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

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Abstract

Objectives: There is a lack of clear guidance regarding the management of ongoing suicidality in young people experiencing major depressive disorder. This study utilised an expert consensus approach in identifying practice principles to complement relevant clinical guidelines for the treatment of major depressive disorder in young people. The study also sought to outline a broad treatment framework for clinical intervention with young people experiencing ongoing suicidal ideation.

Methods: In-depth focus groups were undertaken with a specialist multidisciplinary clinical team (the Youth Mood Clinic at Orygen Youth Health Clinical Program, Melbourne) working with young people aged 15–25 years experiencing ongoing suicidal ideation. Each focus group was audio recorded and transcribed verbatim using orthographic conventions. Principles of grounded theory and thematic analysis were used to analyse and code the resultant data.

Results: The identified codes were subsequently synthesised into eight practice principles reflecting engagement and consistency of care, ongoing risk assessment and documentation, individualised crisis planning, engaging systems of support, engendering hopefulness, development of adaptive coping, management of acute risk, and consultation and supervision.

Conclusions: The identified practice principles provide a broad management framework, and may assist to improve treatment consistency and clinical management of young people experiencing ongoing suicidal ideation. The practice principles may be of use to health professionals working within a team-based setting involved in the provision of care, even if peripherally, to young people with ongoing suicidal ideation. Findings address the lack of treatment consistency and shared terminology and may provide containment and guidance to multidisciplinary clinicians working with this at-risk group.

Keywords

Early intervention, suicide, suicidal ideation, practice principles, major depressive disorder, multidisciplinary, youth mental health, treatment

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Over the last 50 years, global suicide rates for adolescents and young adults have risen.[1–3] Global figures indicate that among those aged 10–24 years, suicide is the second leading cause of death following road-traffic accidents.[4] Importantly, significant advancement has occurred in the field of suicide epidemiology, and antecedents and risk factors for suicide in youth cohorts are well known.[5] For example, the presence of a mood disorder[6,7] and previous suicide attempt[8] each confer a significant increase in suicide risk. Despite advances in knowledge of suicide related risk factors, suicide prediction at the individual patient level is not yet possible,[9] and the

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evidence for suicide prevention intervention in young people is not well established.[10–14]

Suicidal ideation refers to thoughts of engaging in a suicide related behaviour (i.e. a suicide attempt), and suicidal ideation is a known precursor to suicide attempt and death by suicide.[15–17] Suicide-related behaviours are distinct from non-suicidal self-harm, which occurs without conscious suicidal intent.[18] The severity and frequency of ongoing suicidal ideation in young people is associated with functional impairment, and confers a heightened suicide risk.[19] Ongoing suicidal ideation reflects a fluctuating pattern of unremitting, or partially remitting, sub-acute suicide risk. Ongoing suicidal ideation is relatively unresponsive to initial treatments, either psychosocial or pharmacological, and shifts less readily than does acute suicide risk.[20] Retrospective studies suggest that 34% of people experiencing suicidal ideation progress to making a suicide plan, with the majority of suicide attempts occurring in the first 12 months after the onset of ideation.[21] Hence, there is a need to adopt and evaluate early intervention approaches for suicide in young people,[22] targeting the earliest stage of suicidality (i.e. suicidal ideation).[23]

Young people experiencing suicidal ideation are up to six times more likely to experience a psychiatric disorder than are non-suicidal youth.[24,25] For young people experiencing suicidal ideation, the most frequently occurring disorder is major depressive disorder[26] (MDD). Current evidence-based clinical practice guidelines provide a treatment framework for the management of MDD, inclusive of acute suicidality (e.g. high suicide risk indicated by a suicide plan and intent to enact plan).[27–29] However, young people receiving outpatient treatment for MDD vary markedly in their clinical presentation and experience of suicidal ideation,[30] with many experiencing ongoing sub-acute ideation below threshold for acute intervention (i.e. intent to enact a suicidal plan). Research shows that intervention targeting the reduction of depression symptoms alone does not necessarily reduce the subsequent incidence of suicidal ideation or attempt.[31] Hence there is a clinical need to integrate the management of ongoing suicidality into models of outpatient care for young people experiencing MDD, inclusive of appropriate issues related to consent, resources and supports (i.e. caregivers).[32]

While specific collaborative and clinician-rated suicide risk assessment procedures have been developed and evaluated,[33,34] these assessment procedures focus on previous and current acute risk status, providing little recommendation on the management of chronic (i.e. ongoing) suicidal ideation, particularly in young people.[10,11] A range of frameworks have been developed for the treatment of ongoing suicidal ideation, and some of these have been applied to young people.[35–37] General principles recommend that a treatment model be adopted,[38] with sufficient focus on key aspects of managing the suicidal crisis including a focus on the therapeutic relationship,[39,40] suicidal cognitions,[41] fluctuating risk,[37] and salient protective factors.[42] However, there is limited high-quality evidence testing the effectiveness of these interventions in youth cohorts,[4,10,24,43] and it is not yet possible to discern from available randomised controlled trials what is best practice for treating ongoing suicidal ideation in young people.[42,44]

Outpatient treatment of young people who report ongoing suicidality is often anxiety provoking and emotionally demanding for mental health clinicians.[45] The assessment, management and treatment of suicidal young people rates among the most stressful tasks of a clinician.[44] This is largely due to the need to balance and attend to competing, and at times opposing, issues of client confidentiality, therapeutic rapport, duty of care, safety planning and intervention, direct involvement of caregivers and disclosure of risk to crisis or emergency services. Given a structured approach to the management of clinical risk (i.e. suicidality) is associated with reductions to clinician anxiety and containment, and improved client rapport,[46] there is a clear need to work towards the development of best practice guidelines for managing ongoing suicide risk in young people.[47–49] Such principles are needed given the high rates of suicidal ideation expressed by young people who present for mental health care.[50]

In the absence of higher levels of evidence[51] (e.g. randomised controlled trials, or cohort studies), this study utilised an expert consensus approach to identify practice principles to (a) complement the relevant clinical guidelines for the treatment of MDD in young people, and (b) outline a broad treatment framework for clinical intervention with young people experiencing ongoing suicidal ideation. In doing so, this study aimed to gather consensus data from a specialist multidisciplinary clinical team regarding the management of ongoing suicidal ideation (e.g. ongoing suicidal ideation either with or without plan or intent) in young people experiencing MDD.

Methods

Design

A qualitative focus group approach, informed by the principles of grounded theory,[52] was employed. Focus groups allow for more elaborated accounts than individual interviews, enabling participants to build upon (or against) other participants' accounts and comments.[53] The informal nature of focus group discussion avoids repetition and results in more naturalistic data. By diminishing the researcher's control over the discussion, a more egalitarian relationship is developed between the researcher and participants, allowing participants to follow their own agendas and discuss issues of most importance to them.[54] In doing so, unexpected insights can be gained about the topic of discussion, with participants exploring and clarifying individual and shared perspectives.[55]

Setting

The study was undertaken in the Youth Mood Clinic (YMC) at the Orygen Youth Health Clinical Program (OYHCP). OYHCP is a mental health service for young people aged 15–25 years living in the western metropolitan region of Melbourne, Australia. YMC provides specialist multidisciplinary, time-limited (typically 6 to 9 months) outpatient case management for young people with mood disorders, typically moderate-to-severe MDD and bipolar II disorder. YMC provides early intervention services for depressive illnesses, including relapse prevention, and provides support for social and vocational functioning. YMC staff include consultant psychiatrists, psychiatry registrars and case managers (clinical psychologists, mental health occupational therapists and social workers).

Young people are typically referred to YMC following an inpatient psychiatric admission, a recent suicide attempt, persistent suicidal ideation or significant non-suicidal self-harm behaviours. A large proportion of those referred to the clinic have comorbid illnesses, complex psychosocial needs and ongoing suicide risk.[56] Treatment provided by YMC includes youth-specific case management, which may include home visits, support to families and carers, specialised treatments including weekly psychological therapy (cognitive behaviour therapy), medication and family work, psychosocial recovery services such as group programmes, vocational and educational supports and services, youth and family participation, neuropsychological and occupational therapy interventions, and referral and liaison with other community agencies (e.g. drug and alcohol, employment or youth services).

Participants

Two focus groups (lasting 114 and 119 min respectively) were held in November 2012 with clinicians from the YMC. The sampling approach was both convenient (all clinicians at the YMC were invited to participate) as well as purposive (in addition, two specific clinicians from within OYHCP who had relevant experience and expertise in the management of ongoing suicidal ideation also attended). All clinicians provided informed consent, and none declined to participate. As a result, we were able to achieve the overall sampling aim of including clinicians from a range of professional backgrounds with different levels of experience. A total of 12 clinicians participated; 7 clinicians (58.3%) were female, ages ranged from 25 to 45 years (M = 34; standard deviation (SD) = 6.5). Mean years of experience in mental health after graduation from clinical training was M = 9.4; SD = 8.5. Professional backgrounds of participants included clinical psychologists (n = 6), psychiatrists (n = 3), and social workers and occupational therapists (n = 3). All participating clinicians received regular (i.e. weekly) group supervision, in addition to frequent individual clinical supervision.

Procedure

Ethical approval was granted by the Human Research Ethics Committee at Melbourne Health (QA2012112). Based on key issues raised by the clinical service in relation to this client population (e.g. risk assessment, treatment engagement, caregiver involvement, consultation, resource requirements), we devised a semi-structured focus group schedule designed to explore the research questions in detail. Two focus groups were conducted with the same sample group, 1 week apart. The purpose of this design was to allow the initial results of the first session to be summarised and reflected to the group at the start of the second session. In doing so, we were aiming for an in-depth exploration of, and reflection on, the points raised in the first session. Two facilitators and one scribe were used for each focus group, both of which were audio recorded and later transcribed verbatim using orthographic conventions. At the beginning of each focus group, participants were informed that this study focussed solely on management of ongoing suicidal ideation and not non-suicidal self-harm, and that discussion should be limited to suicidal ideation in the context of MDD.

Data analysis

Based on guidelines for the thematic analysis of qualitative data,[57] a structured and systematic data analytic approach was undertaken, using six validated phases: (1) familiarisation with the data, (2) generating codes, (3) searching for themes, (4) reviewing themes, (5) defining and naming themes, and (6) reporting. To begin with, the first author reviewed the focus group audio and verbatim transcripts several times to enable familiarisation with the data (Phase 1). Initial coding was undertaken and then checked against the transcripts by a second researcher (Phase 2). Any discrepancies that arose were discussed and the transcripts were checked in order to reach resolution regarding the consistency of coding. Analysis was informed by pre-defined themes (Phase 3), but also allowed for the introduction of new themes as necessary (Phase 4). Consultation with a second researcher was undertaken in order to refine the ways in which each theme was coded. This process considered the prevalence of themes both within discrete quotes, and throughout the entire focus group, and ensured consistency of coding across the analysis. This consultation process led to the development and rationale of the overarching thematic map, including thematic definitions. This process ensured the thematic map was grounded in the data, and not based on any assumptions beyond the data (Phase 5). Any discrepancies that were identified were discussed and resolved with mutual agreement. A final thematic map was used to inform the reporting of the analysis (Phase 6).

Results

The identified themes were synthesised into eight practice principles. The practice principles are reported below and summarised in Table 1.

Table 1. Summary of practice principles for the management of ongoing suicidal ideation.

Practice principle	Key practice considerations
1. Engagement and consistency of care	• Build therapeutic alliance and trust early in treatment and practice in a collaborative manner • Attend to any engagement barriers and consider assertive outreach via home or school visits • Flexible engagement may be required through text messaging or phone contact, possible through trusted third parties (family, GP, school counsellor) • Where possible, offer therapeutic consistency (i.e. clinical predictability, dependability)
2. Ongoing risk assessment and documentation	• Assess and document a clear chronology of suicidal ideation, including brief formulation of overall risk • Differentiate risk on a continuum, ranging from vague thoughts of death to acute suicidal ideation with plan, access to means, and intent • Consider accessing collateral information from caregivers, friends or others regarding suicide risk • Seek to gain an in-depth appreciation of the young person and include protective factors and reasons for living in assessment and documentation
3. Individualised crisis planning	• Collaboratively develop and continuously review an individualised crisis plan • Ensure the young person, caregivers and crisis services have ready access to crisis plan • Restrict access to suicide means, including medication access if necessary
4. Activate systems of support	• Activate the young person's broader system of support (e.g. family, friends) • Consider integration of family members in therapy sessions to model a safe, contained and calm conversation about the young person's suicidal thoughts • Provide caregivers with a framework for understanding why suicidal ideation may occur[38] • Where possible, provide caregivers with skills and prompts about how to enquire about suicidal ideation
5. Engender hopefulness	• Convey a realistic and hopeful message regarding treatment outcomes • Consider linking the young person to peer support workers to reinforce hope • Promote engagement with meaningful activity • Consider referring to past treatment successes, and/or utilising trained peer support workers who can engender hopefulness by appropriately reflecting on their experiences of recovery from suicidal ideation
6. Develop adaptive coping	• Discuss shared formulation and treatment goals related to suicidal ideation[58] • Emphasise the fluctuating and changing nature of suicidal thinking and identify the likelihood of incremental progress • Ensure young person is realistic in their expectations of treatment • Work towards improving the young person's coping repertoire • Work towards developing insight related to adaptive help seeking (i.e. identification of early warning signs) and enhance problem solving skills
7. Manage acute risk	• Remain attuned to key signs and symptoms necessitating assertive follow-up • Inform consultant psychiatrist/senior clinicians if risk escalates to acute • Develop and review an acute management plan and engage caregivers, also refer to Principle 3: individualised crisis planning • Refer as appropriate to crisis services • Increase frequency of clinical contact by increasing frequency of appointments, regular monitoring, assertive monitoring by an out-of-hours crisis service
8. Consultation and 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

GP: general practitioner.

Principle 1 – engagement and consistency of care

Early engagement in treatment and establishment of a therapeutic alliance was recognised by clinicians as a critical factor for managing suicide risk, especially for new referrals or clients with an unknown risk profile. There was broad agreement that clinicians working with young people should aim to practice as collaboratively as possible. Clinicians felt that this could be done by respectfully negotiating engagement and encouraging the young person to express their opinions, preferences and concerns regarding treatment planning. Clinicians emphasised the need to establish an open atmosphere enabling young people to feel as comfortable as possible in disclosing their level of risk. Clinicians identified barriers to engagement including low expectations for treatment success and past negative treatment experiences, for

which open dialogue should be facilitated. Clinicians also discussed the importance of offering therapeutic consistency to the young person. For example, several clinicians commented on the importance of the treating team reaffirming their longer-term commitment to the young person's treatment, especially when symptoms were resistant to initial treatment.

Principle 2 – ongoing risk assessment and documentation

Participating clinicians highlighted the importance of ongoing suicide risk assessment and appropriate documentation. Clinicians highlighted the need for ongoing clinical documentation to record a clear chronology of risk, including the most pertinent information (e.g. significant changes to presentation), and a formulation of overall risk (e.g. low, moderate, high). To this end, appropriate clinical note-taking was viewed as more efficient and flexible than use of suicide risk checklists (i.e. standardised rating scales). It was acknowledged by the clinicians that young people can at times become frustrated with repeated risk assessment, thus compromising engagement and rapport. In such instances, clinicians advocated for the use of an abbreviated form of risk assessment that entailed briefly reflecting the most recent risk status to the young person and enquiring about any change to this.

Principle 3 – individualised crisis planning

Clinicians indicated that crisis plans should be reviewed on a regular basis to ensure they are current and relevant, and clearly address identified precipitants of deterioration. Clinicians emphasised the need for key support people to be integrated within the crisis plan, with pertinent information being incorporated (e.g. known helpful or unhelpful interventions or strategies, indicators of deterioration, triggers for distress, engagement tips and key strengths). Clinicians highlighted that in early stages of treatment, family members can provide key information and assistance with the development of the crisis plan. It was acknowledged that in acute situations clinicians may need to breach confidentiality to ensure client safety. Caregivers may need to be made aware of escalation of acute risk, and clinicians must ensure a suitable crisis plan is in place. If a breach of confidentiality is required, clinicians highlighted the need to consider repair to any ruptures in the therapeutic relationship with the young person. There was broad agreement from clinicians that suicide contracts should be avoided. Suicide contracts were perceived to be an ineffective intervention in instances of severe distress, trivialising the management of safety as akin to making a legal contract. Several clinicians indicated the need for prescribing medical practitioners to consider restricting access to large quantities of medication for young people experiencing ongoing suicidal ideation, especially in instances of escalating risk, and to ensure related decision making is clearly documented.

Principle 4 – activate systems of support

Given the essential role played by caregivers in monitoring safety, clinicians identified the need to engage key support people throughout treatment, especially in initial phases, and to encourage caregivers to proactively contact treating clinicians when concerned of escalation in risk. Although it was acknowledged that young people could be resistant to caregiver involvement, clinicians stated that appropriate and thoughtful integration of key support people at times of crisis was typically viewed as a positive and supportive experience. Clinicians also stated that caregivers typically welcome information on the current suicide risk of the young person in their care. Such discussions may enable caregivers to identify and respond to any signs of deterioration in the young person's mental state or risk.

Principle 5 – engender hopefulness

Participating clinicians viewed engendering hope in various forms as a critical component in the treatment of young people experiencing ongoing suicidal ideation. However, clinicians identified the need for clinical judgement and balanced discussion in the realistic context of longer-term recovery. Interventions that promote meaningful activity (e.g. pleasant events scheduling, re-engaging with interests) were identified as a possible means to improving hopefulness. Clinicians discussed the importance of validating the young person's distress while communicating an attitude and expectation of symptom improvement. Clinicians also discussed the need to map perpetuating factors for hopelessness and integrate interventions planned to break cycles of hopelessness. Clinicians also discussed the subtle ways by which institutional hope is communicated to clients and caregivers. It was considered essential to ensure clear and consistent communication to young people and caregivers from the wider organisation (i.e. between inpatient, acute and outpatient services) and from individual clinicians (i.e. members of the treating team).

Principle 6 – develop adaptive coping

Clinicians stated that calm and rational discussions regarding the nature of the young person's suicidal ideation could assist in the process of developing realistic treatment goals. There was agreement from clinicians that use of a shared formulation should be mindful of the young person's developmental level and be delivered in the young person's terminology, with sufficient flexibility (e.g. use of diagrams). The development of a young person's adaptive coping repertoire was emphasised. An example of this was the clinician and young person agreeing on specific triggers, using a

formulation-based approach to target such triggers, and outlining possible courses of action and potential consequences. Clinicians acknowledged that young people's failures to answer questions related to their suicidal ideation, or overly provocative answers, may reflect their desire to enact control. Clinicians emphasised the importance of using such information in treatment planning, with interventions designed to enable the young person to express their distress and access required support.

Poor problem solving was identified as a key perpetuating factor for ongoing suicidal ideation. Clinicians stated that although problems may appear to clients as intractable, this is often not the case, and interventions that promote adaptive coping (e.g. development of structured problem solving skills, self-soothing, distancing from suicidal thinking) can result in improved empowerment and self-efficacy (such interventions may utilise aspects of cognitive behaviour therapy or dialectical behaviour therapy). Clinicians identified that through awareness of early warning signs (i.e. withdrawal, hopelessness, lack of purpose, agitation, increased substance use), young people can better proactively use resources available to them (e.g. pre-emptively contacting their clinician, reaching out to their system of support).

Principle 7 – management of acute risk

Acute risk states, indicated by the young person expressing a clear suicide plan with intent to act, necessitate appropriate referral and crisis intervention and may include utilising mental health crisis outreach services with the option of brief inpatient admission. In conjunction with referral to acute services, clinicians identified the need for the development of an appropriate management plan (see crisis planning above). Management of acute risk should take account of any changes in presentation or relevant contributing factors (i.e. personalised known psychosocial stressors). Where appropriate, caregivers should be involved in the development of an acute management plan.

Principle 8 – consultation and supervision

Young people experiencing ongoing suicidal ideation were recognised by all participating clinicians as a highly demanding cohort to work with, at times triggering anxiety, feelings of failure or incompetence for treating clinicians. Regularly scheduled clinical supervision was discussed as a means of providing clinicians with an opportunity for reflective practice and self-care. It was suggested that clinical supervision and consultation could be provided in-person or via telephone or video conference, with complex cases requiring input from particularly experienced practitioners. Clinicians also emphasised the importance of regular access to high-quality, relevant continuing professional development related to managing suicidal ideation. When suicide risk escalates, clinicians emphasised that consultation should be sought with senior staff to determine the need for a crisis referral.

Discussion

This study synthesises consensus agreement from focus group data into practice principles for the clinical management of ongoing suicidal ideation in young people experiencing MDD. These principles provide clinicians with a management framework, and may assist to improve treatment consistency and clinical management within this population. The identified principles highlight that outpatient management of ongoing suicidal ideation in young people should attend to acute risk fluctuation (i.e. ongoing assessment and assertive follow-up) while also simultaneously focussing on longer-term therapeutic components including flexible engagement, activation and integration of support systems (i.e. caregivers) and expansion of adaptive coping behaviours. This should be done within the context of appropriate clinician support (i.e. consultation and supervision), and maintenance of clinician self-care and wellbeing. Nonetheless, it is recognised that young people who experience ongoing suicidal ideation comprise a heterogeneous group, and appropriate flexibility in treatment planning is advised.[59]

The identified practice principles provide guidance on the supervision needs and direct clinical actions required of the clinician (Principles 7, 8, 2), development of a strong therapeutic relationship (Principles 1, 3 and 5), drawing on existing social supports (Principle 4) and working collaboratively with the young person to explore suicidal thoughts and develop effective coping strategies (Principle 6). In doing so, the practice principles address the continuum of care associated with assessment, engagement, intervention and relapse prevention with this population, and complement relevant clinical guidelines[27–29] for working with young people experiencing MDD. There are important areas of overlap between the findings of this study and previous research. Findings complement available resources related to suicide risk assessment[34] and case formulation,[58] and clinical guidelines highlighting the importance of risk assessment, crisis planning and, in cases of acute risk, the need for ongoing regular monitoring and reassessment (including ensuring the young person is in a safe and secure environment).[27,29] There are also noteworthy commonalties between the present practice principles and guidelines drawn from broader expert opinion, which highlight the need to focus on engagement with young people and the therapeutic relationship, ongoing assessment and crisis management, exploration of the nature of suicidal cognitions and enhancing coping and protective factors.[42]

In managing suicide risk, clinicians must always keep in mind key risk factors and warning signs for suicide in depressed populations. Risk factors tend to be more distal and include previous suicide attempt, comorbid psychiatric

disorder and substance misuse,[60] whereas warning signs are more proximal and include hopelessness, dramatic changes in mood, purposelessness and agitation.[61] Indeed, recent research highlights the need to carefully assess previous frequency and duration of ideation (i.e. especially within the last 3 months), overall seriousness of ideation, and extent of preparatory planning, as these factors are associated with a marked increase in the transition of ideation to attempt for young people.[17,62]

Given the lack of clear guidance from the existing evidence-base regarding effective interventions for young people experiencing suicidal ideation,[10–14,44] the results from this study provide mental health services with implementation considerations that can be supported with professional development activities. Such an implementation framework may also assist clinicians in feeling adequately supported and confident in working with a challenging population of young people with ongoing suicidal ideation. Furthermore, the use of a structured approach may also result in improving both clinical outcomes and overall client rapport.[46]

The present findings must be considered in the context of the study's limitations. As the study was based in a specialised youth mental health service, the results may not be generalisable to other settings such as primary care. Furthermore, the reference population focussed on young people experiencing MDD, and additional principles may be required for young people experiencing other disorders or comorbidities. In addition, the focus group did not address all known risk factors related to depression (i.e. bipolar disorder, substance use), and additional assessment and treatment planning should be considered for these populations. The practice principles reflect the consensus view of the present expert sample. As for any data obtained using a focus group methodology, there is potential bias from self-selection and senior members dominating the group, and the possibility of irrelevant discussion distracting from the main purpose, and issues with external validity.[63] Accordingly, the present findings need further validation, and serve as a launching point for implementation and evaluation.

Despite these limitations, the identified practice principles would likely be of use to any health professional working within a team-based setting who is involved in the provision of care, even if peripherally, to a young person with ongoing suicidal ideation. A major limitation of the existing (underdeveloped) evidence-base for interventions for suicidal ideation and suicide prevention is the lack of shared terminology and inconsistencies in frameworks.[11] Hence, the present findings may contribute towards the development of a more consistent approach for working with young people experiencing suicidal ideation. Strengths of this study include use of a consensus approach undertaken over two focus group sittings, a particular focus on young people, provision of a broad clinical framework outlining the effective management of chronic suicidality (which has received significantly less research attention than the management of acute suicidality) and the identification of initial practice principles that may contribute to the subsequent development of comprehensive practice guidelines. Opportunities for future research include evaluation of the implementation of the practice principles within a specialised youth mental health service, and measuring the impact on clinical outcomes as well as clinicians' perceptions of support, guidance and direction in their clinical work.

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Declaration of conflicting interests

The authors declare that there is no conflict of interest.

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