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CONCISE REVIEW FOR CLINICIANS

Practical Suicide-Risk Management for the Busy Primary Care Physician

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Abstract

Suicide is a public health problem and a leading cause of death. The number of people thinking seriously about suicide, making plans, and attempting suicide is surprisingly high. In total, primary care clinicians write more prescriptions for antidepressants than mental health clinicians and see patients more often in the month before their death by suicide. Treatment of depression by primary care physicians is improving, but opportunities remain in addressing suicide-related treatment variables. Collaborative care models for treating depression have the potential both to improve depression outcomes and decrease suicide risk. Alcohol use disorders and anxiety symptoms are important comorbid conditions to identify and treat. Management of suicide risk includes understanding the difference between risk factors and warning signs, developing a suicide risk assessment, and practically managing suicidal crises.

Section snippets

IMPORTANCE TO PRIMARY CARE

Two practice realities have spurred interventions to improve primary care recognition and treatment of depression as a public health suicide prevention strategy.10, 11 First, patients dying by suicide visit primary care physicians more than twice as often as mental health clinicians.[10] A review of studies analyzing this clinical scenario estimated 45% of those dying by suicide saw their primary care physician in the month before their death.[10] Only 20% saw a mental health professional[10] in the...

PATIENT GROUPS AT RISK

Years of research on suicide show those with current psychiatric illness are the most common group dying by suicide.18, 19, 20, 21 Psychological autopsies, incorporating information from medical records and interviews with families and friends of those dying by suicide, find that more than 90% have a psychiatric disorder.18, 19 Specific disorders associated with suicide include mood (ie, bipolar disorder and major depression),[22] substance use,[23] anxiety, impulse control, personality disorders,20...

PRIMARY CARE DEPRESSION TREATMENT AND SUICIDE

Research shows that identification of depression—a critical first step in its management—has improved.[27] Clinical management of 3 other vital suicide risk factors in depressed patients continues to be poor.

First, comorbid alcohol problems frequently remain unidentified and thus untreated. In a study evaluating a patient cohort for receipt of recommended care for 25 acute and chronic conditions, only 11.0% of patients with alcohol use disorders received recommended care vs 82.7% of those with...

DON'T ASK, DON'T TELL, DON'T KNOW

Further reinforcing these findings, a 2007 study[30] found only 36% of simulated patients requesting antidepressant medication were even asked about suicide. Patients with simulated major depressive disorder were slightly more likely to be asked,[30] although more than half of these patients were not asked. Physician-specific factors that were related to training (eg, time since training) or that could have had a bearing on individual beliefs (eg, sex) did not explain the results.[30] Notably,...

SUICIDE INQUIRY

Every patient being evaluated for possible depression or with a history of depression should be asked about suicidal thoughts and behaviors. We recommend using a step-wise approach (Figure

1) that starts with a general question and becomes more specific with each successive question.[32] Clinicians should start by asking whether the patient feels hopeless or has thoughts of death. They should then ask whether the patient has explicit thoughts of suicide, a specific plan and means for carrying it...

RISK FACTORS VS WARNING SIGNS

To better understand and prevent suicide, research has focused on identifying risk factors from clinical samples of convenience and cross-sectional general population studies. Many factors increasing risk of death by suicide are known.[34] Unfortunately, most of these factors are immutable, as for example being white, male, or divorced, having made a previous suicide attempt, or having a family history of suicide.[34] These factors are nonspecific, highly prevalent, unchanging over time, and not...

PREDICTION VS INTERVENTION

Most clinical risk factors for suicide (eg, depression, substance use disorders) are conditions that merit treatment in any case, irrespective of their role in elevating suicide risk. Conversely, we cannot identify those persons already receiving life-saving interventions. The US Preventive Health Services Task Force recommends screening for alcohol misuse in adults, providing brief counseling, and referring for specialized treatment if needed.[38] Screening and treatment of depression are also...

EDUCATION VS PRACTICE MODEL CHANGE

As noted earlier, initial research12, 13, 14, 15, 41 raised hopes that improving identification and treatment of depression could prevent suicides. This prevention effort focused on intensive education of primary care physicians. Importantly, when the intensive intervention stopped, suicide rates returned to previous levels. From the authors' experience in multiple care settings, one-time educational interventions are destined to be unsuccessful. Pragmatically, all primary care practices screen ...

MANAGEMENT WITHOUT COLLABORATIVE CARE

The 2009 US Preventive Health Services Task Force recommendations[39] no longer advise general screening for depression unless collaborative or supportive care staff models (eg, nurse care managers) or other systematic depression treatment approaches are in place. Data from screening alone have not been shown to change outcomes.[40] However, the US Preventive Health Services Task Force notes that there may be considerations for screening in individual patients.[39] Our recommendation for a primary...

ANTIDEPRESSANT EFFICACY

Popular media reports have highlighted recent studies implying that antidepressants are ineffective for the treatment of depression.51, 52 Unfortunately, these superficial reports do not address the complex issues raised by these research findings for clinical practice.[53] Data from multiple investigations comparing antidepressants and placebo show that antidepressants work best for patients with moderate to severe, acute depressive episodes.[29] For patients with long-term depressive symptoms,...

ANTIDEPRESSANT BBW

The 2004 US Food and Drug Administration (FDA) BBW for "suicidality" in patients taking antidepressants confused the public, prescribers, and patients.[55] The BBW was based on reported increases in drug-related suicidal ideation or behaviors, defined as "suicidality," compared with placebo. These increased suicidality reports came from analyzing short-term antidepressant clinical trials. After the initial 2004 BBW release, depression diagnosis and antidepressant prescriptions were reduced across ...

MAKING SENSE OF THE BBW

Two recent studies59, 60 help synthesize practice and research observations and provide helpful guidance for antidepressant prescribing. The first, from Finland,[59] looked at national rates of patients filling, and subsequently refilling, their antidepressant prescriptions vs those filling only their initial prescription and not continuing treatment. The group continuing with treatment showed a significant decrease in all-cause mortality, including suicide.

The second study,[60] a nested...

SUICIDE-RISK MANAGEMENT

Initial clinical management after identification of depression and/or an alcohol use disorder should emphasize 3 areas specific to suicide-risk: (1) the importance of recognizing comorbid anxiety or agitation and its treatment, (2) the performance of a suicide risk assessment, and (3) the implementation of some practical office management tips....

TREATMENT OF ANXIETY AND AGITATION

On the basis of clinical experience and research, acute anxiety and agitation are critical suicide warning signs.[61] Of patients hospitalized in psychiatric or other hospitals who died by suicide,

only 20% endorsed suicidal ideation before their suicide, but 80% either endorsed or manifested severe anxiety or agitation.[37]

After controlling for other psychiatric comorbid conditions, an international epidemiological study[20] found that anxiety disorders (posttraumatic stress disorder, panic...

SUICIDE RISK ASSESSMENT

As a National Patient Safety Goal in both general and psychiatric hospitals, the Joint Commission mandates suicide risk assessments for patients who are identified as being at risk.[65] This mandate stems from inpatient suicides being a frequent sentinel event over time.

Performance of a suicide risk assessment is a long-standing psychiatric practice recommendation. It is typically documented in the assessment/plan of a clinical note; identifies and discusses risk factors or warning signs that...

PRACTICAL MANAGEMENT

In any given person, suicide risk is not fixed but fluctuating, with periods of increased risk in response to precipitating stressors. Sudden interpersonal losses or rejections—the death of a family member or a breakup of a relationship with a significant other—may trigger a suicidal crisis. Hospitalization can provide a safe environment to stabilize patients while allowing the crisis to pass and precipitating stressors to be resolved. Helpful treatment modalities for inpatient units include...

CONCLUSION

Patients with suicidal thoughts and behavior are often seen in primary care practices. Treatment can be effective, and collaborative models of care may have particular benefit in improving depression outcomes and, potentially, reducing suicidal outcomes. Although no way exists to predict those who will go on to die by suicide, treating clear warning signs for suicide can reduce patients' suffering. Asking about suicidal thoughts, plans, and past behavior is essential, while being sensitive to...

CME Questions About Practical Suicide-Risk Management

1. Which *one* of the following *most accurately* represents how many more times likely primary care physicians are to see patients in the month before their death by suicide than mental health clinicians?
   a. No more likely...

b. 1.5 times more likely...

c. More than 2 times more likely...

d. 3 times more likely...

e. Less likely...

...

2. Which *one* of the following percentages *most accurately* reflects the percentage of US antidepressant prescriptions written by generalists?
   a. 45%...

   b. 52%...

   c. 57%...

   d. 62%...

   e. 71%...

   ...

3. Which *one* of the following...

...

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2022, Journal of Psychiatric Research

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Implementing Suicide Risk Screening in a Pediatric Primary Care Setting: From Research to Practice

2022, Academic Pediatrics

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Asking about self-harm and suicide in primary care: Moral and practical dimensions

2021, Patient Education and Counseling

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Sadness and Worry in Older Adults: Differentiating Psychiatric Illness from Normative Distress

2020, Medical Clinics of North America

Stakeholder views regarding a planned primary care office-based interactive multimedia suicide prevention tool

2019, Patient Education and Counseling

> *Citation Excerpt :*
>
> ...Factors limiting middle-aged men's disclosure of suicide thoughts to PCCs include gender-linked norms [29,30]; stigma [31,32]; the belief that PCCs are not equipped to deal with mental health issues [33]; and competing health concerns in brief visits [34]. PCCs also struggle with competing demands in brief visits, and many lack up to date training and resources to engage optimally with suicidal patients [35–40]. While clinician-targeted risk assessment skills training interventions have increased detection of suicidal patients, still many visiting trained clinicians go undetected, indicating room for improvement [19]....

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Saving lives by asking questions: nurses' experiences of suicide risk assessment in telephone counselling in primary health care

2022, Primary Health Care Research and Development

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Recommended articles (6)

Research article

Advancing Training to Identify, Intervene, and Follow Up with Individuals at Risk for Suicide Through Research

American Journal of Preventive Medicine, Volume 47, Issue 3, Supplement 2, 2014, pp. S216-S221

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Research article

Asking Youth Questions About Suicide Risk in the Pediatric Emergency Department: Results From a Qualitative Analysis of Patient Opinions

Clinical Pediatric Emergency Medicine, Volume 14, Issue 1, 2013, pp. 20-27

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Research article

Patterns of Health Care Usage in the Year Before Suicide: A Population-Based Case-Control Study

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Suicide screening scales may not adequately predict disposition of suicidal patients from the emergency department

The American Journal of Emergency Medicine, Volume 36, Issue 10, 2018, pp. 1779-1783

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Research article

Exploring the association between exposure to suicide and suicide risk among military service members and veterans

Journal of Affective Disorders, Volume 207, 2017, pp. 327-335

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Research article

Reducing a Suicidal Person's Access to Lethal Means of Suicide: A Research Agenda

American Journal of Preventive Medicine, Volume 47, Issue 3, Supplement 2, 2014, pp. S264-S272

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On completion of this article, you should be able to (1) express rates of having serious thoughts of suicide and making plans for suicide in the US population, (2) give examples of areas requiring clinical practice improvement associated with depression and suicide assessment in primary care, and (3) recognize the importance of assessment and treatment of anxiety and agitation in suicidal states.

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