Child and Youth Mental Health and Suicide: Knowledge for the Community Health
Why Child and Youth Mental Health?

• It’s very common (13-25%)
• Not everyone gets help (only 1 in 6 access services)
• 70% of adults with a mental illness indicate that it started before they were 18 (50% before 14)
• Suicide is the 2nd leading cause of death in ages 16-24 (Statistics Canada, 2002)
• If one mental health disorder is present, more than likely there will be other problems present (45% have more than 1)
Symptoms
Symptoms + Dysfunction
Symptoms + Dysfunction + Impairment
No Symptoms

Awareness +
Destigmatization +
Prevention & Promotion
Prevention & Promotion +
Early Identification +
Population-based Interventions
Prevention & Promotion +
Targeted Interventions +
Different Levels of Care
Prevention & Promotion +
Specialized Intervention +
Chronic Care

*Shaffer et. al., 1996 (prevalence data from the MECA study)
Mental Health Exists on a Continuum

Mental Health - Mental Illness Continuum

- **Health**
  - Well-being
  - Occasional stress to mild distress
  - No impairment

- **Mental health problems**
  - Emotional problems or concerns
    - Mild to moderate distress
    - Mild or temporary impairment
  
- **Illness**
  - Mental Illness
    - Marked distress
    - Moderate to disabling or chronic impairment
Determinants Of Mental Health

- Individual factors
  - Temperament, genetics, learning ability, social skills

- Family factors (influenced by culture and history)
  - Attachment, parenting style, communication, parental and sibling relations, family structure and circumstances

- Environmental factors
  - Social conditions, school, community, sense of belonging
<table>
<thead>
<tr>
<th>Ear Ache</th>
<th>Psych Ache</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Pain (inside)</td>
<td>✓</td>
</tr>
<tr>
<td>• Dizzy</td>
<td>✓</td>
</tr>
<tr>
<td>• Hard to concentrate</td>
<td>✓</td>
</tr>
<tr>
<td>• Irritable</td>
<td>✓</td>
</tr>
<tr>
<td>• Can’t sleep</td>
<td>✓</td>
</tr>
<tr>
<td>• No appetite</td>
<td>✓</td>
</tr>
<tr>
<td>• Stay home</td>
<td>✓</td>
</tr>
<tr>
<td>• Less social</td>
<td>✓</td>
</tr>
<tr>
<td>• Physical symptoms</td>
<td>✓</td>
</tr>
<tr>
<td>• Go for help right away</td>
<td>?</td>
</tr>
</tbody>
</table>

*(Peggy Austen, 2005)*
Signs and Symptoms

Look for changes (behaviours, appearance, mood)
- School performance, (concentration, motivation)
- Interactions with friends and family
- Extreme mood swings and/or emotional outbursts of anger and rage
- Physical symptoms (headaches, stomach aches, etc.)
- Eating and sleeping
- Dealing with authority
- Risk taking behaviour
- not doing the things he or she used to enjoy
- damaging other people's property
- worrying constantly
- obsessed with his or her weight
- lacking energy or motivation
- Aggression to others or self
When To Be Concerned?

- May be signs of an underlying mental health disorder if they are:
  - intense;
  - persist over long periods of time;
  - inappropriate for the child's age; and
  - interfere with the child's life.
Normal Development: Youth

- Mood swings/temper tantrums
- Low frustration tolerance
- Exaggerated responses to change / setback
- Emotions *before* logical thinking
- *Do not* perceive risk like adults
Youth stay up later and sleep in later (biology)

Secrete melatonin up to two hours later than when they were younger

Melatonin - one of the brain’s sleep chemicals

Teenagers require more sleep than adults

Sleep deprivation leads to emotions that are less controlled and more exaggerated

Strauch 2003
Risk-Taking Behaviour: Youth

- Risk-taking is a normal tool of development
- **Dopamine** - neurotransmitter linked to risk-taking behaviours
- Increased impulsivity
- *Do not* see consequences of their actions
- Make poor decisions when it’s emotional/stressful
- Group mentality
### 6 Month Prevalence Rates of Mental or Addictive Disorders in Children 4-17 years

<table>
<thead>
<tr>
<th>Disorder</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety Disorders</td>
<td>7</td>
</tr>
<tr>
<td>ADHD</td>
<td>5</td>
</tr>
<tr>
<td>Conduct Disorder</td>
<td>4</td>
</tr>
<tr>
<td>Mood Disorders</td>
<td>4</td>
</tr>
<tr>
<td>Substance Use Disorders</td>
<td>1</td>
</tr>
<tr>
<td>Any Disorder</td>
<td>14</td>
</tr>
</tbody>
</table>

Waddell et al, Can J Psychiatry, 2002
“Love looks forward, hate looks back, anxiety has eyes all over its head.”

Mignon McLaughlin, *The Neurotic’s Notebook*
Significant Levels of Stress and Depressed Feelings by Gender

(YN/RA 2009, N=19996)
Suicidal Ideation and Behaviour

Past Suicidal Thoughts | Current Suicidal Thoughts | Past Suicide Attempts
---|---|---
Male
Past Suicidal Thoughts: 17.7
Current Suicidal Thoughts: 6.8
Past Suicide Attempts: 7.1
Female
Past Suicidal Thoughts: 31.3
Current Suicidal Thoughts: 13.3
Past Suicide Attempts: 16.1

(YN/RA 2009, N=19996)
Suicide Attempts By Gender For Mainstream And Marginalized Youth

<table>
<thead>
<tr>
<th>Stream of Youth</th>
<th>Females</th>
<th>Males</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mainstream</td>
<td>12.2</td>
<td>4.6</td>
</tr>
<tr>
<td>Marginalized</td>
<td>36.7</td>
<td>15.0</td>
</tr>
</tbody>
</table>
In spite of the elevated rates of suicidal ideation and attempts, many never disclosed these thoughts or feelings:

- **mainstream**: 37.8%
- **non-mainstream**: 34.9%
- **younger**: 39.3%
- **older**: 35.1%
- **males**: 45.3%
- **females**: 32.3%
Who Would Youth Talk to About Their Mental Health Concerns?

- **Males**
  - Friends: 31.9%
  - No One: 47.8%
  - Others: 6.5%
  - Professional: 1.8%
  - >1: 10.6%

- **Females**
  - Friends: 46.3%
  - No One: 30.7%
  - Others: 2.6%
  - Professional: 1.8%
  - >1: 8.0%
63% of youth indicated that embarrassment, fear, peer pressure, and/or stigma are the major barriers to young people seeking help for mental health problems.

Others would not recognize if they had a problem (19%) or would not know where to get help (12%).

Davidson & Manion, 1996
Mental Health Literacy – What Do You Need To Know?

- Link with general health and wellbeing
- Service delivery model
- Alignment with other initiatives (locally, provincially)
- Roles (their own versus others)
- Awareness of the mental health continuum (especially promotion)
- Stigma reduction
- Creating environments that promote positive mental health
- Signs and symptoms
- Talking to children/youth and parents about mental health
- Relevant legislation
- Pathways to community support
Resources

eMentalHealth.ca

- Where to find local Mental Health Help
  - (Public and private services)
- Mental Health Events Calendar
- Mental Health News
- Mental Health Library
- Personal Mental Health Tools (e.g., self-assessment)
- www.ementalhealth.ca
Suicide / Facts and Figures

Death by suicide

- Overall rate, all ages: 12.3/100,000
  - 18.5/100,000 males 4.2/100,000 females
  - Male deaths 3-6:1, female attempts 2-4:1
- Aboriginal populations:
  - 56.3/100,000 (males), 11.8/100,000 (females)
  - 15-24 year old males: 90/100,000
- GLBTQ youth: 28-42% report having attempted suicide
- 2nd leading cause of death after accidents, accounting for 17.3% of adolescent mortality
- As many as 50% of all suicides by youth have been disguised as accidents
Youth Suicide / Facts and Figures

- Ratio of attempted to completed youth suicide up to 220:1 (morbidity transcends mortality)
  - Hospitalization for suicidal behaviour
    - 265 in 100,000 girls / 98 in 100,000 boys
- 37% repetition rate of suicidal behaviour
- Parental divorce rate = 2x higher in suicidal patients
- In more than half of suicidal attempters, there was failure at school or dropout
- 40% of abused children show life-threatening behaviour
Suicide: What the words mean

Suicidal Ideation: Suicidal ideation refers to thoughts, images or fantasies of harming or killing oneself.

Suicide Intent: The conscious decision to take one’s life – to commit suicide

Suicide Plan: The considered events leading to the attempt on one’s life

Suicide Attempt: A suicide attempt is a purposeful self-inflicted act that is non-fatal and is associated with implicit or explicit intent to die.
Suicide: What the words mean

**Completed Suicide:** Death by suicide is a purposeful self inflicted act that is fatal and is associated with implicit or explicit intent to die.

**Suicidality:** Suicidality refers to any thoughts or actions associated with an implicit or explicit intent to die.

**Self Harm:** Self harm refers to any self-inflicted destructive behaviours not associated with an implicit or explicit intent to die.
Myths Regarding Suicide

- adolescents who talk about suicide rarely attempt or commit suicide
- children don’t think about suicide
- all suicidal adolescents are depressed
- getting youth to talk about suicide increases the risk of suicidal behaviour
Adolescent Risk Factors / Youth Suicide

- poor physical health and disabilities (e.g., chronic illness)
- poor mental health
  - depressive disorders, substance abuse, conduct disorders
- poor school performance
- prior suicidal behaviour
- physical / emotional / sexual abuse
- life stress (relationship break-up)
- risk-taking behaviours (e.g., running, substance use)
Psychological Variables / Youth Suicide

- cognitive distortions and hopelessness
- impulsivity
- lack of assertiveness
- poor affective modulation
- poor interpersonal problem-solving skills
Family Risk Factors / Youth Suicide

- transient lifestyle
- family disintegration
  - hostile separation / divorce
  - family violence
- family hx of psychiatric illness
- parental unemployment
  - low SES
- perceived or real lack of family support
Environmental Factors / Youth Suicide

- contagion/imitation
  - direct exposure
  - indirect exposure
    - fiction (Werther effect)
    - non-fiction
- alienation
  - native Canadians
  - gays & lesbians
- rural (isolated) residence
- access to firearms
Suicidal Ideation by Urban/Rural Dwelling

Armstrong & Manion, 2007; N = 829; Age range = 13-19
WARNING SIGNALS
A. Behavioural Indicators

1. loss of interest of former activities: withdrawal from social contact
2. difficulty in concentrating, problems with judgment and memory
3. dramatic shift in quality of school work and academic performance
4. feelings of sadness, emptiness and hopelessness, often expressed in written assignments
5. sleep disturbances
6. strong and overt expressions of anger and rage
7. excessive use of drugs and/or alcohol
8. promiscuous behaviour
9. uncharacteristic delinquent, thrill-seeking behaviour
B. Verbal or Non-Verbal (Symbolic) Communication

1. occurrence of previous suicidal gestures or attempts
2. statements revealing a desire to die, or a preoccupation with death
3. nihilistic comments: life is meaningless, filled with misery, what’s the use of it all?
4. verbal or written threats
5. self-mutilation
6. planning for death; making final arrangements; giving away favourite possessions
7. sudden cheerfulness after prolonged depression may be manifestation or relief because decision has been taken
Precipitating Events

- break up with boy/girl friend
- conflicts and increased arguments with parents and/or siblings
- loss of close friend
- school related difficulties-conflicts with teachers, classmates
- difficulties with the law
- change in parents’ financial status
- serious illness or injury in family member
Protective Factors

- Problem solving, life & communication skills
- Sociability
- Resilient personality
- A sense of belonging (school, community)
- Secure attachment to positive parent/family
- Access to other caring & supportive adults
- Pro-social peers
- Appropriate discipline, limit setting & structure
- Opportunities to develop self-esteem
- Good mental health
Youth Engagement Promotes Health and Decreases Risk

(Armstrong & Manion, 2007)
Key Features of Effective Community-Based Mental Health Promotion Programs for Youth

- Community capacity building and mobilization
- Strong youth stakeholder participation in the design
- Imbed suicide prevention into broader health promotion efforts
- Appreciation that not all youth are the same
- Implementation and evaluation
- Maintenance of program fidelity
- Rigorous process and outcome evaluation

(Armstrong, 2007)
Healthcare-Based Prevention Programs

• Two factors have been identified most helpful during crisis by suicidal patients (Eagles et al., 2003)
  – Rapid accessibility to appropriate services
  – Decreasing stigmatization

• Many youth say they would seek out their primary care physician as the first point of contact if they were distressed (Davidson & Manion, 1993)

• Only 1 in 10 family physicians involved in a Canadian study reported adequate training in the treatment of youth depression (Kotowycz et al., 2003)

• Just 2% said they felt comfortable treating depression in youth
Healthcare-Based Prevention Programs

• Research suggests that training primary care physicians to recognize, treat, and refer patients who are suffering from mental illness, especially depression can (Beautrais et al., 2007)
  – Increase physician identification of suicidal patients
  – Improve treatment of depression
  – Decrease suicide rates

• Training should be based on a continuing education model, since attenuation of the intervention effect was seen within 3 years of one training program. (Rutz et al., 1992)
Style in Risk Assessment

- remain calm
- establish an alliance (empathy)
- allow patient to express full-range of affect
- remember that the person has disclosed this for you for a reason
- be attentive for warning signs and symptoms
- avoid oath of confidentiality
- assume all threats are real
- repeated monitoring of suicidal potential
- reduce social isolation and withdrawal (involve support network)
- promote self-esteem enhancing activities
- treat coexisting psychiatric disorders
- seek consultation as necessary
The Clinical Interview

General  Specific

Empathy  Gentle Inquiry  Direct Inquiry

I can see how difficult things have been for you lately…

Would you help me understand how this has been for you?

Have you ever felt life was not worth living?

You seem to be having a hard time…

How have things been for you lately?

Have you ever tried to do anything to yourself that could have seriously harmed you or killed you?
Assessing Suicidal Risk

Consider risk factors: child, family, environment, current stressors

Current Plan
- ideation (past, recent, current)
- intent

Prior Behaviour
- any previous suicidal behaviour or models

Resources
- physical and emotional systems which the person at risk feels are helping, caring or supportive, including:
  - friends, family, groups and organizations (including host organization), therapeutic supports already involved
Suicide Intent and Ambivalence

Usually there is some level of **AMBIVALENCE** about taking their own life.

Address this ambivalence in your assessment:

“There seems to be a part of you that wants to live. Let me talk to that part.”
Hospitalize or Not

When in doubt admit
This is serious
Protected time out
Further assessment
Non-Hospitalization Contract

- return appointment (+/- 24 hours)
- no current suicidal intent
- understanding of central problem
- preliminary treatment plan
- backup plan including contact persons and ER option
Outpatient Management

Improve compliance:
• discuss referral in initial interview
• specific appointment time, place and person
• minimal waiting period
• evaluation of outcome of referral
• improve interagency communication
• re-contacting patient after initial interview / reminder / rescheduling

Syer-Solursh (1987)
“Although risk factor evaluation is a necessary component of suicide assessment, no factors have been discovered that predict suicide completion at an individual level”

Stewart, Manion & Davidson (2001)

“It is widely recognized from a scientific standpoint that the accurate prediction of any individual’s behaviour, and especially the prediction of suicide, is statistically impossible”

Fawcett, Clark, & Scheftner (1991)
Suicidality decreased by:

- hope
- problem-solving skills
- communication
- ability to tolerate psychic pain (adolescent and family)
- connectedness
- belongingness
- sense of support
There are many issues that challenge those who care for or work with young people.

Dealing with suicidal behaviors or with suicide can be a stressful “occupational hazard”

We need to address this issue to understand and support.
Care For The Caregiver

Healthy Lifestyle
- Sleep
- Exercise
- Friends
- Family

Recognize signs
- Dreading work
- Burnout

Seek help
- Family Doctor
- Support system
- Mental health professional
- EAP
Working together, we will contribute to the creation of caring and supportive environments that maximize well-being and strengthen young people, families, schools, and communities…
Questions?

Ian Manion: manion@cheo.on.ca
www.excellenceforchildandyouth.ca
Number of Completed Suicides per 1000

Warning was administered in 2004