetine even in mild to moderate depression (Gibbons 2012).
- Same review shows that all SSRIs are now equal in suicide risk. SSRIs reduce factors behind suicide risk such as NSSI, depressed mood and does not directly increase risk of completed suicide.

FDA Review of Studies for Antidepressant Drugs

- 20 placebo-controlled studies of 4100 pediatric patients for 8 antidepressant drugs (citalopram, fluoxetine, fluvoxamine, mirtazapine, nefazodone, paroxetine, sertraline, venlafaxine)
- Excess of suicidal ideation & suicide attempts when receiving certain antidepressant drugs; no suicides
- FDA could not rule out an increased risk of suicidality for any of these medications
- Data was adequate to establish effectiveness in MDD only for fluoxetine based on 2 studies (by Emslie et al)

FDA approval

Figure 1. FDA-Approved Pediatric Age Ranges and Indications for Antidepressant Medications



*Fluoxetine is FDA approved for the treatment of MDD in pediatric patients up to 18 years old.

Depression-TADS-Kennard 2009

- At 36 weeks combination of CBT with SSRI was better than either alone, CBT slightly better than FLX

- Majority of patients remitted by 9 months

Depression-TORDIA study updates June 2011- Vitiello et al

- 334 initial SSRI treatment resistant depressed teenagers (12-18 years) randomized to another SSRI (fluoxetine, citalopram, paroxetine), Venlafaxine with or without CBT.
- Most patients (2/3) remitted at 24 weeks but ¼ remitters relapsed
- Best response to SSRI+CBT
- NSSI & CSA worsened chance of suicide attempts
- Those with a h/o physical response responded poorly to SSRI + CBT treatment

Other Antidepressants

- Agomelatine (25-50 mgs) MT1/MT2 receptor agonist, 5 HT2C antagonist was studied in >200 patients vs Fluoxetine
- Agomelatine superior to Fluoxetine Hale et al 2010 Oct
- Agomelatine was found to improve depressive symptoms & improving sleep
- Rates of liver injury found to be higher. (agomelatine 4.6%, 1.4% for escitalopram, 0.6% for paroxetine, 0.4% for fluoxetine, and 0% for sertraline).

Other Antidepressants

Desvenlafaxine- Prestig SNRI

- 50-200 mg once daily dose
- Gradual withdrawal may be required to prevent discontinuation syndrome
- Main side effect is nausea
- Double blind placebo-controlled studies underway

Vortioxetine (Brintellix)

- 5–20 mg/day is generally safe and well tolerated and is associated with continued effectiveness in children (aged 7–11 years) and adolescents (aged 12–17 years) with a depressive and/or anxiety disorder.

Newer antidepressants

Duloxetine (Cymbalta)-SNRI

- Half life is 12 hours so requires twice daily dosing
- Dose: 30 -120 mg a day
- Deemed safe for use in children and teenagers (7-17 years). Possibly efficacious (Burkhart 2012)
- Useful in treating ADHD in teenagers (Mahmoudi Gharei et al 2011). Improvements noted in 5 weeks

Cardiac toxicity of Citalopram & Escitalopram

- Mohammed et al Dec 2010: OD with Escitalopram (15-20 tabs)with Lithium (15-20 tabs of 300 mgs)
- Fayssoil Et al Jan 2011: Single case report of Lonq QTc with Citalopram taken with Amiodarone
- Liotter Oct 2011: OD with Citalopram caused long QTc
- Howland et al Nov 2011: Not enough clinically significant evidence to justify FDA caution
- Yager et al May 2013:1.1% of patients receiving citalopram *or* sertraline experienced ventricular arrhythmias. Cardiac deaths occurred in 3.3% of citalopram recipients and 4.0% of sertraline recipients

Transcranial Magnetic Stimulation TMS

- TMS is a non-invasive form of brain stimulation that involves using a magnetic coil to stimulate the brain.
- Sessions typically last around 30 minutes.
- A course of at least 20 sessions over consecutive weekdays is typically recommended for therapeutic results.
- TMS has antidepressant effects when applied over the frontal areas of the brain.
- There are now well over 30 studies in adults with depression, showing that TMS is an effective treatment for depression.
- Studies being planned with adolescents at OYH

References

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https://www.jaacap.org/action/showPdf?pii=S0890-8567%2819%2932234-8
- A 6-Month Open-Label Extension Study of Vortioxetine in Pediatric Patients with Depressive or Anxiety Disorders
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5771527/#:~:text=Most%20patients%20from%20the%20lead,a%20depressive%20and%2For%20anxiety
- A systematic literature review of the clinical efficacy of repetitive transcranial magnetic stimulation (rTMS) in non-treatment resistant patients with major depressive disorder
https://bmcpsychiatry.biomedcentral.com/articles/10.1186/s12888-018-1989-z
- Transcranial Magnetic Stimulation for Adolescent Depression
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6221455/#:~:text=Transcranial%20magnetic%20stimulation%20(TMS)%20has,cognitive%20behavioral%20therapy%20and%20SSRIs.
- Suicidality in sleep disorders: prevalence, impact, and management strategies
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5609851/

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  https://www.psychiatrictimes.com/view/strong-relationship-between-sleep-and-suicide
- Psychoeducational interventions in adolescent depression: A systematic review
  https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5933524/
- A Web-Based Psychoeducational Intervention for Adolescent Depression: Design and Development of MoodHwb
  https://pubmed.ncbi.nlm.nih.gov/29449202/
- Randomized study of school-based intensive interpersonal psychotherapy for depressed adolescents with suicidal risk and parasuicide behaviors
  https://pubmed.ncbi.nlm.nih.gov/19531111/
- Children's Physical Activity and Depression: A Meta-analysis
  https://pediatrics.aappublications.org/content/139/4/e20162266

Resources

- ASQ: Ask Suicide screening Questions
  https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials/asq-tool/screening_tool_asq_nimh_toolkit_155867.pdf
- Brief Suicide Safety Assessment
  https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials/youth-asq-toolkit#emergency
- The Columbia Suicide project (Lighthouse): screening and assessment tools, info cards for parents, teachers, coaches etc
  https://cssrs.columbia.edu/the-columbia-scale-c-ssrs/cssrs-for-communities-and-healthcare/#filter=.general-use.english
- Management of Paediatric depression
  https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6213890/
  https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6532464/
- Pittsburg Sleep Quality Index
  https://www.opapc.com/uploads/documents/PSQI.pdf

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Case studies

Breakout 1 – Case study

Sarah is a 15-year-old girl who lives with her parents and two older siblings. She attends her local Catholic school. Sarah's mum Sue describes Sarah as dark and broody and recalls that as a young child Sarah suffered from separation anxiety and struggled to make friends, was shy and would refuse to leave her mum's side.

Sarah began cutting herself at age 13 in seventh grade after learning about this behaviour from friends and the Internet. After trying it once or twice, she felt 'hooked'. Initially she cut herself on her forearms, but then switched to her upper thighs to conceal the injuries.

Sarah's primary reason for engaging in self-injury was to release built-up emotional pressure. Episodes typically occurred after an emotional conflict with her parents or a perceived rejection by a peer. Sarah's parents divorced when she was in the third grade. Both her parents now have stable partners, and joint custody of Sarah and her two siblings.

Breakout 1 – Case study Continued

The parents say that they are unsure if the self-harming has become more a habit now and a coping pattern rather than a warning sign of suicidality. They admit to sometimes getting angry with Sarah for the self-harming, sometimes mum tells her to “be serious, if you want to do it, do it properly” when frustrated.

A teacher at Sarah’s school has become aware of Sarah’s self-harm and notified Sarah’s parents who are extremely concerned.

- How would you assess Sarah’s problems? How would you assess her suicide risk?
- What are some significant features that you may look for in Sarah’s family history and Sarah’s early developmental history?
- How would you help Sarah, and her parents navigate the next steps following this revelation?

Breakout 2 – Case study

Sarah has been diagnosed with moderately severe depression. Sarah's mum Sue discusses the diagnoses with Sarah and suggests that Sarah start therapy to get help with her depression.

- What if Sarah does not want to attend therapy?
- What if Sarah does not feel connected to her therapist?
- Is there one form of therapy that may suit Sarah more over another?
- Sarah's dad, Jack is averse to her starting medication, as he is worried that she will get 'addicted' to it. How will you educate him?
- Do you think that Sarah may benefit from medication? Yes/ No? Why?

Session Conclusion

Next session – Tuesday 3rd October on Eating Disorders (same time – 6:30-8pm)

You will receive a post session email within a week which will include slides and resources discussed during this session.

Attendance certificate will be received within 4-6 weeks.

RACGP CPD hours will be uploaded within 30 days.

To attend further education sessions, visit,

https://nwmphn.org.au/resources-events/events/

This session was recorded, and you will be able to view the recording at this link within the next week.

https://nwmphn.org.au/resources-events/resources/

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