How to monitor suicide risk in people with depression

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Definitions & terminology

- **Suicide**: The deliberate act of killing oneself. It must also be established by a coronial enquiry that the death resulted from a deliberate act of the deceased with the intention of ending his or her own life (*ABS 2008:3303.0 Causes of death. Australia, Canberra, Australia 2008*).

- **Suicide attempt**: “a non-fatal, self-inflicted potentially injurious behaviour with any intent to die as a result” (*Crosby 2007*), which may or may not result in injury, or death (*Silverman et al. 2007*).

- **Suicidal ideation**: “thoughts of engaging in behaviour intended to end one’s life” (*Nock et al. 2008*). These can be broken down further to encompass ideation with some intent, ideations where intent is undetermined, and ideation with no intent (*Silverman et al. 2007*).

- **Deliberate self-harm (DSH)**: “The deliberate harming of oneself regardless of intention or purpose”

- **Non-suicidal self injury**: “Self harm with no intent to die as a result”
Australian suicide rates 2012 (ABS, 2014)
Rates of suicide-related behaviour in young people

**Suicidal ideation**
- Lifetime: 29.9%
- Past year: 24%

*(Nock et al. 2008; Evans et al. 2005)*

**Suicide attempt/DSH**
- Lifetime: 12-17%
- Past year: 5-10%

*(Patton et al. 1997; Hawton et al. 2002; De Leo and Heller 2004; Skegg 2005; Nock et al. 2008)*

**Suicide**
- In 2014 age <25 N=383
- i.e. 1 in 3 deaths

*(ABS, 2016)*
Knowledge check ....

Suicidal ideation can include: (choose one)

(a) Suicidal thoughts with some intent to act
(b) Suicidal thoughts where intent is undetermined
(c) Suicidal thoughts with no intent to act
(d) All of the above
Knowledge check ....

Suicidal ideation can include: (choose one)

(a) Suicidal thoughts with some intent to act
(b) Suicidal thoughts where intent is undetermined
(c) Suicidal thoughts with no intent to act
(d) All of the above
Depression and suicide
Depression

[Graph showing DALYs (100,000s) for various causes, with Depression at the top, followed by Traffic accidents, Schizophrenia, Bipolar disorder, Violence, Alcohol, HIV/AIDS, Self-inflicted injuries, Maternal sepsis, and Abortion.]
Depression and suicide

- 70% to 91% of young people who attempt suicide or report suicidal ideation have a psychiatric disorder
- 60% to 80% of young people have a diagnosis of depression at the time of a suicide attempt
- 60% of suicide deaths attributable to mood disorders
- Up to 15% of people with unipolar depression eventually die by suicide
Clinicians need to be vigilant to the risk of suicide and suicide related behaviour in those with depression.
# Treatment recommendations for depression in young people

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dysthymia or mild major depressive disorder</td>
<td>Careful monitoring Non-directive support or group CBT/IPT Guided self help and lifestyle support</td>
</tr>
<tr>
<td>Mild to moderate major depressive disorder</td>
<td>CBT//IPT if available Guided self help</td>
</tr>
<tr>
<td>Moderate to severe major depressive disorder</td>
<td>Psychological therapy (CBT/IPT) if available + fluoxetine if necessary (where psychological therapy has not been effective, is not available or is refused or symptoms are severe)</td>
</tr>
<tr>
<td>Severe major depressive disorder</td>
<td>Psychological therapy (CBT/IPT) if available + fluoxetine to reduce symptoms in short term</td>
</tr>
</tbody>
</table>
### Risk of suicide related behaviours for young people on antidepressants

| Study or Subgroup | Antidepressant Events | Placebo Events | Risk Ratio | Risk Ratio
<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Event</td>
<td>Total</td>
<td>Event</td>
<td>Total</td>
</tr>
<tr>
<td><strong>1.6.1 Paroxetine</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Berard 2006</td>
<td>9</td>
<td>177</td>
<td>3</td>
<td>91</td>
</tr>
<tr>
<td>Enzle 2003</td>
<td>1</td>
<td>181</td>
<td>0</td>
<td>79</td>
</tr>
<tr>
<td>Keller 2001</td>
<td>8</td>
<td>50</td>
<td>7</td>
<td>47</td>
</tr>
<tr>
<td>Placebo Trial 1</td>
<td>0</td>
<td>27</td>
<td>0</td>
<td>14</td>
</tr>
<tr>
<td>Subtotal (95% CI)</td>
<td>77</td>
<td>305</td>
<td>6</td>
<td>272</td>
</tr>
<tr>
<td>Total events</td>
<td>20</td>
<td>6</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Heterogeneity: $I^2 = 0.62$; $Chi^2 = 5.84$, df = 4 (P = 0.19); $I^2 = 61$
| Test for overall effect: $Z = 0.79$ (P = 0.43) |

| **1.6.2 Fluoxetine** |
|-----------------------|-------------------|----------------|------------|-------------|
| Enzle 2007            | 2     | 40    | 2     | 40    | 1.04 (0.55, 1.98) |             |
| Enzle 2002            | 3     | 109   | 6     | 116   | 1.08 (0.56, 2.08) |             |
| TADS 2004             | 10    | 109   | 5     | 112   | 0.94 (0.47, 1.89) |             |
| Subtotal (95% CI)     | 20    | 279   | 12    | 227   | 1.07 (0.55, 2.07) |             |
| Test for overall effect: $Z = 0.12$ (P = 0.90) |

| **1.6.3 Sertraline** |
|-----------------------|-------------------|----------------|------------|-------------|
| Wagner *et al.* 2001  | 6     | 149   | 2     | 151   | 2.23 (0.81, 5.97) |             |
| Subtotal (95% CI)     | 28    | 187   | 2     | 192   | 2.97 (0.81, 14.22) |             |
| Test for overall effect: $Z = 1.94$ (P = 0.05) |

| **1.6.4 Chlorpromazine** |
|--------------------------|-------------------|----------------|------------|-------------|
| Van Kraning 2005         | 10    | 124   | 8     | 120   | 1.04 (0.65, 1.63) |             |
| Wagner 2004              | 1     | 39    | 2     | 37    | 0.43 (0.23, 0.80) |             |
| Subtotal (95% CI)        | 12    | 205   | 8     | 206   | 1.04 (0.55, 2.02) |             |
| Test for overall effect: $Z = 0.62$ (P = 0.52) |

| **1.6.5 Trazodone** |
|---------------------|-------------------|----------------|------------|-------------|
| Enzle 2004          | 18    | 154   | 15    | 157   | 1.03 (0.50, 2.15) |             |
| Wagner 2006         | 1     | 155   | 1     | 153   | 0.81 (0.46, 1.43) |             |
| Subtotal (95% CI)   | 20    | 208   | 16    | 210   | 1.01 (0.57, 1.84) |             |
| Test for overall effect: $Z = 0.20$ (P = 0.84) |

| **1.6.6 Venlafaxine** |
|-----------------------|-------------------|----------------|------------|-------------|
| Enzle 2003            | 15    | 134   | 1     | 132   | 1.23 (1.17, 9.76) |             |
| Subtotal (95% CI)     | 28    | 184   | 1     | 182   | 1.23 (1.17, 9.76) |             |
| Test for overall effect: $Z = 0.29$ (P = 0.77) |

| **1.6.7 Mirtazapine** |
|----------------------|-------------------|----------------|------------|-------------|
| McElroy *et al.* 1982| 1     | 170   | 1     | 168   | 1.00 (0.69, 1.42) |             |
| Subtotal (95% CI)    | 20    | 170   | 1     | 168   | 1.00 (0.69, 1.42) |             |
| Test for overall effect: $Z = 0.29$ (P = 0.77) |

| **Total (95% CI)**   |
|----------------------|-------------------|----------------|------------|-------------|
| 1703                 | 1325              | 100.00% | 1.23 (1.17, 9.76) |             |

Total events: 92
Heterogeneity: $I^2 = 0.14$; $Chi^2 = 16.62$, df = 3 (P = 0.22); $I^2 = 22$
Test for overall effect: $Z = 2.84$ (P = 0.00)
Test for subgroup differences: $Chi^2 = 0.86$, df = 6 (P = 0.35); $I^2 = 25.6$

* Favour antidepressants
* Favour placebo
Regulatory responses to safety

• FDA ‘black box’ warning for antidepressants
  – initially for children & adolescents
  – later extended for young people up to 25 years

WARNING: SUICIDALITY AND ANTIDEPRESSANT DRUGS

Antidepressants increased the risk compared to placebo of suicidal thinking and behavior (suicidality) in children, adolescents, and young adults in short-term studies of Major Depressive Disorder (MDD) and other psychiatric disorders. Anyone considering the use of PROZAC or any other antidepressant in a child, adolescent, or young adult must balance this risk with the clinical need. Short-term studies did not show an increase in the risk of suicidality with antidepressants compared to placebo in adults beyond age 24; there was a reduction in risk with antidepressants compared to placebo in adults aged 65 and older. Depression and certain other psychiatric disorders are themselves associated with increases in the risk of suicide. Patients of all ages who are started on antidepressant therapy should be monitored appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior. Families and caregivers should be advised of the need for close observation and communication with the prescriber. PROZAC is approved for use in pediatric patients with MDD and Obsessive Compulsive Disorder (OCD) [see Warnings and Precautions (5.1) and Use in Specific Populations (8.4)]. When using PROZAC and olanzapine in combination, also refer to Boxed Warning section of the package insert for Symbyax.
Risk of suicide related behaviours for adults on antidepressants

• One meta-analysis has shown that there is some weak evidence for an increase in self harm for adults on antidepressants
• Risk much high in 9 days vs 90 days after prescription
• Risk even higher still in one month preceding; with drop in risk after initiation of antidepressant but remains high
• Risk of suicide attempt increased but suicide and overall mortality was decreased for those on any antidepressants compared with those not using medication
Clinicians need to be vigilant to the risk of suicide and suicide related behaviour in those with depression who are initiated/even when initiated on antidepressants.
Guidelines (youth)

“Ongoing monitoring of depression symptoms and suicide risk [is necessary] to ensure appropriate risk management and ongoing treatment planning”

- Guidelines recommend this as essential for those initiating on antidepressant medication, given the increased risk of suicidal ideation and behaviours
How to interpret and implement these guidelines

• Currently not adequate; not done, not clear, not documented

• Research shows reliance on spontaneous report does not sufficiently identify all those at risk of suicide
Why ongoing systematic monitoring?

- The severity of suicidal ideation can change on a daily basis; and this variability is important in understanding the risk of future self harm
- Better information is obtained when monitoring is done using a structured assessment rather than a clinical interview
A note about risk assessment

• Most frequently used/tested=Manchester Self Harm Rule, Buglass and Horton Scale, Beck Suicide Intention Scale, Edinburgh Risk Rating Scale, SAD Persons Scale

• Pooled sensitivity 0.55=just over ½ of future self harm identified; PPV 0.33 (individual patient level)=1 in 3 positive tests would go on to self harm

• Pooled specificity 0.75=¼ who will not go on to self harm will be classified as high risk; NPV 0.88 (individual patient level) indicates 12% of those who will go on to self harm will be classified as safe to discharge

• Accuracy of a range of predictive instruments are poor and not clinically useful to classify individuals as high risk (needing treatment) or low risk
Clinicians need to be vigilant to the risk of suicide and suicide related behaviour in those with depression who are initiated/even when initiated on antidepressants and this vigilance means routine and systematic risk based assessment/monitoring.
Initiating a risk based assessment

• Initiating the assessment about suicidal ideation and behaviour
  – Standardised symptom assessment tools e.g. PHQ-9 specific item about suicidal ideation; DASS has items about e.g. life is meaningless
  – HEADS psychosocial assessment style questioning: start with 1) does this situation make you feel sad/down/depressed; then 2) have you ever felt so low that have had thoughts that you would be better of dead or that you wished you were dead or have harmed
In pairs – practice asking these questions

• Sometimes when people feel really down they have thoughts of ending their lives, is this something that is going on for you?
• Have you ever wished you were dead; or wished you could go to sleep and didn’t wake up?
• Have you actually had any thoughts about killing yourself?
• Have you been thinking about how you might kill yourself?
• Have you had these thoughts and had some intention of acting on them?
• Have you started to work out, or worked out the details of how to kill yourself? Do you intend to carry out the plan?
Conducting a risk based assessment

Gain a clear understanding of suicidal ideation:
- Nature of thought and intent (motivation for self harm)
- Frequency and intensity of thoughts
- When they have these thoughts, who they tell, how they resolve
- How long they have had these thoughts: chronology

Gain a clear understanding of any history of suicide attempts and self-harm:
- Number, nature i.e. lethality of method, rescuing/others available, strength (e.g. knowledge of means)

Gain a clear understanding of access to means

Gain a clear understanding of risk factors
Risk factors for suicide

Underlying risk factors

**Psychiatric**
- Depression
- Substance use
- Anxiety disorder
- Personality disorder
- Conduct disorder

**Social & familial**
- Childhood adversity
- Interpersonal difficulties
- Poor peer relationships

**Psychological**
- Impulsivity
- Poor problem solving
- Hopelessness
- Anger/hostility

**Behavioural**
- Past suicide-related behaviour*

Situational risk factors

**Adverse life events**
- Relationship difficulties
- Interpersonal losses
- Conflict (parents; peers; boy/girl friends)
- Legal problems
- Living situation
- Suicide-related behaviour in others, especially in school settings

**Recent discharge**

**Intoxication**

**Availability of means**

**Certain types of media reporting***
Key risk factors

**Past suicide-related behaviour:**
- Significant indicator of future suicidality in general & clinical populations
- Suicidal ideation and attempts can begin as young as 10 years of age, and show the highest hazard ratios at age 15
- While 60% of transitions along the continuum from suicidal ideation to subsequent attempt occur within 1 year of initial ideation onset, risk remains elevated for much longer.

**Psychiatric disorder:**
- 60 - 80% of young people have a diagnosis of depression at the time of a suicide attempt
- Risk is also high in other disorders e.g. psychotic illness; substance use & personality disorder
- However, not all young people with SI report symptoms of mental disorder & interpersonal stressors are especially significant for youth
- Not all people experiencing psychiatric disorder will develop suicide risk

**Hopelessness:**
- Hopelessness has long been linked to an increased risk of suicide-related behaviour even when depression, is controlled for
- Not only is hopelessness one of the key factors mediating the relationship between depression and suicidal ideation but it also increases risk among already suicidal patients and can increase overall risk of eventual suicide by at least three-fold
- Hopelessness has also been postulated as a mediating factor between problem-solving ability and suicidal ideation.
Examples of Tools

- Suicide Assessment Kit (SAK) from the National Drug and Alcohol Research Centre

- Australian Institute for Suicide Research and Prevention: Framework of a Suicide Risk Screening Tool

- Collaborative Assessment and Management of Suicidality

- Columbia Suicide Severity Rating Scale (for history of suicide behaviour only)
  - [http://www.cssrs.columbia.edu](http://www.cssrs.columbia.edu)
Columbia Suicide Severity Rating Scale

**SUICIDE IDEATION DEFINITIONS AND PROMPTS:**

<table>
<thead>
<tr>
<th>Question</th>
<th>Past month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ask questions that are in bolded and underlined</td>
<td>Yes/NO</td>
</tr>
<tr>
<td><strong>Ask Questions 1 and 2</strong></td>
<td></td>
</tr>
<tr>
<td>1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up?</td>
<td></td>
</tr>
<tr>
<td><em>Have you wished you were dead or wished you could go to sleep and not wake up?</em></td>
<td></td>
</tr>
<tr>
<td>2) Suicidal Thoughts: General non-specific thoughts of wanting to end one’s life/commit suicide, “I’ve thought about killing myself” without general thoughts of ways to kill oneself/associated methods, intent, or plan.</td>
<td></td>
</tr>
<tr>
<td><em>Have you actually had any thoughts of killing yourself?</em></td>
<td></td>
</tr>
<tr>
<td>If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6</td>
<td></td>
</tr>
<tr>
<td>3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. “I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it...and I would never go through with it.”</td>
<td></td>
</tr>
<tr>
<td><em>Have you been thinking about how you might kill yourself?</em></td>
<td></td>
</tr>
<tr>
<td>4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as oppose to “I have the thoughts but I definitely will not do anything about them.”</td>
<td></td>
</tr>
<tr>
<td><em>Have you had these thoughts and had some intention of acting on them?</em></td>
<td></td>
</tr>
<tr>
<td>5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out.</td>
<td></td>
</tr>
<tr>
<td><em>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</em></td>
<td></td>
</tr>
<tr>
<td>6) Suicide Behavior Question <em>Have you ever done anything, started to do anything, or prepared to do anything to end your life?</em> Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn’t swallow any, held a gun but changed your mind or it was grabbed from you, went to the roof but didn’t jump, tried to shoot yourself out</td>
<td></td>
</tr>
</tbody>
</table>
AISRAP tool (STARS)

- **Domains:**
  - Current suicide risk: suicidal thoughts, current mood, access to methods, previous attempts, plans/intent, psychiatric care/help
  - Risk Factors: home, health, education/employment, activities (connectedness/isolation), affect, loss of hope, drugs/alcohol, marital status (imminent break-up), family history of mental illness and suicide behaviour, known others who have died by suicide, grief and loss.
  - Protective factors: social support/sense of belonging, self-esteem, norms and values, coping/problem solving, religion, cultural identity

Collaborative Assessment and Management of Suicidality

- Psychometrically sound
- Not a prediction tool
- Facilitates treatment with a focus on suicidality
CAMS Suicide Status Form (SSF-IV-R) Initial Session

Section A (Patient):

Rate and fill out each item according to how you feel right now. Then rank in order of importance 1 to 5 (1=most important to 5=least important).

Rank
1) RATE PSYCHOLOGICAL PAIN (hurt, anguish, or misery in your mind; not stress; not physical pain):
Low pain: 1 2 3 4 5 : High pain

What I find most painful is:

2) RATE STRESS (your general feeling of being pressured or overwhelmed):
Low stress: 1 2 3 4 5 : High stress

What I find most stressful is:

3) RATE AGITATION (emotional urgency; feeling that you need to take action; not irritation; not annoyance):
Low agitation: 1 2 3 4 5 : High agitation

I most need to take action when:

4) RATE HOPELESSNESS (your expectation that things will not get better no matter what you do):
Low hopelessness: 1 2 3 4 5 : High hopelessness

I am most hopeless about:

5) RATE SELF-HATE (your general feeling of disliking yourself; having no self-esteem; having no self-respect):
Low self-hate: 1 2 3 4 5 : High self-hate

What I hate most about myself is:

6) RATE OVERALL RISK OF SUICIDE:
Extremely low risk: 1 2 3 4 5 : Extremely high risk (will not kill self)

N/A

1) How much is being suicidal related to thoughts and feelings about yourself? Not at all: 1 2 3 4 5 : completely
2) How much is being suicidal related to thoughts and feelings about others? Not at all: 1 2 3 4 5 : completely

Please list your reasons for wanting to live and your reasons for wanting to die. Then rank in order of importance 1 to 5.

<table>
<thead>
<tr>
<th>Rank</th>
<th>REASONS FOR LIVING</th>
<th>Rank</th>
<th>REASONS FOR DYING</th>
</tr>
</thead>
</table>

I wish to live to the following extent:
I wish to die to the following extent:

The one thing that would help me no longer feel suicidal would be:
CAMS Suicide Status Form (SSF-IV-R) Initial Session

Section B (Clinician):

Y N Suicide ideation Describe: 

- Frequency ___ per day ___ per week ___ per month
- Duration ___ seconds ___ minutes ___ hours

Y N Suicide plan When: 

Where: __________________ Access to means Y N
How: __________________ Access to means Y N

Y N Suicide preparation Describe: 

Y N Suicide rehearsal Describe: 

Y N History of suicidal behaviors Describe:
  • Single attempt Describe:
  • Multiple attempts Describe:

Y N Impulsivity Describe:

Y N Substance abuse Describe:

Y N Significant loss Describe:

Y N Relationship problems Describe:

Y N Burden to others Describe:

Y N Health/pain problems Describe:

Y N Sleep problems Describe:

Y N Legal/financial issues Describe:

Y N Shame Describe:

Section C (Clinician):

TREATMENT PLAN (Refer to Sections A & B)

<table>
<thead>
<tr>
<th>Problem #</th>
<th>Problem Description</th>
<th>Goals and Objectives</th>
<th>Interventions</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Self-Harm Potential</td>
<td>Safety and Stability</td>
<td>Stabilization</td>
<td>Plan Completed</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
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</tr>
</tbody>
</table>

YES ___ NO ____ Patient understands and concurs with treatment plan?
YES ___ NO ____ Patient at imminent danger of suicide (hospitalization indicated)?

Patient Signature ___________________________ Date ____________
Clinician Signature ___________________________ Date ____________

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CAMS Suicide Status Form (SSF-IV-R) STABILIZATION PLAN

Ways to reduce access to lethal means:

1. ____________________________________________

2. ____________________________________________

3. ____________________________________________

Things I can do to cope differently when I am in a suicide crisis (consider crisis card):

1. ____________________________________________

2. ____________________________________________

3. ____________________________________________

4. ____________________________________________

5. ____________________________________________

6. Life or death emergency contact number: _____________________________

People I can call for help or to decrease my isolation:

1. ____________________________________________

2. ____________________________________________

3. ____________________________________________

Attending treatment as scheduled:

<table>
<thead>
<tr>
<th>Potential Barrier</th>
<th>Solutions I will try</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. __________________</td>
<td>____________________</td>
</tr>
<tr>
<td>2. __________________</td>
<td>____________________</td>
</tr>
</tbody>
</table>

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Section D (Clinician Post-Session Evaluation):

MENTAL STATUS EXAM (circle appropriate items):

ALERTNESS: ALERT DROWSY LETHARGIC STUPOROUS
OTHER:

ORIENTED TO: PERSON PLACE TIME REASON FOR EVALUATION
MOOD: EUTHYMIC ELEVATED DYSPHORIC AGITATED ANGRY
AFFECT: FLAT BLUNTED CONSTRUCTED APPROPRIATE LABILE
THOUGHT CONTINUITY: CLEAR & COHERENT GOAL-DIRECTED TANGENTIAL CIRCUMSTANTIAL
OTHER:
THOUGHT CONTENT: WNL OBSESSIONS DELUSIONS IDEAS OF REFERENCE BIZARRENESS MORBIDITY
OTHER:

ABSTRACTION: WNL NOTABLY CONCRETE
OTHER:

SPEECH: WNL RAPID SLOW SLURRED IMPOVERISHED INCOHERENT
OTHER:
MEMORY: CROSSLY INTACT
OTHER:
REALITY TESTING: WNL
OTHER:

NOTABLE BEHAVIORAL OBSERVATIONS:

DIAGNOSTIC IMPRESSIONS/DIAGNOSIS (DSM/ICD DIAGNOSES):


PATIENT’S OVERALL SUICIDE RISK LEVEL (check one and explain):

☐ LOW (WTL/RFL) Explanation: ________________________________

☐ MODERATE (AMB) ________________________________

☐ HIGH (WTD/RFD) ________________________________

CASE NOTES:

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Next Appointment Scheduled: _______ Treatment Modality: _______
Summarising level of risk

- A combination of warning signs and risk factors contribute to overall suicide risk
- Differentiate phenomena on a continuum, ranging from vague thoughts of death to acute suicidal ideation with plan, access to means, and intent
- Understand frequency and intensity of thoughts, how long they remain, how they resolve

Formulation of risk:
- *Long term vulnerability:* early loss or separation from parents, difficult relationships with parents signified by rejecting or overprotective parenting styles, abuse. Enduring psychological characteristics and psychiatric problems including suicide attempt and self harm
- *Short term vulnerability:* difficulties in relationships, social or living circumstances, lack of support, work or health related problems, drug or alcohol misuse, exacerbation of psychological symptoms
- *Precipitating:* experienced in last few days such as relationship problems, financial worries, anniversaries, death or other loss
- *Presentation:* current mental state, distress and hopelessness, nature of SI with intent and means
Summarising level of risk

- High chronic risk
- Acute high risk
- Chronic low risk
- New emerging risk

- Chronic pattern of self-harm behaviour
- New pattern of self-harm behaviour
- High-lethality method of self-harm
- Low-lethality method of self-harm
Individualised plan for coping

• **Collaboratively** develop and continuously review an individualised plan to help client cope with:
  – Distress (that can lead to suicidal ideation);
  – Suicidal ideation (depending on what is relevant); and
  – Any crisis that arises

• Ensure the person, caregivers/support people and crisis services (if the level of risk means this is indicated) have ready access to **crisis plan**

• Restrict access to suicide **means**, including medication access if necessary
Plan for coping/crisis plan

<table>
<thead>
<tr>
<th>My early warning signs</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel...</td>
</tr>
<tr>
<td>I think...</td>
</tr>
<tr>
<td>I notice...</td>
</tr>
<tr>
<td>I do these things...</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Things I can do that may provide a distraction or help soothe my distress</th>
</tr>
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<table>
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<tr>
<th>Things my friends and/or family do to support me</th>
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</table>

<table>
<thead>
<tr>
<th>Things that will make my environment safer</th>
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<table>
<thead>
<tr>
<th>People and social settings that provide a distraction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
</tr>
<tr>
<td>------</td>
</tr>
<tr>
<td>Name</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Professionals or agencies I can call during a crisis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
</tr>
<tr>
<td>------</td>
</tr>
<tr>
<td>Name</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Local Mental Health Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Emergency Services Phone</td>
</tr>
<tr>
<td>Lifeline</td>
</tr>
<tr>
<td>Kids Help Line</td>
</tr>
<tr>
<td>BeyondBlue support service</td>
</tr>
</tbody>
</table>
Plan for coping/crisis plan

My early warning signs
I feel: lonely, bored, sad
I think: I have no friends, life is pointless, meaningless
I notice: I have isolated myself; said no to social events, stopped exercising. I do these things: stay at home, do nothing, drink.

Things I can do that may provide a distraction or help soothe my distress
Read a good book; go for a walk or swim; give myself a manicure; watch TV.

Things my friends and/or family do to support me
Watch TV with me (I don't really want to have to talk); be kind to me; not demanding or cross about my mood; give me a hug; do an activity with me.

Things that will make my environment safer
Make sure there is no alcohol in the house
Make sure there is no pain relief in the house

People and social settings that provide a distraction
Name: Joe  Place: Movies  Phone: 96230928
Name: Carla  Place: Coffee  Phone: 0458979714

People I know I can rely on who I can call for help
Name: Mum  Phone: 0466888222
Name: Brother  Phone: 0466999111

Professionals or agencies I can call during a crisis
Clinician Name  Phone
Clinician Name  Phone
GP  Phone
Local Mental Health Services  Phone
Local Emergency Services  Phone
LifeLine  131114
Kids Help Line  1800551800
beyondblue support service  1300224636
CAMS Suicide Status Form (SSF-IV-R) STABILIZATION PLAN

Ways to reduce access to lethal means:
1. 
2. 
3. 

Things I can do to cope differently when I am in a suicide crisis (consider crisis card):
1. 
2. 
3. 
4. 
5. 
6. Life or death emergency contact number: 

People I can call for help or to decrease my isolation:
1. 
2. 
3. 

Attending treatment as scheduled:

Potential Barrier: 
Solutions I will try:
1. 
2. 

CAMS Suicide Status Form (SSF-IV-R) Copyright David A. Jobes, Ph.D., All Rights Reserved
Risk assessment and documentation

Document:

- Details of SI (when did you last have a thought; what was the nature of it; how many times last week; how long did it last for; what stopped the thought, what happened before, what happened after; where you ever worried that you would act on that thought)
- Details of other risk and protective factors
- Management plans; plan for coping
- The rational and reasons for management plans
- Contact details for the person at risk, support people including other professionals
- Details of ongoing monitoring of suicidal ideation, including reassessment of risk factors and suicidal phenomena in response to clinical intervention
Suicide risk based assessment is an enduring and ongoing process

- Suicidal risk is dynamic and fluctuating
- Assessment must not rely on a single measurement at one time point
- It is not a prediction tool
Ongoing monitoring; how to?

How to?

- Brief screening e.g. PHQ-9: screening item or simple question to prompt suicide risk based assessment, understand treatment progress, inform treatment planning, and in particular if there is a need for an evidence based intervention that targets suicide ideation.
Ongoing monitoring; how to?

– More detailed screening tools: SIQ (costs money); CSSR-S; our new three-item screener (in press; 0-4 response option):
  • Thinking over the last week, how often have you thought about killing yourself?
  • When you have thought about killing yourself, how strong have those thoughts been?
  • When you have thought about killing yourself, did you feel like you had the control to stop yourself from making the suicide attempt?

– Even more detailed: CAMS
### Section A (Patient):
Rate each item according to how you feel right now:

1) RATE PSYCHOLOGICAL PAIN (hurt, anguish, or misery in your mind, not stress, not physical pain):
   - Low pain: 1 2 3 4 5 : High pain

2) RATE STRESS (your general feeling of being pressured or overwhelmed):
   - Low stress: 1 2 3 4 5 : High stress

3) RATE AGITATION (emotional urgency; feeling that you need to take action; not irritation; not annoyance):
   - Low agitation: 1 2 3 4 5 : High agitation

4) RATE HOPELESSNESS (your expectation that things will not get better no matter what you do):
   - Low hopelessness: 1 2 3 4 5 : High hopelessness

5) RATE SELF-HATE (your general feeling of disliking yourself; having no self-esteem; having no self-respect):
   - Low self-hate: 1 2 3 4 5 : High self-hate

6) RATE OVERALL RISK OF SUICIDE:
   - Extremely low risk: 1 2 3 4 5 : Extremely high risk
     (will not kill self) (will kill self)

**In the past week:**
- Suicidal Thoughts/Feelings Y_ N_
- Managed Thoughts/Feelings Y_ N_
- Suicidal Behavior Y_ N_

### Section B (Clinician):
Resolution of suicidality, if: current overall risk of suicide ≤ 3; in past week: no suicidal behavior and effectively managed suicidal thoughts/feelings □ 1st session □ 2nd session

**Complete SSF Outcome Form at 3rd consecutive resolution session**

**TREATMENT PLAN UPDATE**

**Patient Status:**
- □ Discontinued treatment
- □ No show
- □ Cancelled
- □ Hospitalization
- □ Referred/Other: ________________

<table>
<thead>
<tr>
<th>Problem #</th>
<th>Problem Description</th>
<th>Goals and Objectives</th>
<th>Interventions</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Self-Harm Potential</td>
<td>Safety and Stability</td>
<td>Stabilization</td>
<td>☐</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td>Plan Updated</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Section D (Clinician Post-Session Evaluation):

**MENTAL STATUS EXAM (circle appropriate items):**

- **Alertness:** Alert, Drowsy, Lethargic, Stuporous
- **Orientation to Person:**
  - Place
  - Time
  - Reason for Evaluation
- **Mood:**
  - Euthymic
  - Elevated
  - Dysphoric
  - Agitated
  - Anger
- **Affect:**
  - Flat
  - Blunted
  - Constricted
  - Appropriate
  - Labile
- **Thought Continuity:**
  - Clear & Coherent
  - Goal-Directed
  - Tangential
  - Circumstantial
- **Thought Content:**
  - WNL
  - Obsessions
  - Delusions
  - Ideas of Reference
  - Bizarreness
  - Morbidity
  - Other:
- **Abstraction:**
  - WNL
  - Notably Concrete
  - Other:
- **Speech:**
  - WNL
  - Rapid
  - Slow
  - Slurred
  - Impoverished
  - Incoherent
  - Other:
- **Memory:**
  - Grossly Intact
  - Other:
- **Reality Testing:**
  - WNL
  - Other:

**NOTABLE BEHAVIORAL OBSERVATIONS:**

---

**DIAGNOSTIC IMPRESSIONS/DIAGNOSIS (DSM/ICD DIAGNOSES):**

---

**PATIENT'S OVERALL SUICIDE RISK LEVEL (check one and explain):**

- [ ] LOW (WTL/RFL)  
  Explanation:

- [ ] MODERATE (AMB)

- [ ] HIGH (WTD/RFD)

**CASE NOTES:**

---

Next Appointment Scheduled: __________  Treatment Modality: __________

---

Clinician Signature: __________  Date: __________
Mood monitoring project
Aims

To investigate:

1. Whether the tool facilitated improved monitoring;
2. How useful this was for clinicians and clients;
3. The trajectory of change in depression and suicidal ideation over time;
4. Whether a refined (shorter) tool could be implemented.
Methods

• The Patient Health Questionnaire (PHQ-9)
  – A scale of 1 to 10

• The Suicidal Ideation Questionnaire—Junior (SIQ-JR)
  – A brief (3-item) suicidal ideation symptom measure was developed on the basis of the tool developed and tested by Clum & Curtin

• *Side effect and impact on cognition measurement (this was for an imbedded study looking at side effects of medication)*
Methods

• Participants
  – 12-25 years old
  – Depressive symptoms (PHQ-9) or a depressive disorder (clinician report)

• Settings
  – Peninsula Family General Practice (PFGP)
  – Two local headspace centres (Sunshine and Glenroy)
  – Youth Mood Clinic (YMC) at Orygen Youth Health (OYH)
Procedure

Waiting room:  Client completes tool

In appointment:  Clinician views graph at start of appointment

End of study:  Clients and clinicians provide feedback on tool
What the clinician sees

Summary of client's responses (clinician-only page)

Your client homer has completed the Mood Monitor questionnaire and has been asked to pass the iPad to you.

Depression scores

Their depression score was: 3.
This suggests that they are not currently experiencing depression.

Suicidal Ideation scores

Their suicidal ideation score was: 15.
This suggests that further assessment is not required before the next appointment.
The following key SIQ questions scored over 4 out of 6: None.
What the clinician sees

**What happened this week?**

Your client's answer to the question *Did anything bad happen this week that impacted your mood?* was:

Feeling good about work

This client has responded to the quiz 10 times.

**Mood Monitor Scores**
red = high risk, yellow = moderate risk, green = low risk

Hover over data points for the client's answer on that day to the question: "Did anything happen in the last week that impacted your mood?"
Mood monitoring: results

*Participants: mean age 18.7; 20% male*

<table>
<thead>
<tr>
<th>Number of visits</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>39</td>
<td>38.6</td>
</tr>
<tr>
<td>2</td>
<td>20</td>
<td>19.8</td>
</tr>
<tr>
<td>3</td>
<td>21</td>
<td>20.8</td>
</tr>
<tr>
<td>4</td>
<td>13</td>
<td>12.9</td>
</tr>
<tr>
<td>5</td>
<td>2</td>
<td>2.0</td>
</tr>
<tr>
<td>6</td>
<td>2</td>
<td>2.0</td>
</tr>
<tr>
<td>7</td>
<td>2</td>
<td>2.0</td>
</tr>
<tr>
<td>8</td>
<td>2</td>
<td>2.0</td>
</tr>
</tbody>
</table>
Mood monitoring: results

*Client assessment of tool*

<table>
<thead>
<tr>
<th>Description</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Easy to complete</td>
<td>87%</td>
</tr>
<tr>
<td>Like the tool</td>
<td>96%</td>
</tr>
<tr>
<td>Found tool useful</td>
<td>87%</td>
</tr>
<tr>
<td>Helped me understand my symptoms</td>
<td>73%</td>
</tr>
<tr>
<td>Helped me understand what caused mood to fluctuate</td>
<td>49%</td>
</tr>
<tr>
<td>Helped me feel more in control of my symptoms</td>
<td>78%</td>
</tr>
<tr>
<td>Reassured me clinician knew all they needed to know about how I was feeling</td>
<td>78%</td>
</tr>
</tbody>
</table>
Results: client feedback

“Gives me a chance to reflect on the week without the personal/emotional worries; the iPad doesn’t judge or react”

“It was easy and gave my therapist an idea of what had been going on before my appointment”

“it was a great way to express feelings I didn't necessarily have the confidence to say out aloud”

“Liked that it told my psychologist things that she needed to know”
Mood monitoring: results

Clinician assessment of tool

<table>
<thead>
<tr>
<th></th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Easy to complete</td>
<td>100%</td>
</tr>
<tr>
<td>Like the tool</td>
<td>100%</td>
</tr>
<tr>
<td>Found tool useful</td>
<td>100%</td>
</tr>
<tr>
<td>Helped me understand my clients symptoms</td>
<td>92%</td>
</tr>
<tr>
<td>Helped me understand my clients risk</td>
<td>92%</td>
</tr>
<tr>
<td>Informed treatment planning</td>
<td>50%</td>
</tr>
<tr>
<td>Helped with engagement</td>
<td>50%</td>
</tr>
<tr>
<td>Did the cost outweigh the benefit</td>
<td>33%</td>
</tr>
</tbody>
</table>
“Would be great to see this project expanded - especially into real time, where clinicians could see how clients are tracking on a day-to-day basis”

“Very helpful with one client who found it difficult to disclose risk face to face”

“Very useful to get a summary of risk prior to beginning the appointment”

“Helps to start discussion about risk right away in session, maximising clinical time”
Mood monitoring: results

What happened to depression and SI over time?

• A significant deceasing time trend for both PHQ-9 total score and SIR-JR total score
• Linear mixed effects model analysis (rate of improvement per day):
  – PHQ-9 total score = 0.54
  – SIQ-JR total score = 0.27
Mood monitoring: results

How can we make the tool shorter?

Depression

<table>
<thead>
<tr>
<th>Visit</th>
<th>Correlation</th>
<th>P-Value</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visit 1</td>
<td>-0.64</td>
<td>&lt;0.001</td>
<td>101</td>
</tr>
<tr>
<td>Visit 2</td>
<td>-0.61</td>
<td>&lt;0.001</td>
<td>62</td>
</tr>
<tr>
<td>Visit 3</td>
<td>-0.37</td>
<td>0.015</td>
<td>42</td>
</tr>
<tr>
<td>Visit 4</td>
<td>-0.76</td>
<td>&lt;0.001</td>
<td>21</td>
</tr>
</tbody>
</table>
Mood monitoring: results

How can we make the tool shorter?

Suicidal Ideation

1. I thought it would be better if I was not alive
2. I thought about killing myself
3. I thought about how I would kill myself
4. I thought about when I would kill myself
5. I thought about people dying
6. I thought about death
7. I thought about what to write in a suicide note
8. I thought about writing a will
9. I thought about telling people I plan to kill myself
10. I thought about how people would feel if I killed myself
11. I wished I were dead
12. I thought that killing myself would solve my problems
13. I thought that others would be happier if I was dead
14. I wished that I had never been born
15. I thought that no one cared if I lived or died
Mood monitoring: results

How can we make the tool shorter?

Suicidal Ideation

1. Thinking over the last week, how often have you thought about committing suicide?

2. When you have thought about committing suicide, how strong have those thoughts been

2. When you have thought about committing suicide, did you feel like you had the control to stop yourself from making the suicide attempt?
Mood monitoring: results

How can we make the tool shorter?

Suicidal Ideation

<table>
<thead>
<tr>
<th></th>
<th>Suicidal Ideation Screener Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Correlation</td>
</tr>
<tr>
<td>SIQ-JR</td>
<td></td>
</tr>
<tr>
<td>Visit 1</td>
<td>0.84</td>
</tr>
<tr>
<td>Visit 2</td>
<td>0.85</td>
</tr>
<tr>
<td>Visit 3</td>
<td>0.87</td>
</tr>
<tr>
<td>Visit 4</td>
<td>0.72</td>
</tr>
<tr>
<td>PHQ-9</td>
<td></td>
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<tr>
<td>Visit 1</td>
<td>0.63</td>
</tr>
<tr>
<td>Visit 2</td>
<td>0.52</td>
</tr>
<tr>
<td>Visit 3</td>
<td>0.66</td>
</tr>
<tr>
<td>Visit 4</td>
<td>0.45</td>
</tr>
</tbody>
</table>
Summary of Results

• Monitoring was improved: more did it and it was done using good tools
• Clinicians and clients found it useful and helpful
• Facilitated disclosure
• It provided some insight into the trajectory of depression and suicidal symptoms; is safe
• We know we can make it shorter
Critical discussion point

• The *intention* of the tool is as a starting point to help clinicians break the silence with the client around discussing suicidality

• It is not for risk prediction

• It should lead to engagement of client in discussion of suicidal thoughts and intentions, risk and protective factors, and treatment progress, which in turn informs treatment planning
Feedback informed and targeted treatment approaches

Development of practice principles for the management of ongoing suicidal ideation in young people diagnosed with major depressive disorder

Simon M Rice1,2, Magenta B Simmons1,2, Alan P Bailey1,3, Alexandra G Parker1,3, Sarah E Hetrick1,3, Christopher G Davey1,3, Mark Phelan1,3, Simon Blakie1 and Jane Edwards1

The treatment of depression in young people

By Simon Rice Assoc NAPS, Dr Christopher Davey FRANZCP, Dr Tracy Garvin and Dr Sarah Hetrick, Orygen Youth Health, Melbourne

The treatment of youth depression has become increasingly specialised and is now recognised as distinct from adult and paediatric treatment models. Adolescence and young adulthood are characterised by rapid physical, cognitive and psychosocial changes, and form not only the peak period for the emergence of mood disorders (Bush et al., 2000), but also herald a window of opportunity for early intervention and prevention of long-term negative psychosocial impact and functional impairment. Though supporting data remain scarce, effective treatment of youth depression may assist to decrease relapse or recurrence in later life (Treatment for Adolescents with Depression Study, 2000). This article outlines the formulation-based assessment and early intervention multimodal treatment model used by clinicians in the Youth Mood Clinic at Orygen Youth Health where working with adolescents and young adults experiencing moderate to severe major depressive disorder.

Identification and engagement

A number of specific approaches have been identified in assessing and treating depression in young people, and practitioners are encouraged to familiarise themselves with the benchmarks for the Australian Guidelines for Depression and Anxiety in Australia that has both biological and social components, emphasising the high likelihood of favourable treatment outcomes and improved quality of life with regular attendance, and linking young people with online peer and professional support communities. As such as the e-space enhance online mental health project (for further engagement tips see www.mcguire.com, Chambers, Foster, Drew, & Bever, 2017). Degree of input and involvement with family members should be negotiated early in treatment, and relevant ethical and confidentiality issues (including limits to confidentiality) should be considered in the context of the mature minor principle.

Psychotherapy

Concrete behavioural strategies may be needed for earlier adolescents, whereas older adolescents and young adults may be better able to utilise cognitive interventions (Belen, Garben, & Shelton, 2005). In addition to supportive counselling, simple interventions for mild depressive presentations for younger clients may focus primarily on behavioural factors, including behavioural activation, mood monitoring, chain analysis, development of problem solving skills, and encouraging activities that promote competence.
Feedback informed and targeted treatment approaches

Where to from here?
Technology and apps
Technology and apps

• Real time?
• Include brief intervention
• Adopt formal Feedback Informed Treatment approaches e.g. ORS/SRS
• Shared decision making
Outcome Rating Scale

Looking back over the last week (or since your last visit), including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels. If you are filling out this form for another person, please fill out according to how you think he or she is doing.

Individually:
(Personal well-being)

Interpersonally:
(Family, close relationships)

Socially:
(Work, school, friendships)

Overall:
(General sense of well-being)

International Center for Clinical Excellence
Session Rating Scale

Please rate today’s session by placing a mark on the line nearest to the description that best fits your experience.

Relationship
I did not feel heard, understood, and respected. | I felt heard, understood, and respected.

Goals and Topics
We did not work on or talk about what I wanted | We worked on and talked about what I wanted to

Approach or Method
The therapist’s approach is not a good fit for me. | The therapist’s approach is a good fit for me.

Overall
There was something missing in the session today. | Overall, today’s session was right for me.
Youth participation and co-design
Youth participation and co-design

• Include mood monitoring; are you in a ‘good space’ or in a ‘not so great space’
• Pre-selected distraction/self soothing activities
• Notification to support person
• Information to clinician
A note on consultation/supervision

• Access supervision and consultation **regardless of level** of clinical experience

• Work in collaboration and consultation with senior colleagues and where needed, access multidisciplinary support

• Higher risk clients may require frequent peer supervision review

• Clinicians to be mindful of maintenance of self-care and wellbeing; YP experiencing ongoing suicidal ideation can be a very challenging group to work with.
A note on language


e.g. ‘committed suicide’: the word commit associated with negativity and wrong-doing; ‘suicide attempt’: implies that success will be achieved if death is the outcome; referring to non-fatal outcomes as ‘failed’ attempts‘ problematic; self-harmers’: dismissive and pejorative language
Key references for ongoing monitoring


Hetrick SE. Monitoring of suicide risk throughout the course of treatment with antidepressants for depression is required, but vigilance is required for those on some particular antidepressant agents. Evidence Based Mental Health 2015;18(3):86.


Key references for treatment


Thank you

shetrick@unimelb.edu.au