

Assessment of Suicide Risk in Adolescents

What have I learnt
in the last 20 years

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The Adolescent Brain

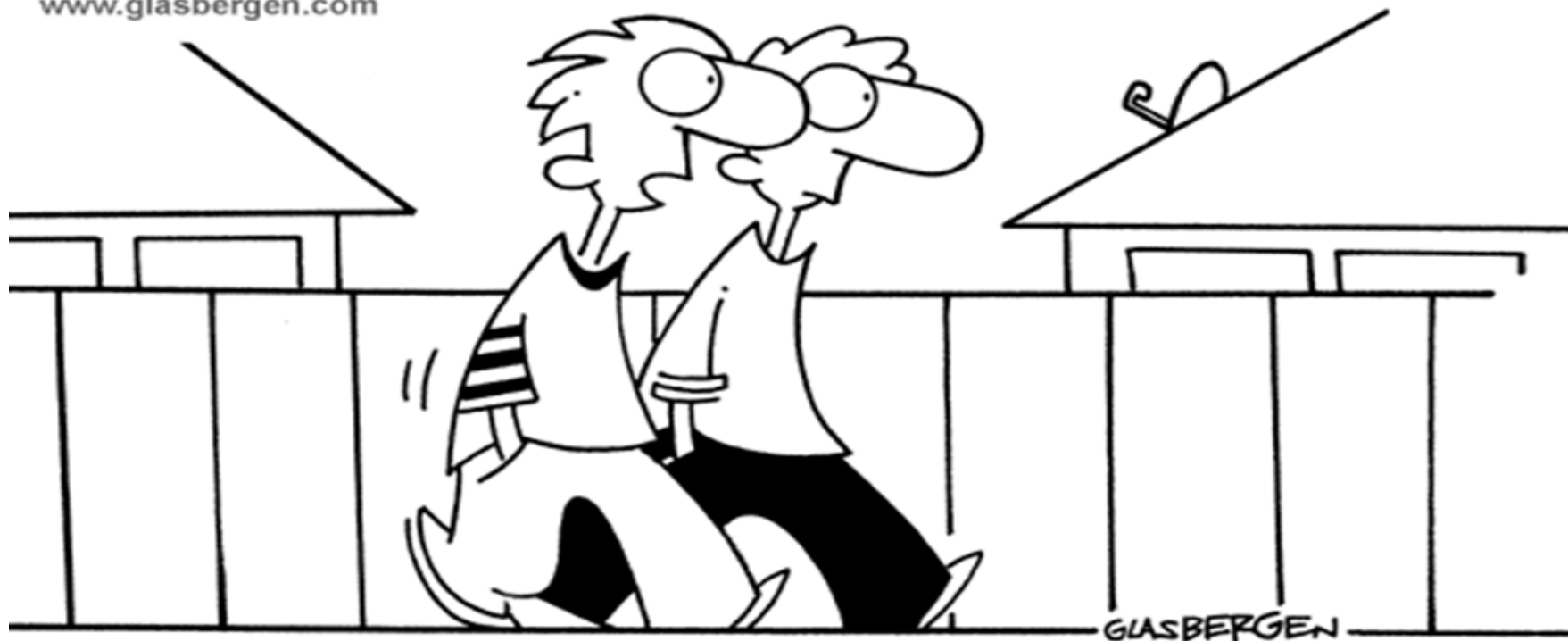
Adolescence is defined as the period of life that starts with the biological, hormonal and physical changes of puberty and ends at the age at which an individual attains a stable, independent role in society.



BAD PRESS

- More than half of the stories about teenage boys in national and regional newspapers were about crime. The word most commonly used to describe them was "yobs" (591 times), followed by "thugs" (254 times), "sick" (119 times) and "feral" (96 times).
- “We found some news coverage where teen boys were described in glowing terms – 'model student', 'angel', 'altar boy' or 'every mother's perfect son'," the research concluded, "but sadly these were reserved for teenage boys who met a violent and untimely death.”
- The research found that – for all the coverage of teenage issues – the boys' voices themselves were rarely heard in newspapers. Fewer than one in 10 articles about young people actually quoted young people or included their perspectives in the debate.

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**"WHEN I WAS 5 EVERYONE TOLD ME TO BE A BIG BOY.
WHEN I WAS 10 THEY TOLD ME I SHOULD BE MORE MATURE.
NOW THEY SAY IT'S TIME TO START ACTING LIKE AN ADULT.
AT THIS RATE, I'LL BE ELIGIBLE FOR SOCIAL SECURITY
BEFORE I GRADUATE FROM HIGH SCHOOL!"**

Brain Development

Thanks to the use of technology such as MRI, and functional MRI we can now explain behaviour in biological terms. In adolescence there is a massive decline in grey matter in the prefrontal cortex, due to **synaptic pruning** and mediated by the environment.

The prefrontal cortex is responsible for:

- Ability to take other peoples perspectives
- Impulse control
- Emotional regulation
- Focusing and attention
- Complex planning
- Ability to ignore external distractions

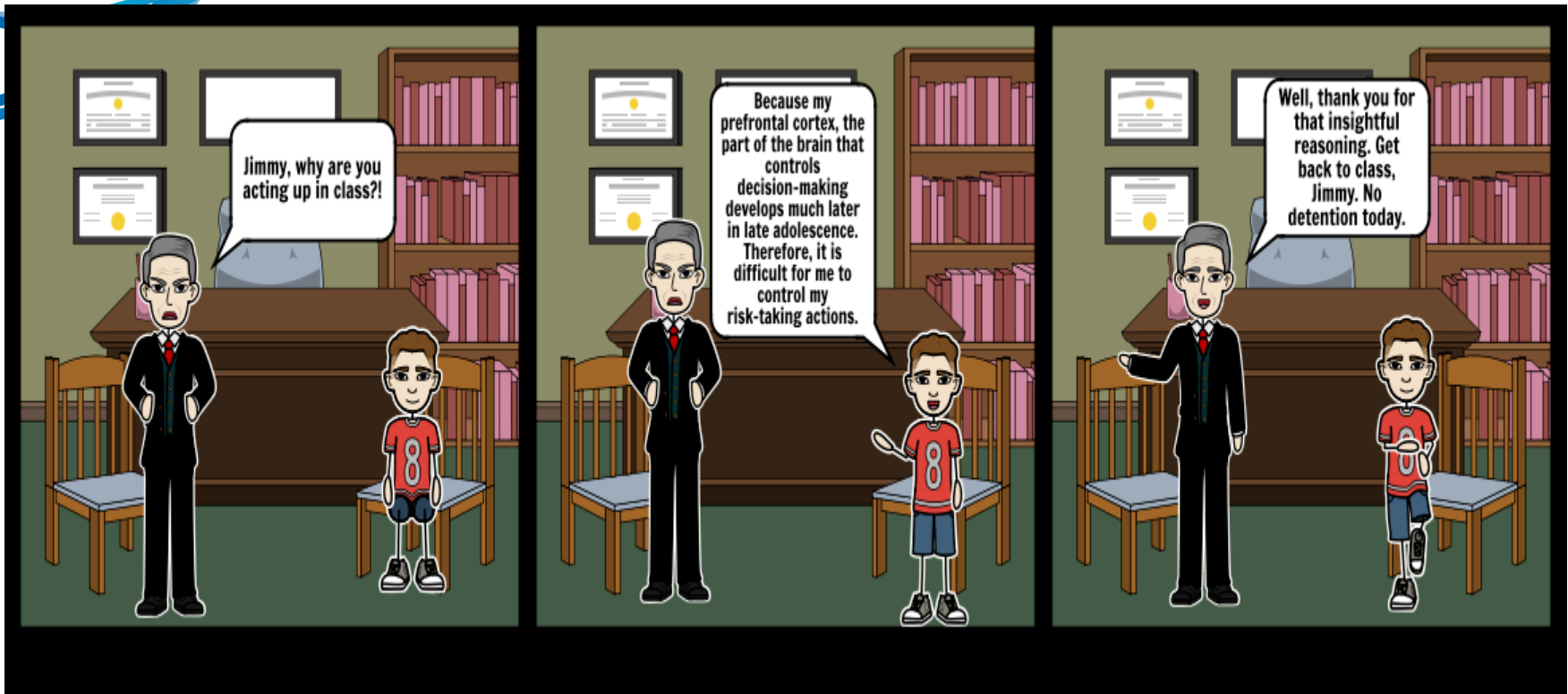
The ability to inhibit impulsive behaviours matures gradually during childhood and adolescence, but effective control is not achieved until adulthood.

What are they like?

1. Anxiety: "a future-oriented mood state in which one is ready or prepared to attempt to cope with upcoming negative events" suggesting that it is a distinction between future versus present dangers that divides anxiety and fear. Normal reaction to stress.
2. Mood swings: "an abrupt and unaccountable change of mood". Caused by hormonal changes, brain development changes
3. Confusion/Indecision: Multiple changes, to their bodies, environment, expectations (their own, and others)... **THEY CAN'T KEEP UP!!!**

What are they like?

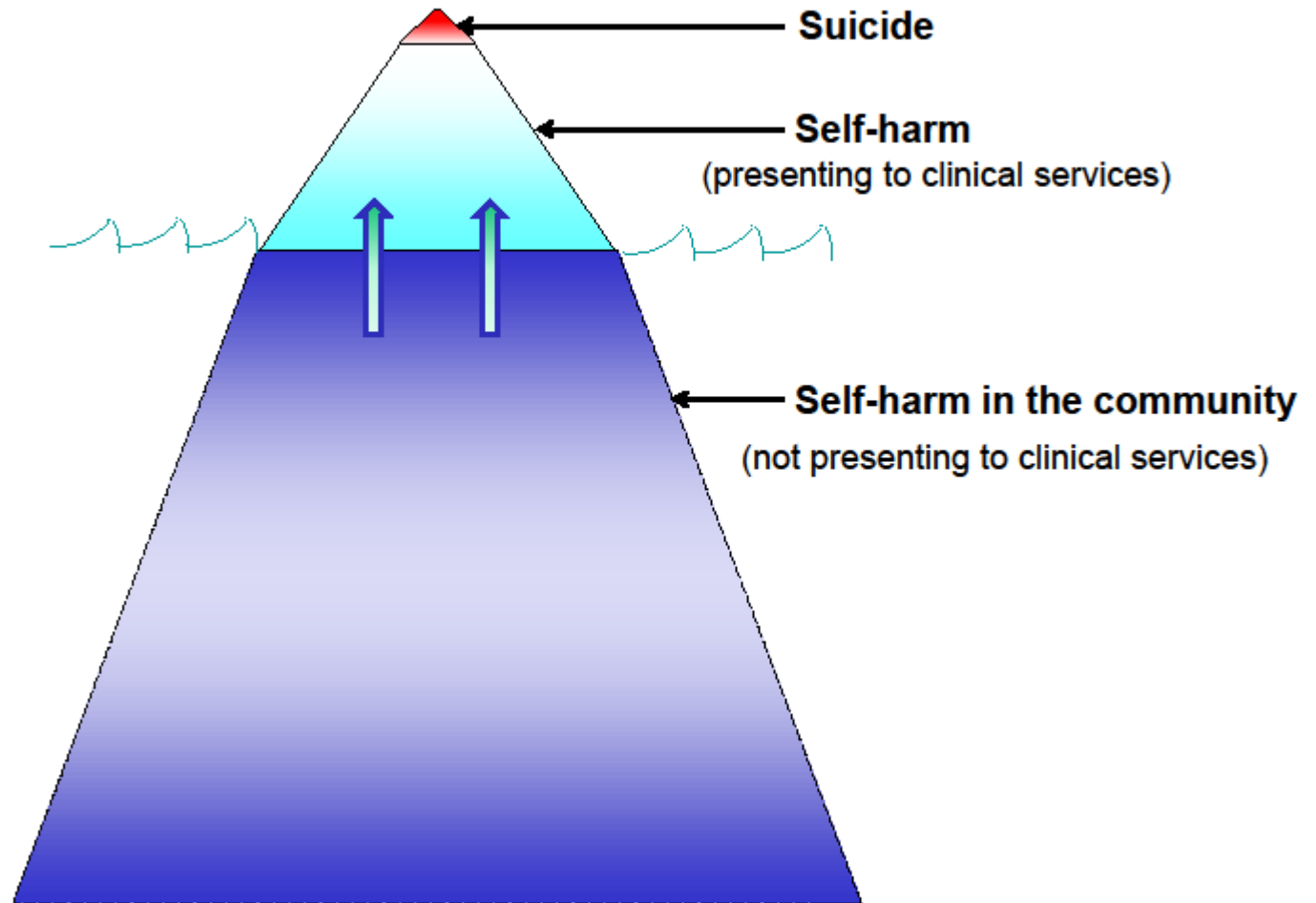
4. Lethargy: They don't prioritize eating or resting.
5. Argumentation: they want to take decisions themselves and want to do things their way, while adults (parents and teachers) want them to behave like mature individuals
6. Anger/Irritability: In adolescents, thwarting of desires, interruption of activities in progress, constant fault finding, teasing, lecturing, or making unfavourable comparisons with other children lead to anger.
7. Experimentation: Risk taking, greatly influenced by their peer group.



Suicide in Young People

- 5000 people die every year from suicide in England. On average that is one person every 2 hours.
- Around 700 of them are under 20 years old.
- Suicide accounts for 20% of all deaths in young people between 15 and 24 years old.
- It is the commonest cause of death in men under 35
- Around 25,000 young people present to A and E with DSH each year in the UK
- The actual rates of suicide are probably 50% higher than these values, as many deaths are recorded as “misadventure” – a reflection of the stigma surrounding the issue of suicide in young people.

Iceberg model of self-harm and suicide in young people

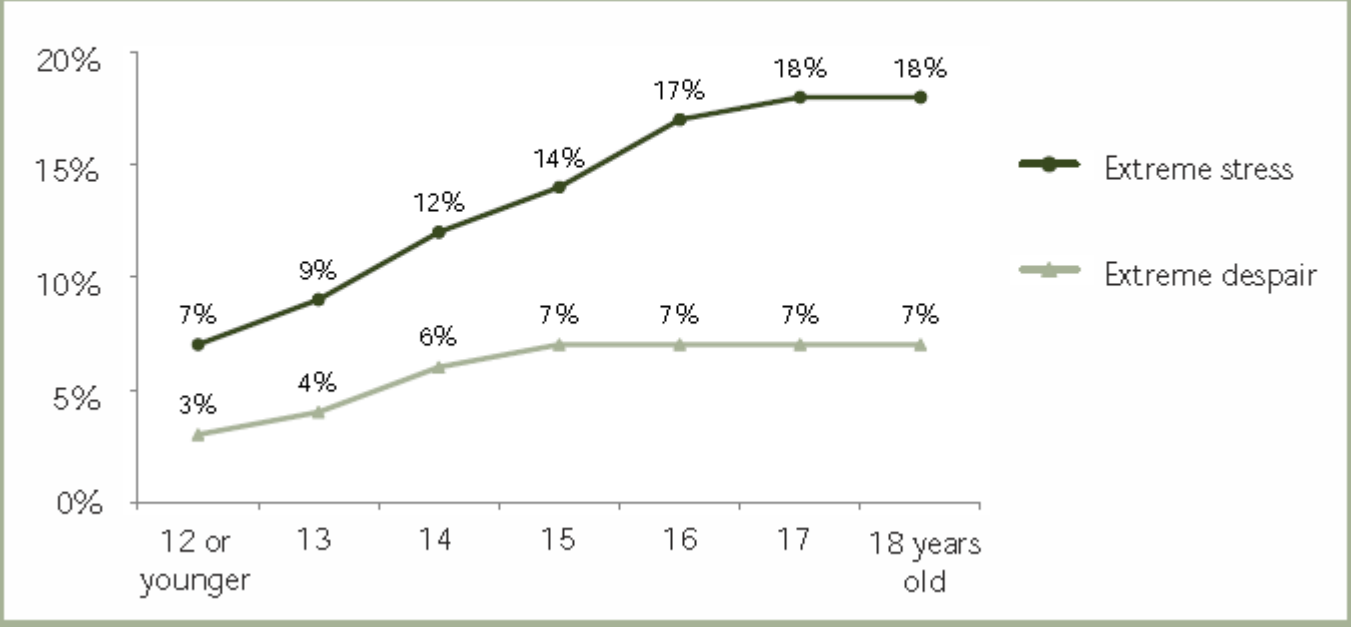


Mental Illness & Suicide

- Lifetime risk in all mood disorders = 2.2%
- Lifetime risk in schizophrenia = 4.9%
- Lifetime risk in bipolar disorder = 6%
- Lifetime risk in addictions = 6%

A significant proportion of those who commit suicide do not have a diagnosable mental illness

Extreme stress and despair by age



DSH and Suicide

Study looking at records of self-harm among children and adolescents aged 10 to 19 between 2011 and 2014 found:

- Overall rates across the study period were 37.4 per 10,000 in girls and 12.3 per 10,000 in boys.
- Among girls aged 13-16 rates increased by 68% between 2011 and 2014, rising from 45.9 to 77.0 per 10,000.
- Rates were highest in the most deprived areas, 27.1 per 10,000 compared to 19.6 per 10,000 in the least deprived areas.
- Girls aged 13 to 16 were the only group where the rate of self-harm sharply increased across the study period.
- Many cases involved drugs or alcohol, higher rates in more deprived areas.

DSH and Suicide

Findings on what happened in the 12 months after self-harm was reported included:

- In both boys and girls, roughly 1 in 5 self-harmed again, although this was slightly more common in girls.
- Only 44% had a documented referral to mental health services – in 12% of cases this was before the self-harm episode.
- About 1 in 5 girls were prescribed antidepressants.
- Those in the most deprived areas were less likely to be referred or be prescribed medication.

In the UK between 2010 and 2015 suicide rates among 15 to 19 year olds rose from 3.2 to 5.4 per 100,000.

Other facts about Suicide

- 10% of people who make a suicide attempt will later die by suicide
- 1% of all suicides occur in NHS psychiatric hospitals
- If every mental health treatment team magically protected every person they saw for 1 month, about 70% of suicides would still occur.
- In the last 20 years rates have fallen in older people but risen in the young. Highest rates are now in men aged 30 to 39 years old.

Motivation

- Anomic – school pressure, shifting social pressures, family losses/changes
- Fatalistic – Hopelessness about the future, repeated disappointments
- Isolation – isolated communities, gay/bisexual/transgender youth, victims of trauma
- Altruism – protecting parents or friends, remorse over perceived infraction

One other motivation.....

- No Motivation.....

The 4 C's of Suicide Assessment

- Collateral information
- Confidence
- Common Sense
- Changeability

Changeability

NOT CHANGEABLE

- Age
- Sex
- Family History of Suicides
- Family History of Mental Disorder
- Prior Attempts of Suicide
- Historical Diagnosis of Psychiatric Disorder
- Historical use of Psychotropics
- Remote Loss/Trauma

CHANGEABLE

- Access to Lethality
- Untreated Mental Health Disorder
- Worsening Mental Health Disorder
- Dealing with Recent Loss/Life Crisis
- Lack of Social or Formal Support
- Non-response to Medication
- Caregiver/Family Unavailable to care
- Addictions

So what do we do?

Chronic suicide risk

- No changeable factors
- Chronic pattern of suicide attempts as a coping mechanism:
 - ❖ Makes a strong case for CAMHS intervention (encouraging coping, strength, improving contacts with emergency services)
 - ❖ Makes a weak case for hospitalization, as discharge criteria would be undefined.

So what do we do?

Acute Suicide Risk

- Changeable risk factors
- Mechanisms of coping are inadequate to handle stressors
- ❖ Makes a strong case for CAMHS treatment, if able to engage in treatment and safety planning. The aim is to address and change the changeable risk factors.
- ❖ Hospitalization might be needed, if imminent risk factors threaten safety.

So what do we do?

Acute on Chronic Suicide Risk

- Acute change in situation increases the emergency of an already-established suicidal risk
- ❖ Makes a case for hospitalization to address the acute risk factors and changes, but discharge would occur after this was dealt with to encourage coping and strength for chronic risk factors.

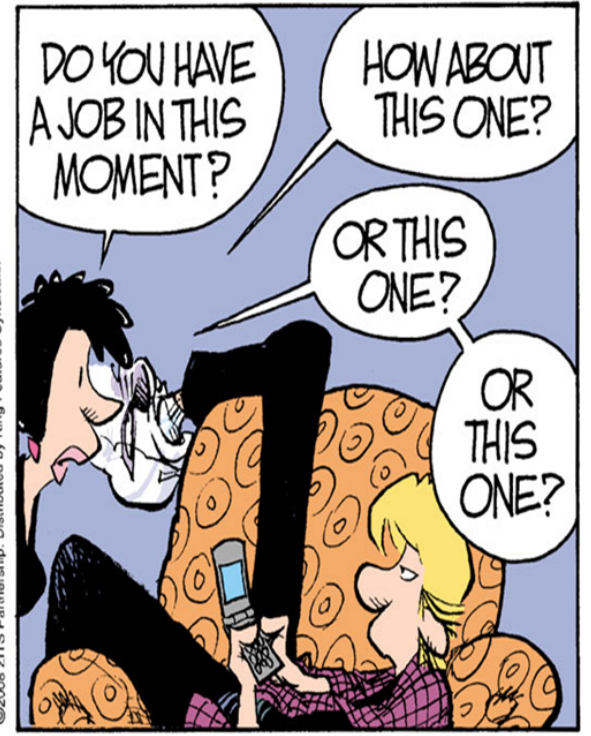
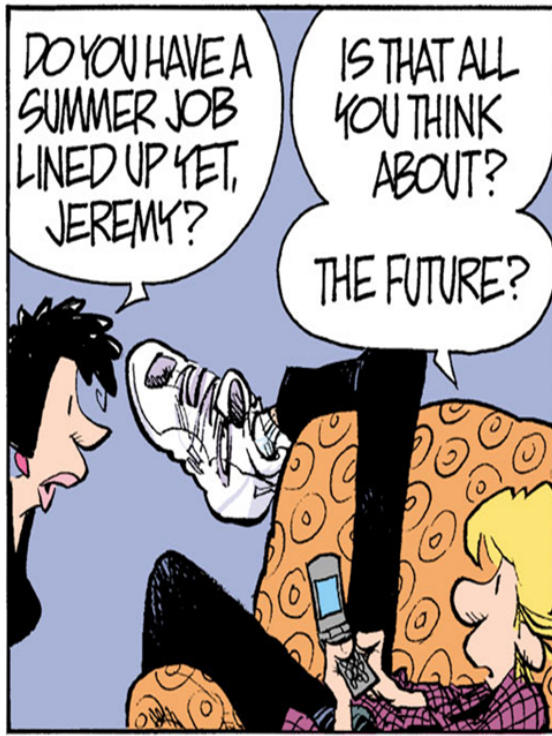
Is Hospital safe?

How does it add to the risk?

- Fear response (anxiety and stress): Procedures and tests, meeting new people, family separation, worry about health
- Feelings of isolation: Not seeing friends, hard to see family
- Decreased pro-social activity: Playing sports, engaging with friends
- Major life changes
- Parental upset / stress
- Contagion

Conclusion

- Suicide is a multifactorial problem with a multifactorial solution
- Risk assessment tools have poor evidence
- Evidence to support management of suicide risk has not been robust: a good history and clinical nose remains the most accurate risk assessment tool.
- Be curious, be compassionate, be honest and be humorous if you can.



References

- Professor Sarah-Jayne Blakemore. The secret life of the teenage brain
- Incidence, clinical management, and mortality risk following self harm among children and adolescents: cohort study in primary care. *BMJ* 2017; 359 doi:<https://doi.org/10.1136/bmj.j4351> (Published 18 October 2017)