Assessing Suicide Risk in Patients: From an Primary Care Prospective

David Paulk, D.O.
Objectives

• Understand importance of identifying patients that may be at an increased risk for suicide

• Understand tools used to assess for depression

• Be able to identify tools used to risk stratify suicidal patients
Some Quick Data About Suicide

• 2nd leading cause of death: children 10-16
  • Bully victims 2-9x more likely to consider suicide
• 3rd leading cause of death: adolescents
• ~10% of High School students attempt suicide each year
• ~Every 15 minutes someone dies by suicide in the U.S.
Identify Early

- **Preparation Behaviors**
  - Stockpiling pills, razors, or loaded weapon
  - 8x more likely to die by suicide

- **Interrupted Suicide Attempts**
  - 3x more likely to die by suicide

- **Aborted Suicide Attempts**
  - 2x as likely to make additional attempts
Depression

• Prior studies have shown that an estimated 75% of patients with depression receive care in non-mental health clinics making screenings critical in these settings.

• Recognize medical conditions/complications linked or suspicious for psychiatric illnesses.
Definition

Must be experiencing 5 or more symptoms during the same 2-week period and at least one of the symptoms should be either (1) depressed mood or (2) loss of interest or pleasure.

1. Depressed mood most of the day, nearly every day.
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day.
3. Significant weight loss when not dieting or weight gain, or decrease or increase in appetite nearly every day.
4. A slowing down of thought and a reduction of physical movement (observable by others, not merely subjective feelings of restlessness or being slowed down).
5. Fatigue or loss of energy nearly every day.
6. Feelings of worthlessness or excessive or inappropriate guilt nearly every day.
7. Diminished ability to think or concentrate, or indecisiveness, nearly every day.
8. Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.
Etiology

• Likely multi-factorial
  – Genetic
  – Environmental factors
    • Chaotic home environment
    • Abuse
  – Cultural influences
Uncommon encounters?

• 15.3% to 22% of all patients seen in primary care offices

• 2nd most common cause of primary care visits

• In 2002, the US Preventive Services Task Force endorsed screening for depression in primary care settings particularly when screening is coupled with system changes that help ensure adequate treatment and follow-up
Do No Harm

Of persons who committed suicide 40% had visited their primary care physician in the month before their death.

The risk of depression is often higher in individuals with serious medical conditions:
- Up to 33% of patients who have experienced a heart attack
- Up to 25% of those diagnosed with diabetes
- Ranging from 25-50% percent of people with cancer
- Up to 50% of stroke survivors (possible even as high as 50% in select neurological conditions)

There is strong evidence that treatment of depression may have a beneficial effect on the overall functioning and recovery and rehabilitation process of the physically ill individual both in quantity and quality of life:
- Lack of follow-up contributes to poor antidepressant adherence rates
- 50% stop taking their medication as early as 3 months after starting treatment
- >70% discontinue medication before 6 months
Primary focus from task force development is emphasis on evidence based guideline therapies:

- Both the APA Guideline and the Institute for Clinical Systems Improvement (ICSI) Health Care Guideline: *Major Depression in Adults in Primary Care, Thirteenth Edition*, recommend long-term maintenance treatment with antidepressants in order to prevent relapse and recurrence of depression.

- The APA Guideline states that the treatment that was effective in the acute and continuation phases should be used in the maintenance phase.

- The ICSI Guideline specifies that the dosage of antidepressant drug resulting in a therapeutic response should be the dose that is used for the maintenance phase, i.e., six to 12 months for the first depressive episode, three years for the second episode, and indefinitely for a second episode with complicating factors or for a third/subsequent episode.

- The National Committee for Quality Assurance/Health Plan Employer Data and Information Set standards for adequate follow-up care for depression require at least 3 visits over 90 days, and surveys show most large health care systems meet this standard less than 25% of the time.
ACP Screening Recommendations

• The most widely used and best-validated instruments in the primary care setting are the PHQ-9 and PHQ-2

• A meta-analysis of 14 studies found that the PHQ-9 is 81 % sensitive and 92 % specific for MDD in the primary care setting
Special Diagnosis Considerations

Patients with active suicidal plans warrant urgent referral to a psychiatrist or emergency hospitalization in order to immediately treat their depression.

Seasonal affective disorder is a cyclical depression usually occurring in the fall and winter months with improvement in spring and summer.

Lack of exposure to sunlight seems to be the triggering factor.

Postpartum depression occurs in up to 15% of women within 6 months of giving birth and can lead to significant negative outcomes in both mother and child, such as decreased effectiveness at home and work, increased risk of maternal suicide, and poorer infant-mother bonding.
Special Management Considerations

Several classes of antidepressant agents with proven efficacy in relieving depressive symptoms

Choice of agent is based on side effect profile, cost, prominent symptoms, and patient preference

Treatment should be to remission of symptoms, and symptoms should be monitored regularly

Antidepressants have been associated with a risk of precipitating suicidal ideation in children, adolescents, and young adults; therefore, close monitoring is required

The risk of suicide in untreated depression, however, is likely much greater.
Personality Disorders

The enduring pattern leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning

Pattern is stable and of long duration, and onset can be traced back at least to adolescence or early adulthood

Not better explained as a manifestation or consequence of another mental disorder

Not attributable to the physiological effects of a substance or other medical condition
Definition

**DSM-5 Criteria**

- An enduring pattern of inner experience and behavior that manifests in two or more of the following:
  - cognition (i.e., ways of perceiving and interpreting self and others)
  - Affectivity (i.e., range, intensity, lability)
  - Interpersonal functioning
  - Impulse control

- The enduring pattern is inflexible and pervasive across a broad range of personal and social situations
## Previous and Current Types

<table>
<thead>
<tr>
<th>Type</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>OCPD</td>
<td>2-7.9%</td>
</tr>
<tr>
<td>Paranoid</td>
<td>2%</td>
</tr>
<tr>
<td>Antisocial</td>
<td>1-4%</td>
</tr>
<tr>
<td>Schizoid</td>
<td>1%</td>
</tr>
<tr>
<td>Schizotypal</td>
<td>1%</td>
</tr>
<tr>
<td>Avoidant</td>
<td>1-2%</td>
</tr>
<tr>
<td>Histrionic</td>
<td>2%</td>
</tr>
<tr>
<td>Borderline</td>
<td>2-3%</td>
</tr>
<tr>
<td>Dependent</td>
<td>0.5%</td>
</tr>
<tr>
<td>Narcissistic</td>
<td>.5-6%</td>
</tr>
</tbody>
</table>
Why do we care?

Common:
- Estimated prevalence between 6-13% of the US adult population
  - Up to 30% of Primary Care patients

Recognizing can guide your tx approach

Assist with assessing for comorbidities including Axis I disorders and suicide risk
- Poorer health status
- Poorer treatment outcomes
- Higher rates of healthcare use
- Higher overall healthcare costs
Suicide Risk Assessment Tools
Some Options

• Columbia Suicide Severity Risk Scale-Screen (CSSRS)

• SAFE-T
Online resource

http://www.integration.samhsa.gov
References


Whooley MA, Avins AL, Miranda J, Browner WS. Case-finding instruments for depression. Two questions are as good as many. *J Gen Intern Med*. 1997;12(7):439–445

http://www.thecommunityguide.org/mentalhealth/index.html

www.uspreventiveservicestaskforce.org