General practitioners training: (second) a strategic response to treatment gaps for

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Suicide prevention: Training and education of family physicians

(identification and intervention amongst persons with suicide behavior during early phase of life)

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Learning objectives

1. Review suicide behavior in children and adolescents
2. To understand role of family physicians in suicide prevention
3. To discuss evidence based preventive measures in family practice
4. To examine role of education and training for family physicians for suicide prevention
5. To discuss designing training program
Suicide rate: Canada

Intentional injury rate per Hundred Thousand

2007: 10.2
2008: 10.4
2009: 10.7
2010: 10.7
2011: 10.1
suicide rate has only marginally fallen

Suicide rate age 10-14 years

- 2006: 1.6
- 2011: 1.5
Rank as cause of death

- Age 10 to 14: 5
- Age 10 to 24: 2
Mode of suicide

- Asphyxia by hanging: 68%
- Shooting: 11%
- Others: 21%
Health care services: basic

Availability
Accessible
Affordable
Adequate
Across the setting
All consumers
1. Review suicide behavior in children and adolescents
# Risk factors

<table>
<thead>
<tr>
<th>Static or stable risk factor</th>
<th>Dynamic Risk factors</th>
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</thead>
<tbody>
<tr>
<td>History of self harm</td>
<td>ideation, communication, intent</td>
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<tr>
<td>seriousness of previous suicidality</td>
<td>hopelessness</td>
</tr>
<tr>
<td>mental disorder</td>
<td>active psychological symptom</td>
</tr>
<tr>
<td>substance use disorder</td>
<td>substance abuse</td>
</tr>
<tr>
<td>personality disorder /traits</td>
<td>treatment adherence</td>
</tr>
<tr>
<td>childhood adversity</td>
<td>Psychiatric admission and discharge</td>
</tr>
<tr>
<td>family history</td>
<td>psychological stress</td>
</tr>
<tr>
<td>age, gender</td>
<td>problem solving deficits</td>
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</tbody>
</table>
42% of children aged 5 to 12 years reported suicidal ideation.
Genetics and family history

1. Genetic predisposition

2. Family history of first-degree relatives having attempted suicide, especially mothers,

3. 5 times more common mothers died by suicide and twice more common where father had committed suicide
Childhood physical and sex abuse

Parental substance abuse,
Child abuse,
Family discord,
Parental loss and other
Negative life experiences.
Developmental risk and parenting

1. Cognitive Development and Maturity
2. Family Characteristics/Psychopathology
3. Negative Life Stressors/Environmental Influences

Past suicide attempts,
Stressful life events, Trauma and loss

1. Family discord, lack of family cohesion
2. Poor family behavioral control and parental loss due to separation or divorce and/or death,
3. Especially death of a parent before the child reaches the age of 12
Psychiatric disorders and comorbidities

90% have a psychiatric disorder

Psychiatric disorders, most notably depression,

Mood and anxiety disorder commonest risk factor: a 13 year follow up study

past attempts predict additional attempts in adolescents,
Low Incidence

No definite marker

Small number & duration of studies

‘It is a specific constellation’

Pathways of attempt is not clear.
Prevention

1. Most prevention programs for lowering suicide are focused on adolescents.

2. School-based primary prevention programs may have significant beneficial effects.

3. Programs should be implemented at an early age, prior to the onset of suicidal thinking.
2. To understand role of family physicians in suicide prevention

Family practice: merit, opportunities and challenges in management of suicide behavior
More than 90% physicians express their opinion that they require more knowledge and training for treatment of suicide.
Why should we work with family physicians for suicide prevention

1. Pivotal role in health care which provides easy access to care
2. They are frequently contacted prior to an attempt
3. They have basic skills for identification, intervention and referrals
4. Patients attending PCP have high rates of suicidal ideation (30%), & depression (>40%)
Why should we work with family physicians for suicide prevention

1. They are the first contact for suicide
2. For a number of patients GP is the last contact before suicide
3. They have strong therapeutic rapport and a position of authority
Barriers for effective management of suicide behaviour in PCP

1. High case load and poor motivation
2. Lack of skills, confidence and competency
3. Poor support from mental health services
4. Fear of legal problems
5. Psychiatric patients are challenging
6. Stigma among medical professionals
7. Lack of educational opportunities
## Challenges in managing suicide behavior in primary care

<table>
<thead>
<tr>
<th>Challenges</th>
<th>Undetected</th>
<th>Untreated</th>
<th>Resources</th>
<th>Stigma</th>
<th>Awareness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responses</td>
<td>Identification</td>
<td>Intervention &amp; Referrals</td>
<td>Optimization of resource utilization, New facilities</td>
<td>Risk reduction &amp; Public health awareness</td>
<td>People's &amp; Participation of patient's relatives</td>
</tr>
<tr>
<td>How to achieve</td>
<td>General Practitioner's educational programs</td>
<td>Support from Mental Health systems</td>
<td>Programs involving patient's and advocacy groups in conjunction with family practice</td>
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Frequent contact by the patients

Contact with family physicians prior to suicide

- Within One year: 75
- During previous year: 33
- With Adolescents: 50

A number of patients see their family physicians prior to an attempt

- GP contact prior to attempt:
  - Elderly: 70
  - Adult Adolescents: 50
  - Adolescents: 30

(From: O'Donnell 2010; Lennart et al. 2002; Olesen & Møller 1994)
Help Seeking

50% of adolescents in a month prior

80% within final 6 months

78% within final one year
3. To discuss evidence based preventive measures in family practice

Developing suicide prevention strategy for suicide prevention in PCP
Evidence of success in suicide prevention by family physicians

1. identification and treatment of Depression.
2. Prescribing pattern of antidepressant drugs.
3. Early intervention of prodromal states
4. Success of Educational programs for general practitioners
5. Brief psychotherapeutic interventions are effective and feasible
6. Involvement in public health programs
1. Evidence-based and effective interventions

2. New learning from training: about identification, intervention, referrals and continuity of care for prevention

3. Risk assessment of suicide potentials and decision making
4. To enhance skills of family physicians

5. Therapeutics

6. Developing community specific newer programs
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<tr>
<td>7. Administration and evaluation of programs</td>
<td></td>
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<tr>
<td></td>
<td>8. Resource development for placement of mental health professionals in family practice</td>
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<tr>
<td></td>
<td>9. Active involvement with advocacy groups and community agencies</td>
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<tr>
<td></td>
<td>10. To develop health system for delivery of care Administration and evaluation of the program</td>
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</table>
Detection of suicide by General Practitioners

Detected  Not detected

Patients with Suicidal Ideation, N=405

22  55
<table>
<thead>
<tr>
<th>Treatment of depression’</th>
<th>Evidence-based effective intervention</th>
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<tbody>
<tr>
<td>Antidepressant drugs did not increase rate of suicide in Canada in Age up to 19 Years in a recent study</td>
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<table>
<thead>
<tr>
<th>Incidence of depression &gt; 50%</th>
<th>Incidence of suicidal ideation &gt; 30%</th>
<th>Incidence of depression in Physical illness seen in practice &gt;20%</th>
<th>Detection rate: approximately 30%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance abuse with depression approximately 20%</td>
<td>Screening for depression and suicide in clinics</td>
<td>Development of community care programs</td>
<td>Antidepressant drugs may treat primary and comorbid depression and anxiety</td>
</tr>
</tbody>
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Depression: identification and treatment in family practice

suicide 401 in 1739 patients

- General-practice based data, N = 1739
- 172 practice, One year follow up
- Age >18 years
- Incidence of depression,
- Male 719 Female 1440/100,000
- 1762 new events in 1753 patients
Depression among youth: Primary care models for delivering mental health services

- Outreach program for those who do not report to the clinics
- Developing more accurate strategies for detection of depression in Primary care
- Developing more accurate strategies for detection of depression in Primary care
Depression among youth: Primary care models for delivering mental health services

- Developing Newer intervention strategies
- Increased access to care
- Strategies for increasing compliance to treatment
- Collaborative model of care involving family physicians
4. To examine role of education and training for family physicians for suicide prevention
Education: Increased identification

Increased identification

Physicians feel more competent and comfortable

They can provide intervention in their clinics and make appropriate referral.

They can take up the role of trainers for other health workers
Educational Intervention increases identification

- Study: 34%
- Control: 0.9

Suicide rate decrease

Increase by
Reduction in suicide rate after education: Early intervention program. 2 years follow up

- Before education: 59.9
- After education: 49.9
- Reduced by years rate: 5
Suicide rate in at-risk individuals

Suicide rate in early phase of illness: Psychosis
## Program based intervention

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<tr>
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<th>Community with EI</th>
<th>Community without EI</th>
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<tbody>
<tr>
<td>Rates of suicidal ideation &amp; attempt</td>
<td>56%</td>
<td>39%</td>
</tr>
<tr>
<td>Previous attempt</td>
<td>16%</td>
<td>5%</td>
</tr>
<tr>
<td>Decrease in Rates after first clinical contact</td>
<td>Similar</td>
<td>Similar</td>
</tr>
<tr>
<td>SUD</td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td>Suicidal behaviors</td>
<td>Low</td>
<td>High</td>
</tr>
</tbody>
</table>
Efficacy of empowerment
Suicide index reduction in Slovenia: the impact of primary care provision
Reduced Suicide index in Slovenia 1998–2008

National programs

Suicide Index

35 30 25 20 15 10 5 0

Suicide index reduction in Slovenia: the impact of primary care provision.
Beškovnik I, Juričič NK, Svab V.
Dr Amresh Shrivastava - dr.amresh@gmail.com
5. To discuss designing training program
GP- educational context

Well informed about precipitating factors

Less informed about Warning sings, risk factors, demographics

Implications of treatment and prevention

Considerable individual variability exists

To be merely knowledgable does not guarantee identification of at-risk individuals adequate and accurate knowledge is the minimum requirement for effective identification of suicidal clients.

Severe depression is more likely to be picked up though minor depressionas are also at risk for suicide
Educational awareness

1. 60% of physicians were unaware of previous suicidal behavior in individuals who ultimately complete suicide.

2. 17% of adolescents who had previously attempted suicide were subsequently asked about suicide ideation or behaviour by their medical practitioner.

3. Suicidal ideation and prior suicidal behaviour – strongest predictor and 50% of suicides are preceded by a history of suicide attempts.
Objective and characteristics of the training curriculum

1. To develop educational module and training program which needs to be
2. Specific, need based, and comprehensive contents
3. Easy to use/administer, Engaging and case-based
4. Addressing the issue of competency and skill development for identification, intervention and prevention of suicide behavior
5. Utilizing standardized tools for screening
6. With contents for dealing with stigma, raising awareness, and health advocacy
GP Training and Education Initiatives: Guidelines

Positive outcome

Specific program for suicide

Embedded in broader mental health education program

Programs focusing heavily on depression recognition and treatment provide the best therapeutic models for lowering suicide rates.
Screening tools and measurements in family practice

1. May be used for identification and screening in general population as well as in patients attending primary care clinics

2. General health questionnaire (GHQ) and primary health questionnaire (PHQ) have been successfully used.

3. These tools have been developed by WHO, tested in a number of countries and have a high validity, sensitivity and specificity

4. Item 3 on ‘Hamilton depression rating scale’ (HDRS) also has high validity for screening

5. These tools re easy to administer and can provide important information about identification of suicidal client.
GHQ-12

- 12 item, 1960
- all 12 questions useful, however a physician can ask only the most sensitive ones
  - “Been feeling unhappy or depressed?”
  - “Felt constantly under strain?”
  - “Is there something with which you would like help?”
Other Questions with high Sensitivity (96%) and specificity (57%)

“during the past month have you often been bothered by feeling down, depressed or hopeless?”

“during the past month have you often been bothered by little interest or pleasure in doing things?”

Effective questions

“In past month have you been feeling depressed”

“In past one month have you felt loss of pleasure?”
Curriculum development: key topics to be covered

1. Clinical features and presentations
2. clinical assessment (how to examine),
3. Comorbidity and substance abuse
4. assessment of suicide behaviour and psychiatric assessment (how to ask and what to ask)
5. Risk assessment
Curriculum development: key topics to be covered

6. structured interview, measurement tools
7. screening tools
8. formulation and decision making
9. identification,
10. intervention in the clinic
Curriculum development: key topics to be covered

11. Intervention in hospitals or specialists clinic
12. Medications and monitoring
13. CBT
14. Outcome measurement, monitoring progress
15. Treatment resistance
16. Prevention of first attempt
17. Prevention of future attempt
18. Long term management and compliance
19. Family interaction and posttension
20. Dealing with legality in suicide prevention
1. On an average each item will be of 500 words. Total curriculum will be of 10000 words

2. Divided into 4 sessions / lectures. Each covering 5 topics

3. Workshops and case based learning 2 situation for 30 mts each
Curriculum development:
key topics to be covered

1. Q&A for one hour

2. Total course duration will be of
   1. 4 hours theory (didactic and workshop model),
   2. one hour case-based learning and
   3. one hour Q&A
Methodology

6. Course to be conducted every 4 months in first year, every 6 month in second year and once in a year thereafter

7. Modality: 1) face to face and 2) web-based

8. For web based learning online webinar needs to be developed

9. Face to face teaching can be done by one faculty for 4 hours duration
Evaluation

Pre and post course evaluation using a structures format for assessment of knowledge, competency and capability
what should be done?

Increased curriculum in medical education
Training across all specialty
Interdisciplinary collaborations for suicide prevention
1. Suicide prevention is one of the most important clinical emergency
2. It is a public health problem
3. There is robust evidence that its incident can be reduced by a number of means, most notably being treatment of depression
4. Education and training of family physician is the most effective way for prevention
5. It empowers physicians and enhances their skills, competency and level of comfort
6. A training course will be of utmost importance to address the issue of suicide prevention in family practice