Child Mental Health CoP Session 3: Depression, suicidality and self-harm

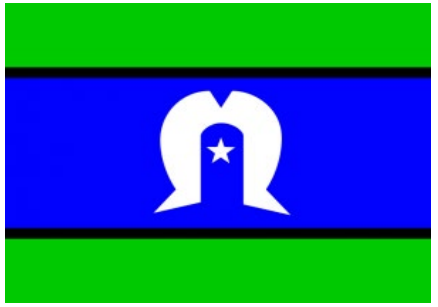
Tuesday 25 June 2024

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.

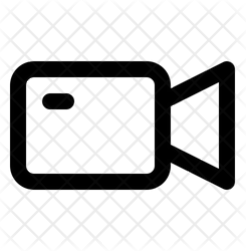


CoP guidelines
We agree to…

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**

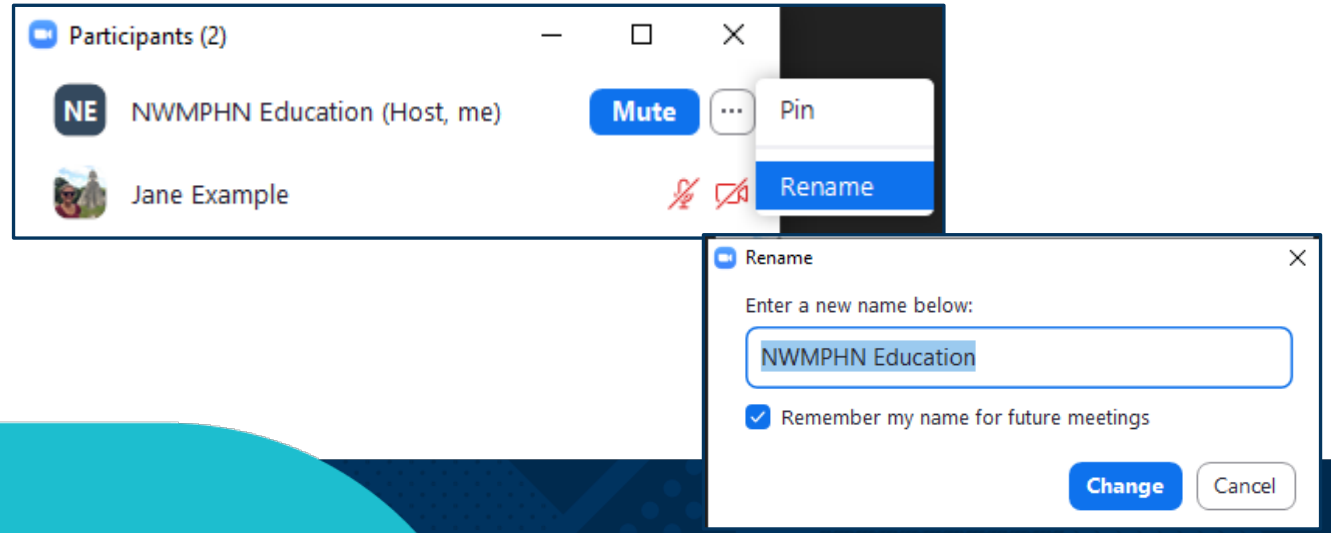
Ask **questions**

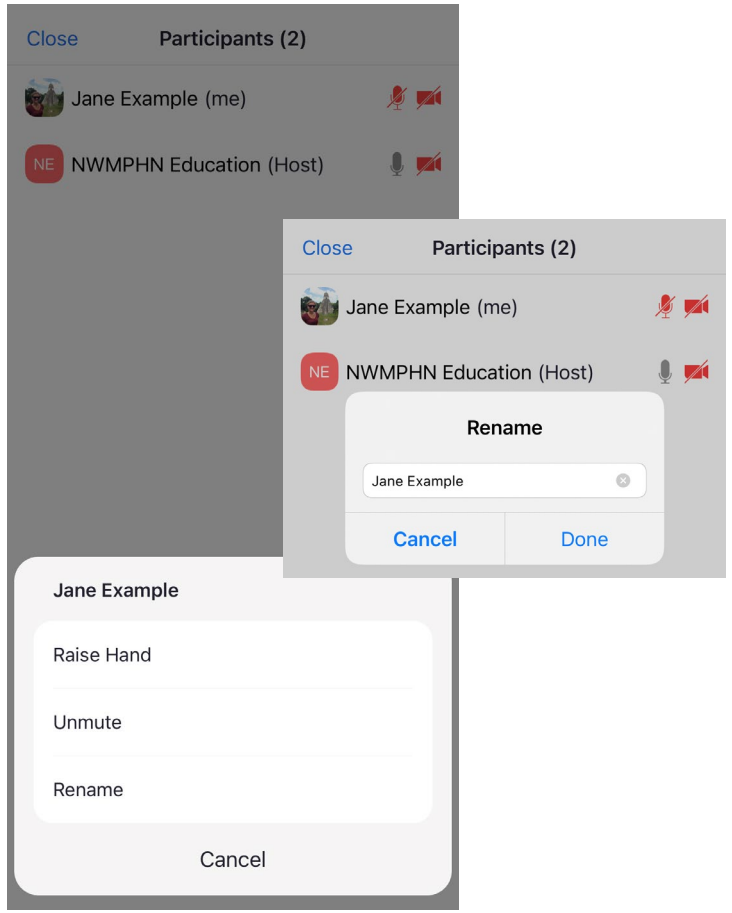
No question is silly

Please ensure you join the session using the same name you registered with and add your role next to your name

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

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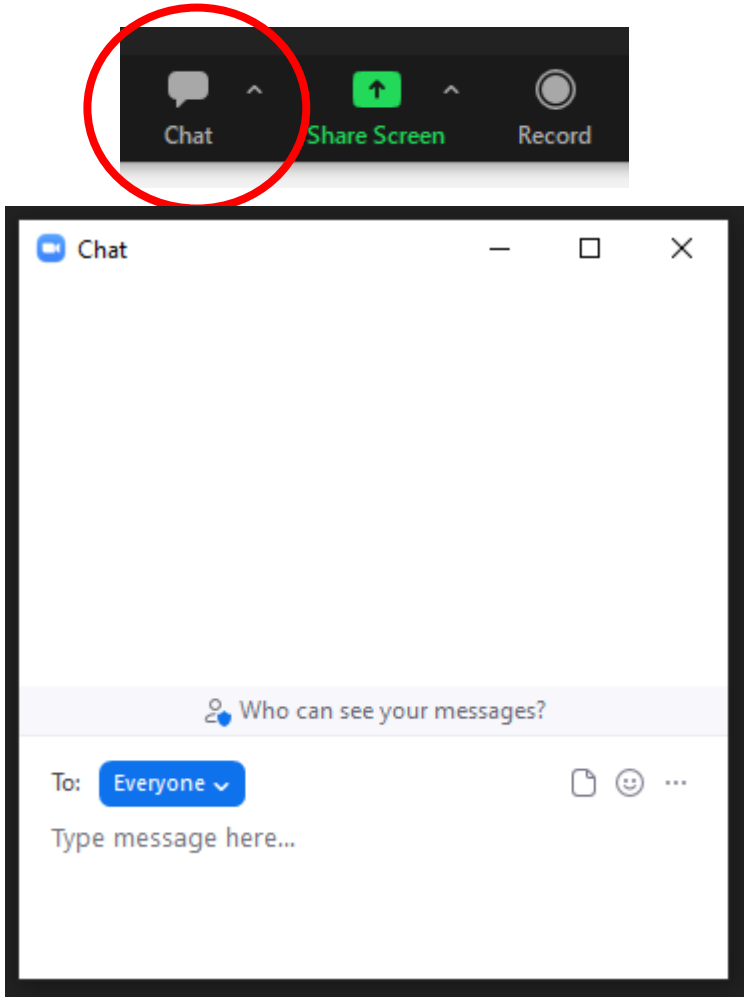
Certificates and CPD will not be issued if we cannot confirm your attendance



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 11 years

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

Agenda

Introduction and housekeeping	5 minutes
Education component *Psychiatrist Dr. Chidambaram Prakash*	30 minutes
Health Pathways	5 minutes
Case discussion Part 1 – Breakout room	15 minutes
Breakout room discussion	9 minutes
Case discussion Part 2 – Breakout room	15 minutes
Breakout room discussion	9 minutes
Conclusion	2 minutes

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Education component: Management of depression and suicide

CHIDAMBARAM PRAKASH

Concept of death: 5 factors

1.Universality: Everyone dies someday in some way, no one lives forever

2.Causality: The cause of death is the failure of vital organs in the body (heart, brain, other organs) and is different to the mode of death (natural, accident, suicide, murder etc.)

3.Permanence or Irreversibility: Those who die, cannot be brought back and will not return on their own

4.Non functionality: When a person dies their body, and the organs will no longer function

5.Extracorporeal identity or non corporeal continuation: physical self (body, mind and intellect/cognition) is different to the spiritual self (spirit)

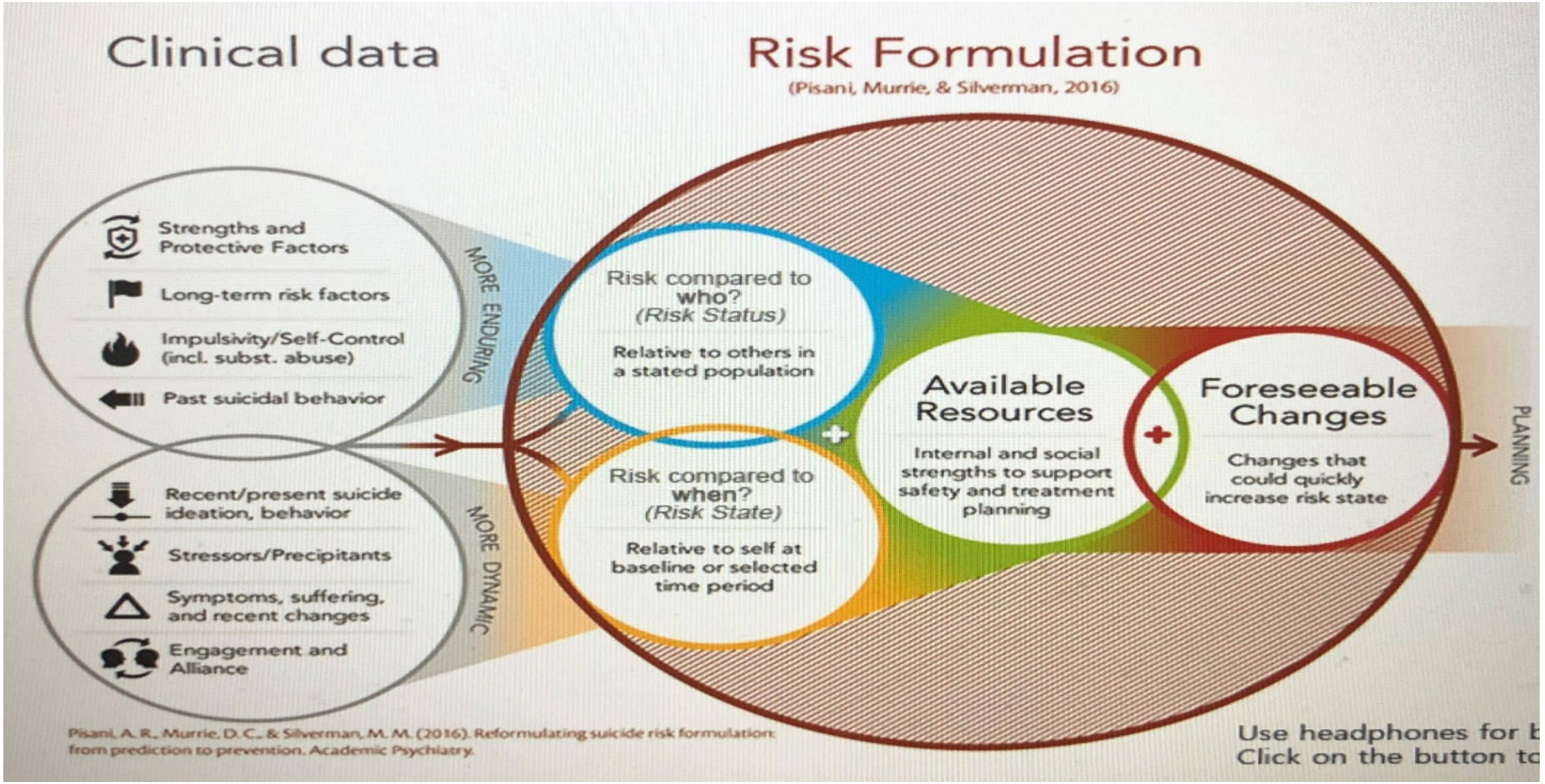
Concept of death in children

- School-age children (aged 6 –12), that 71% understood that death is final.
- Although the word ‘suicide’ was not familiar to most of the children in grades 1 and 2, the idea of ‘killing oneself’ was found to be understood by 95% of the sample.
- 2/3 of 1st graders expressed the belief that dead people can still have experiences (e.g., seeing and hearing)
- Children ages 6 to 12 have typically already had 4 to 5 death-related experiences in their lives

Formulation and its importance

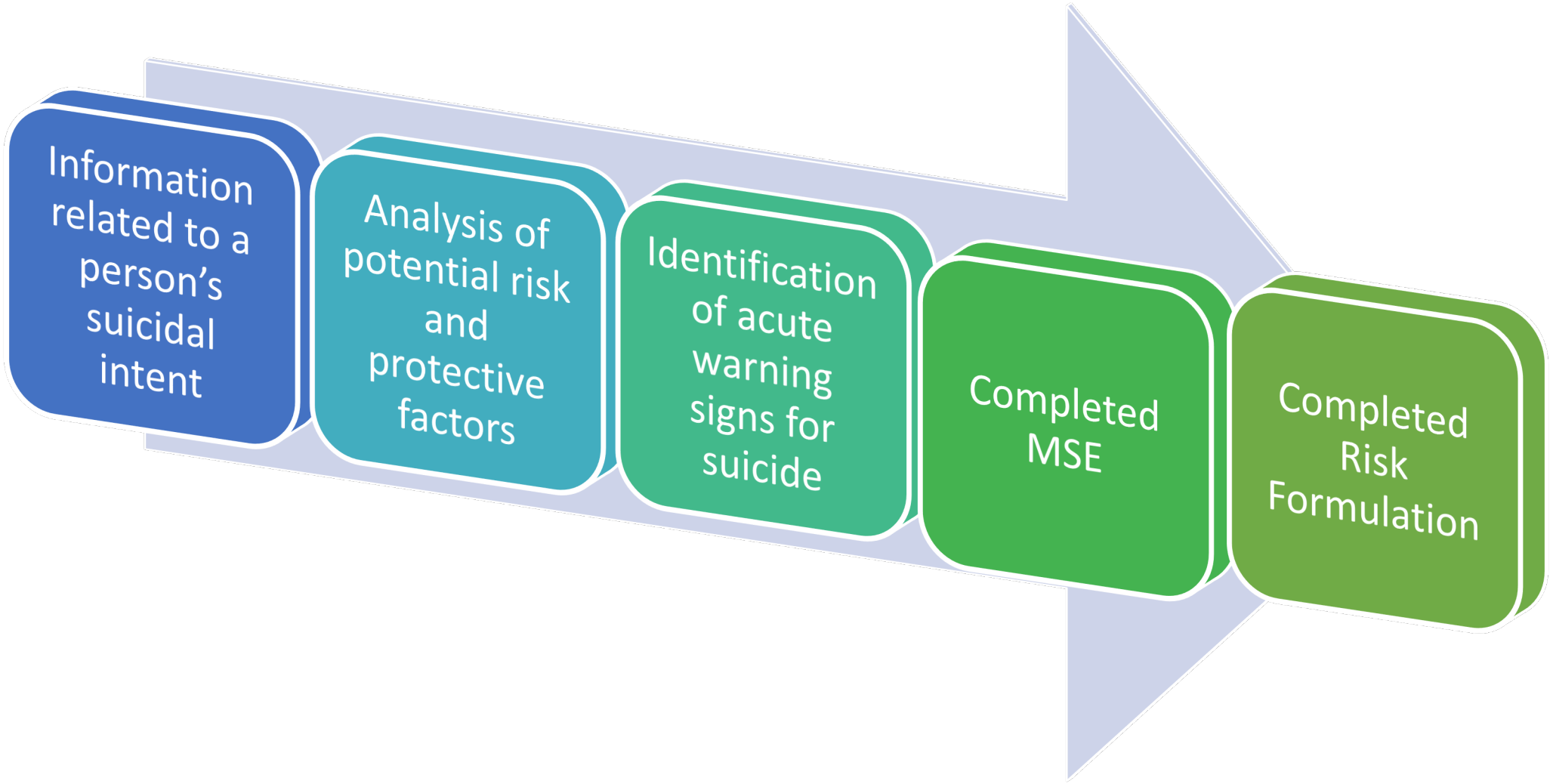
- The first step post assessment is to create a formulation.
- Formulation helps guide the focus of treatment especially the psychological therapy in depression.
- It helps choose the type of therapy that is most likely to be useful for the consumer
- Ratings of suicide risk based on a Likert type low, 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.

Pisani model suicide risk prevention formulation

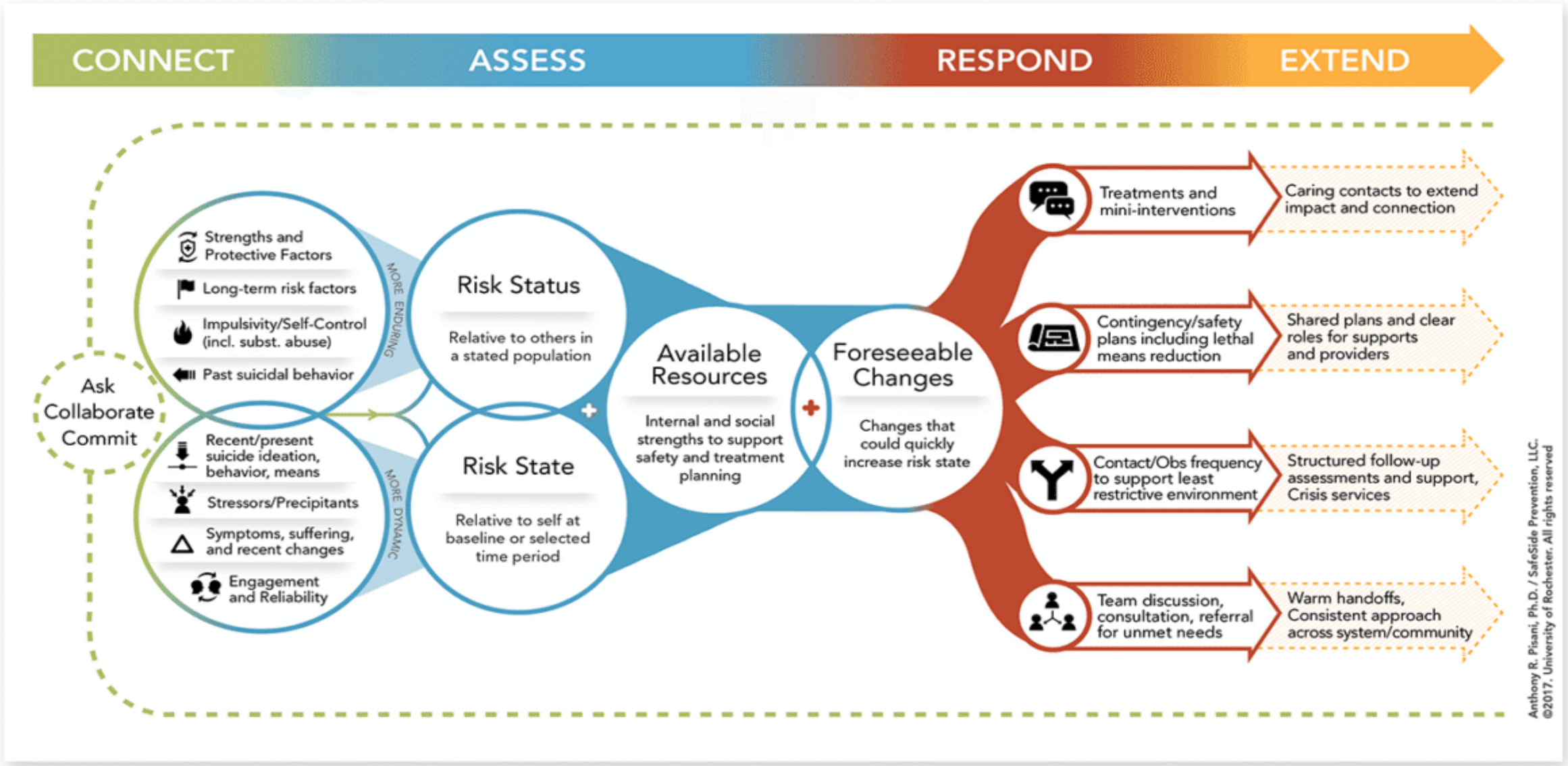


The process of risk prevention

The sequence of a risk assessment



Risk prevention care and communication



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.

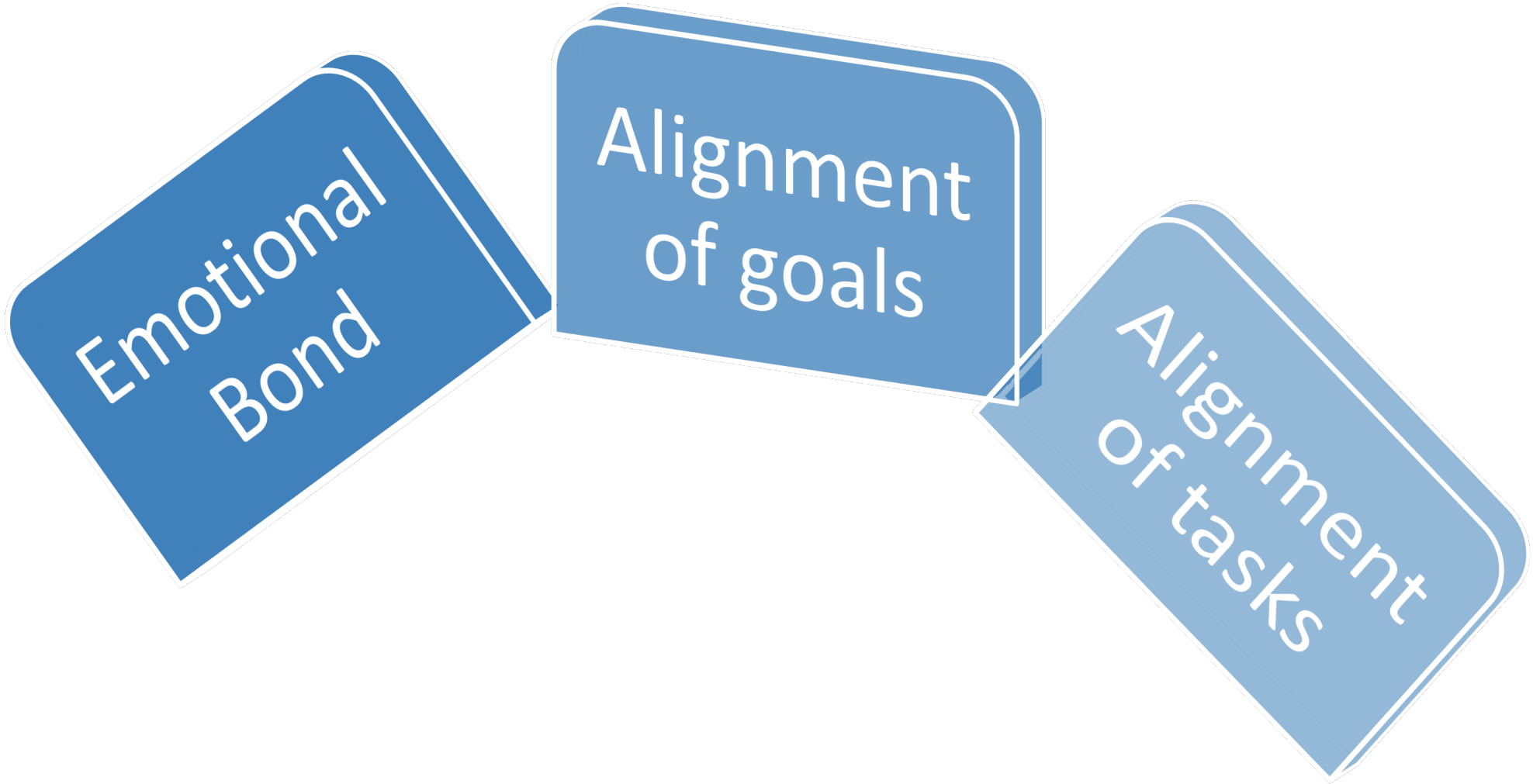
Improving insomnia and reducing suicidality

- 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

Therapeutic Engagement: 3 basic parts



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 comnfirt or assistance when feeling distressed and suicidal

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.

Medications

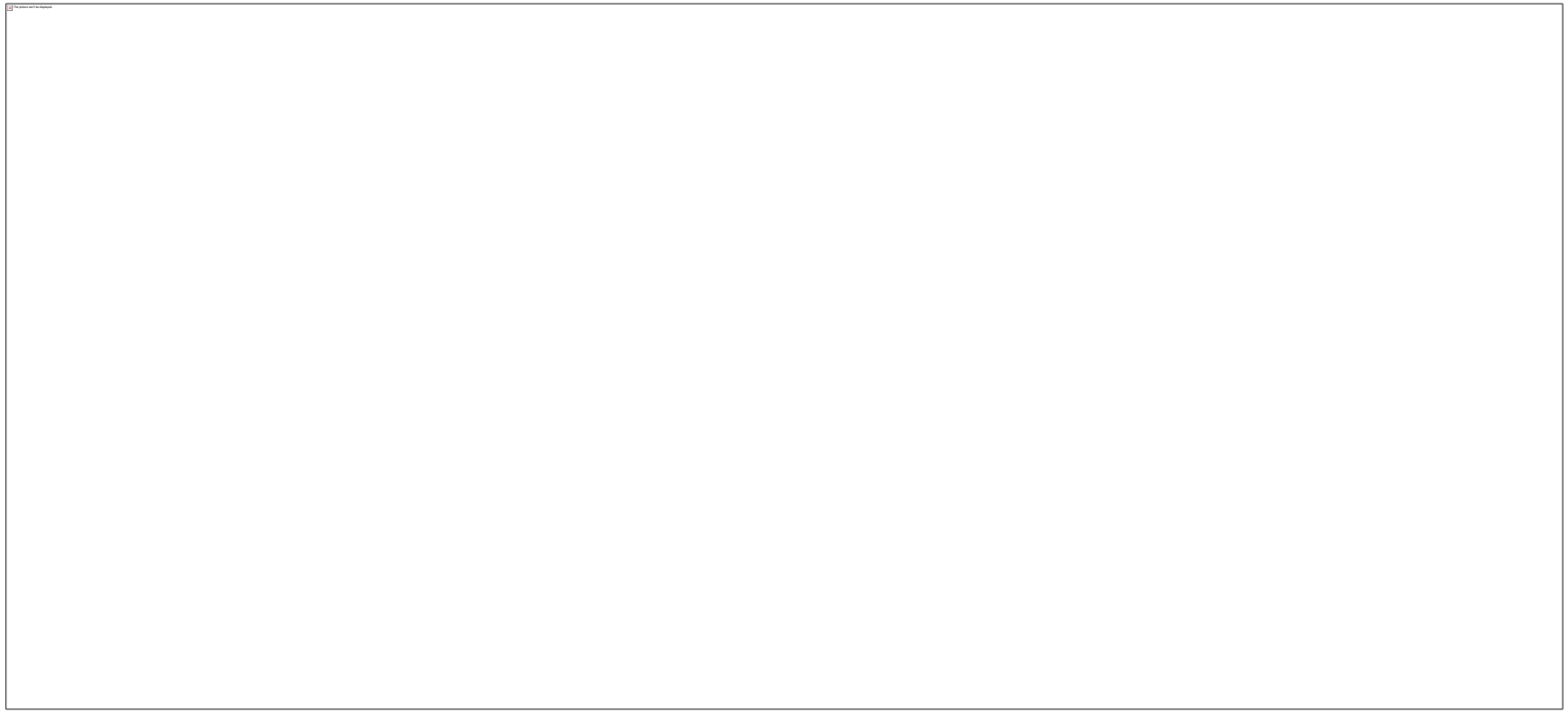
SSRIs

- 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



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

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

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).

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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

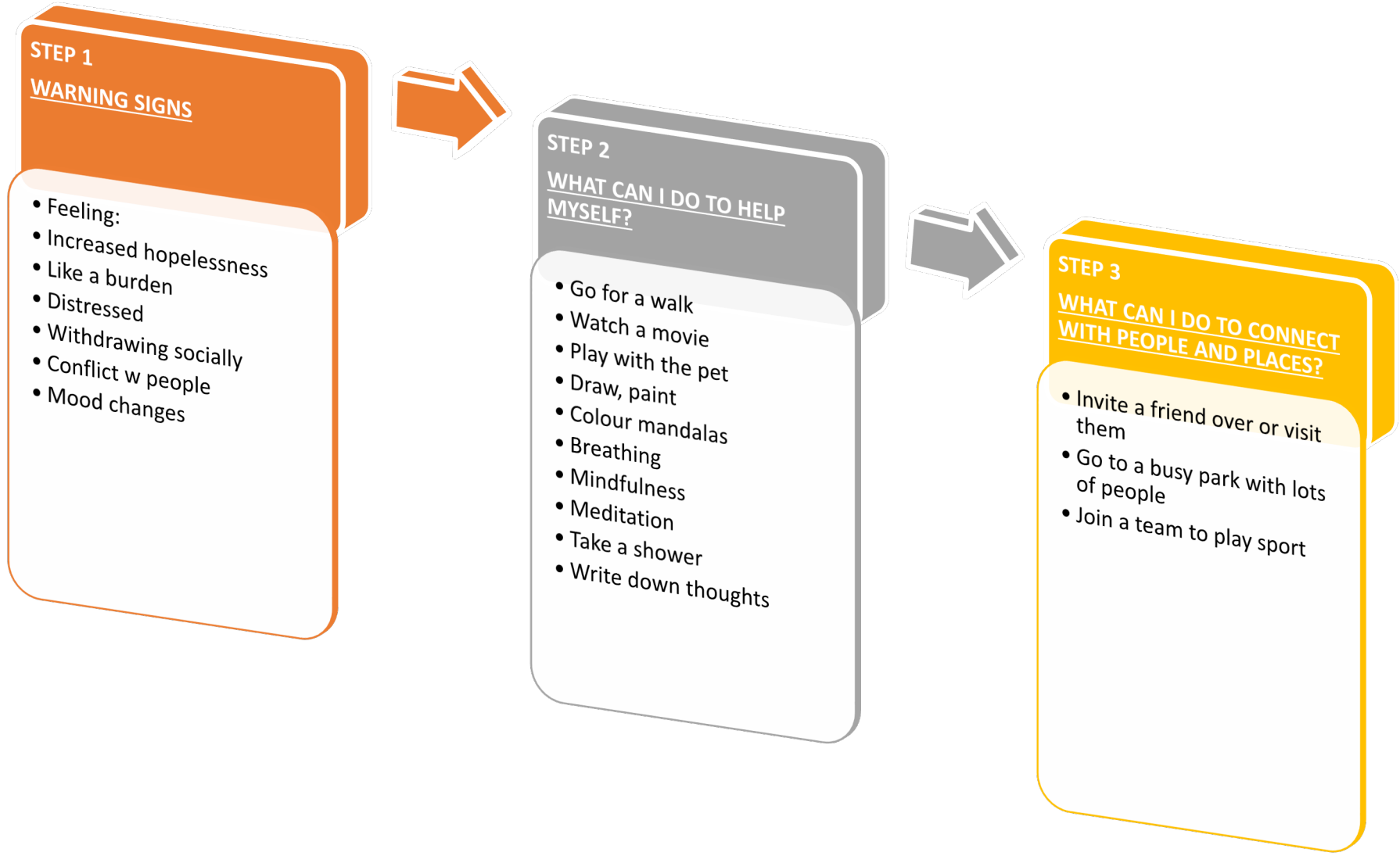
- TMS is a non-invasive form of brain stimulation that involves using a magnetic coil to stimulate the brain.
- Sessions typically last around 30 minutes.
- A course of at least 20 sessions over consecutive weekdays is typically recommended for therapeutic results.
- TMS has antidepressant effects when 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

Safety Planning

- Consumer centred
- Collaborative
- Dynamic, ongoing process
- Meaningful, current
- Accessible and useful
- Must increase confidence in the consumer and the clinician that consumer will be safe

NOT JUST A DOCUMENT THAT HAS TO BE DONE.

The 7 Steps in crisis planning



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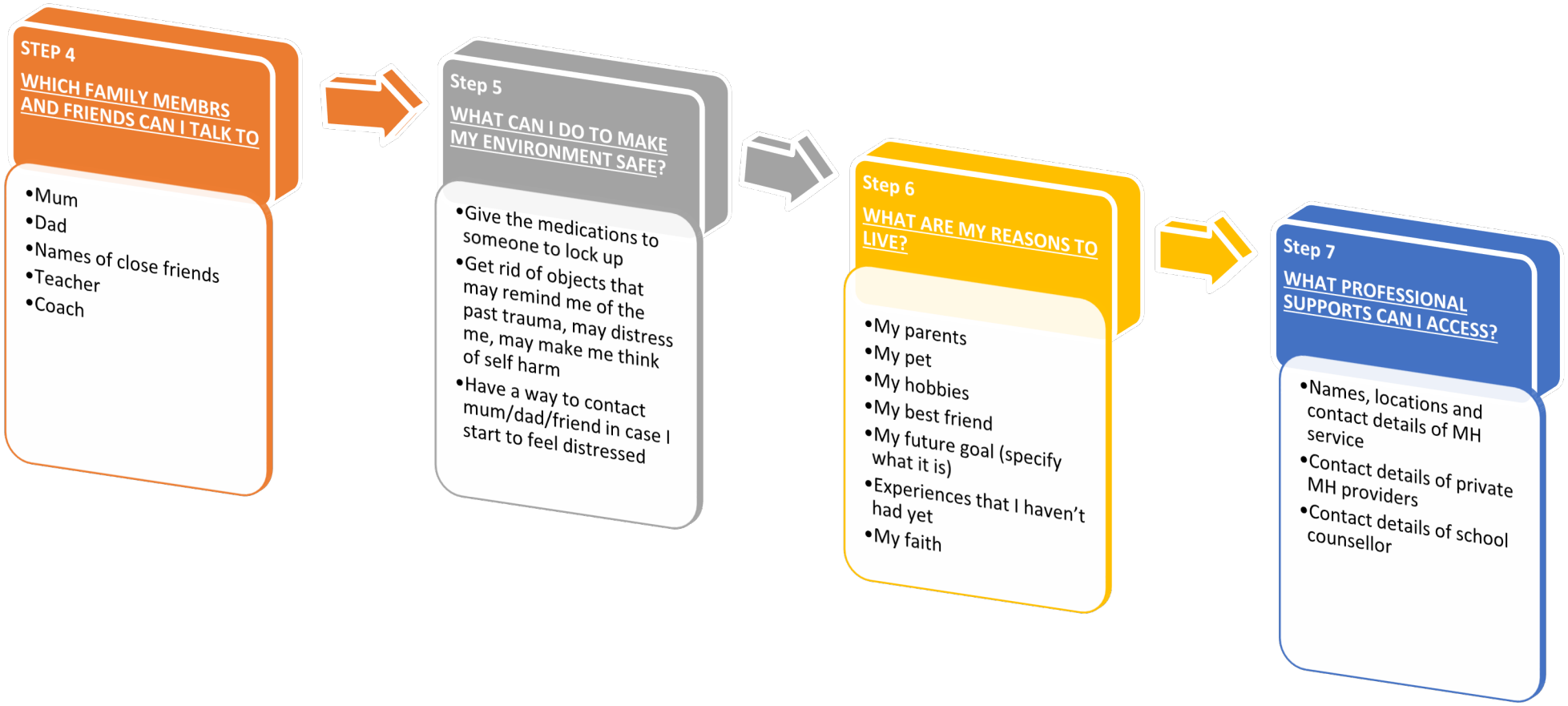


Chain Analysis of Suicide Attempt

- Precipitant
- Motivation
- Negative affect experienced at the time
- Hopelessness increased or static at the time
- Emotion regulation problems that worsened before the suicide attempt
- Environmental response to the person right after the attempt.

Reducing access to lethal means

- Negotiate most secure situation possible
- Parental regulation of medication, other items that can be used to harm self.
- If living next to a train station/line or a bridge

References

- Systematic Review and Meta-analysis: Outcomes of Routine Specialist Mental Health Care for Young People With Depression and/or Anxiety

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/

References

- The Strong Relationship Between Sleep and Suicide

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: **A**sk **S**uicide screening **Q**uestions

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/

Resources

- Pittsburg Sleep Quality Index

https://www.opapc.com/uploads/documents/PSQI.pdf

HealthPathways – Anxiety in Children and Adolescents

melbourne.healthpathways.org.au

Pathways are written by GP clinical editors with support from local GPs, hospital-based specialists and other subject matter experts

- clear and concise, evidence-based medical advice
- Reduce variation in care
- how to refer to the most appropriate hospital, community health service or allied health provider.
- what services are available to my patients

Relevant and Related Pathways

Relevant Pathways

ADHD in Children and Youth
Anxiety in Children and Adolescents
Child and Youth Mental Health
Depression in Children and Adolescents
Psychological Trauma in Children
Self-harm
Suicide Prevention

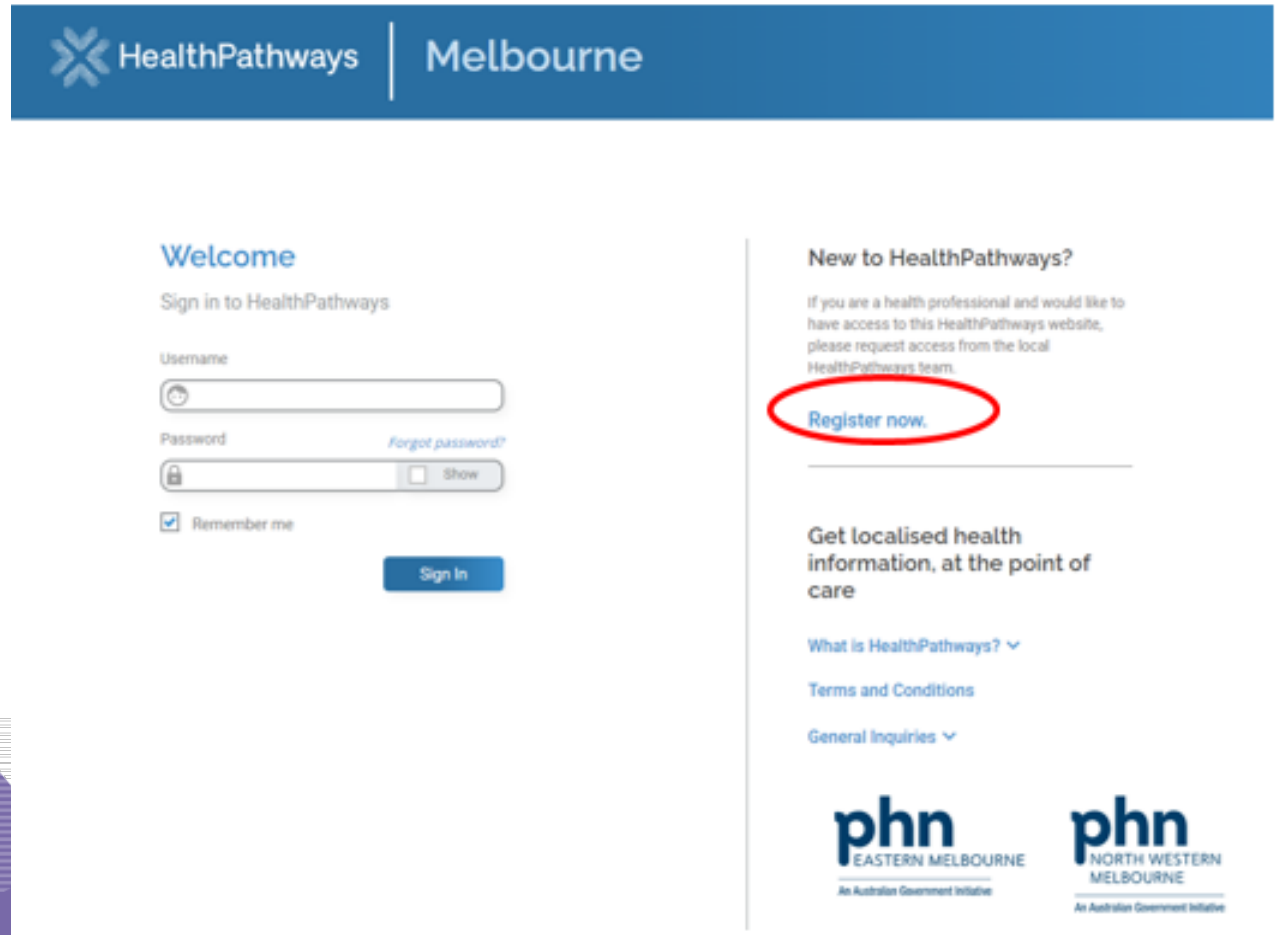
Referral Pathway

Acute Child and Adolescent Psychiatry Referral or Admission (Same-day)
Child and Youth Mental Health Support Services
Non-acute Child and Adolescent Psychiatry Referral (> 24 hours)
Paediatric Psychology and Counselling Referral

Related Pathways

Carer Support - Mental Health
E-Mental Health Services
GP Mental Health Treatment Plan
Mental Health Community Support Services

Accessing HealthPathways: Go to melbourne.healthpathways.org.au



Register via QR code

info@healthpathwaysmelbourne.org.au

Disclaimer: For presentation purposes only

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Case studies

Breakout 1 – Case study

Amy, 15, presents to you with her grandmother as her grandmother is worried about her. Amy's grandmother describes Amy as socially awkward and not very open about her feelings. Amy has been living with her grandmother as she has been removed from her mother's custody due to maternal Amphetamine abuse. Sandy (Amy's grandmother) noted some marks consistent with cutting on Amy's legs as she was trying some new shorts while out shopping with her. Sandy is extremely worried and does not know how to navigate this situation and how to help Amy.

Sandy reported that Amy had been missing school as she stays up late at night and is often "too tired" to attend school. She appears disinterested in most things. She struggles to interact with new people and has a 'negative perception' about most things.

Amy has 2 half siblings who live with their biological dad. Sandy really wants to help Amy as she "doesn't want Amy to end up like her mum" and is seeking support from you.

How would you approach Amy? What further information would you like to obtain from Amy and Sandy?
How would you assess Amy's suicide risk?
How would you make a safety plan for Amy?

Take a photo

Breakout 2 – Case study

On further assessment, you get to know that Amy's mother has history of recurrent relapses of Amphetamine use. However, she did not use any recreational drugs during her pregnancy.

Amy was born at term. She had significant speech delay and attended speech therapy on and off for 2 years. She was referred to a paediatrician due to some developmental concerns raised by the kinder teacher but Amy never attended that appointment as her mother relapsed into drug use. Amy also has no contact with her biological dad. She struggles to initiate and maintain friendships and can be very blunt with her peers. Grandmother describes her as "very black and white" in her approach to things.

Amy feels sad and appears quite withdrawn. Amy has been self harming since age of 12 as it helps her to release her feelings. She reports recurrent suicidal ideations but no intent or plan.

You establish that Amy has moderate to severe depression. You discuss arranging a mental health care plan, referral to a psychologist and a paediatrician/child and adolescent psychiatrist.

Take a photo

How can you support Amy while she is waiting for a psychologist appointment?
Considering Amy's history, what sort of therapy will be best suited for her?
Amy feels she would rather take tablets than going to "therapy ". Though, her grandmother has reservations regarding Amy being drug dependent like her mother. How would you respond ?
How can you support Sandy as she feels overwhelmed herself?

Session Conclusion

Next session on eating disorders

– Tuesday 6th August (same time)

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/

We value your feedback, let us know your thoughts.

Scan this QR code