May 16, 2014

General practitioners training: a strategic response to treatment gaps for suicide prevention

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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 suicide prevention in primary care practice
3. To examine merits of education and training for suicide prevention
4. Curriculum
5. Interviewing skills
6. Scale for assessment of suicide behavior

Suicide behavior

This presentation will discuss following aspects regarding suicide behavior

Epidemiology	Concepts & understanding	Risk reactors	Assessment
Intervention	Prevention	Education & Family physicians	Curriculum .

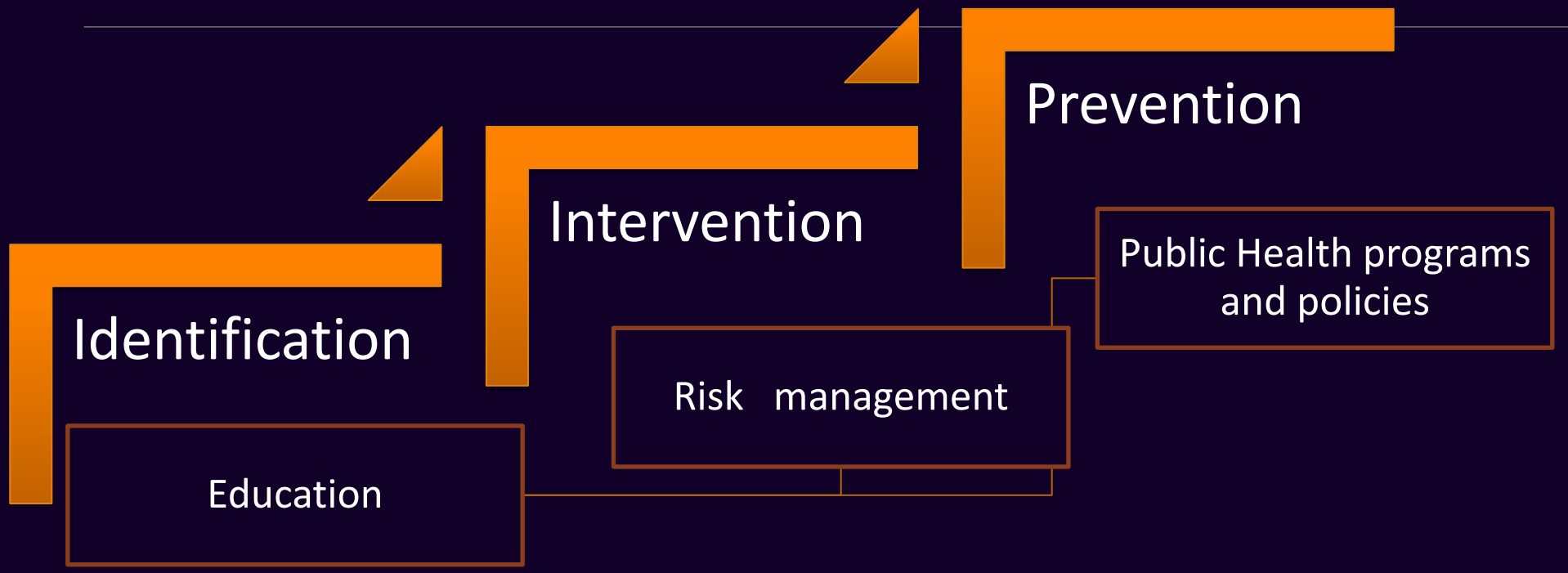
Suicide is a:

Global Challenge

Life threatening condition

A preventable death

Main clinical issues is to reach out to people in distress and provide services which means:



Response to Clinical Problem

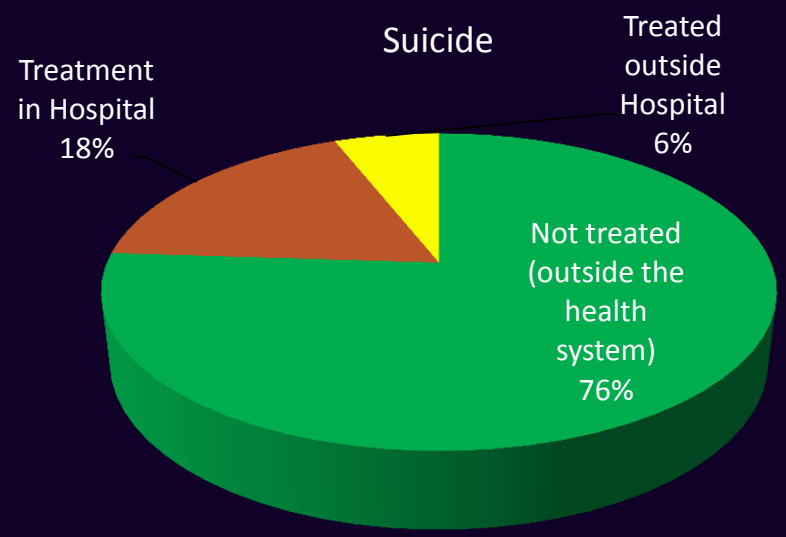
Suicide is a public health problem

One million
suicide every year globally

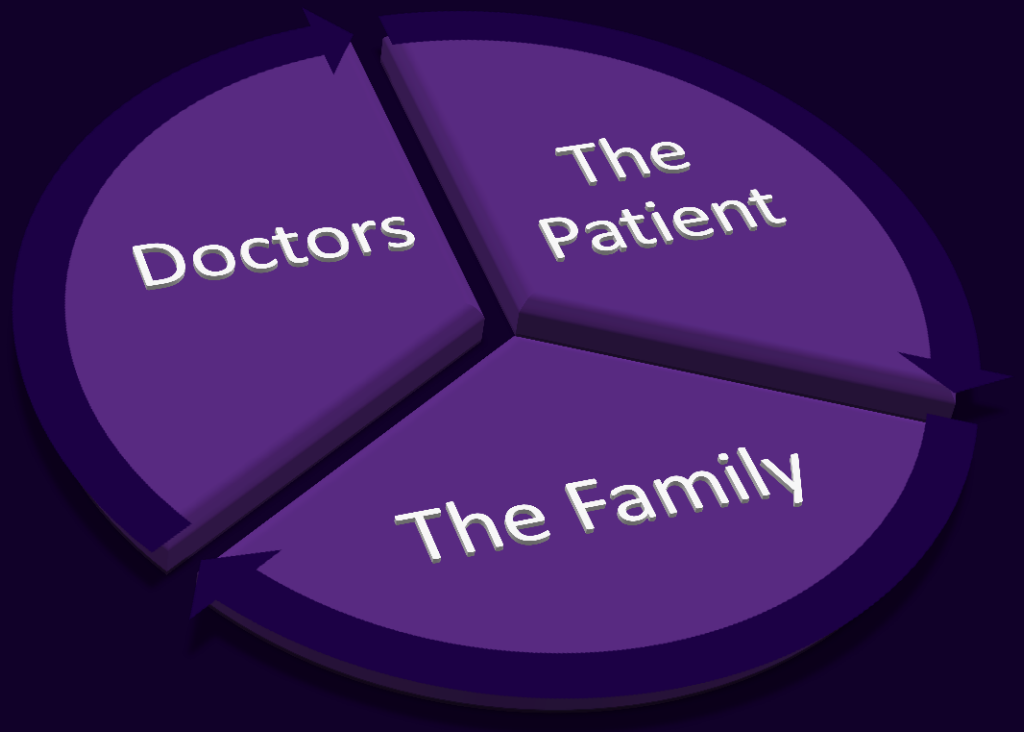
90,000
children
die every year

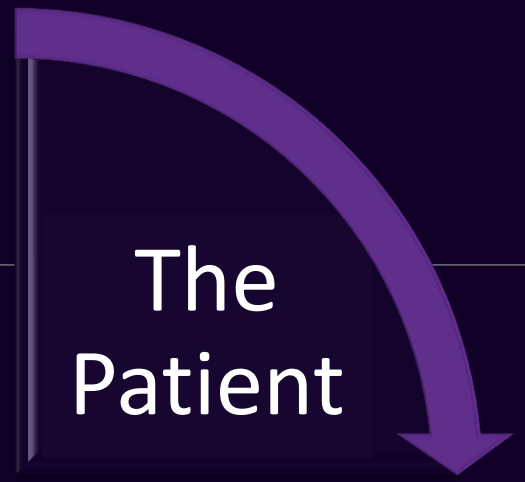
Suicide is grossly Unreported

People do not utilize health care services



Partners in suicide prevention





‘No one to talk to’

The Family

‘Could have been saved?

Doctors

‘We need more support’

‘We need to know more’.

mental health services: People are asking

Suicide rates high amongst all causes of death

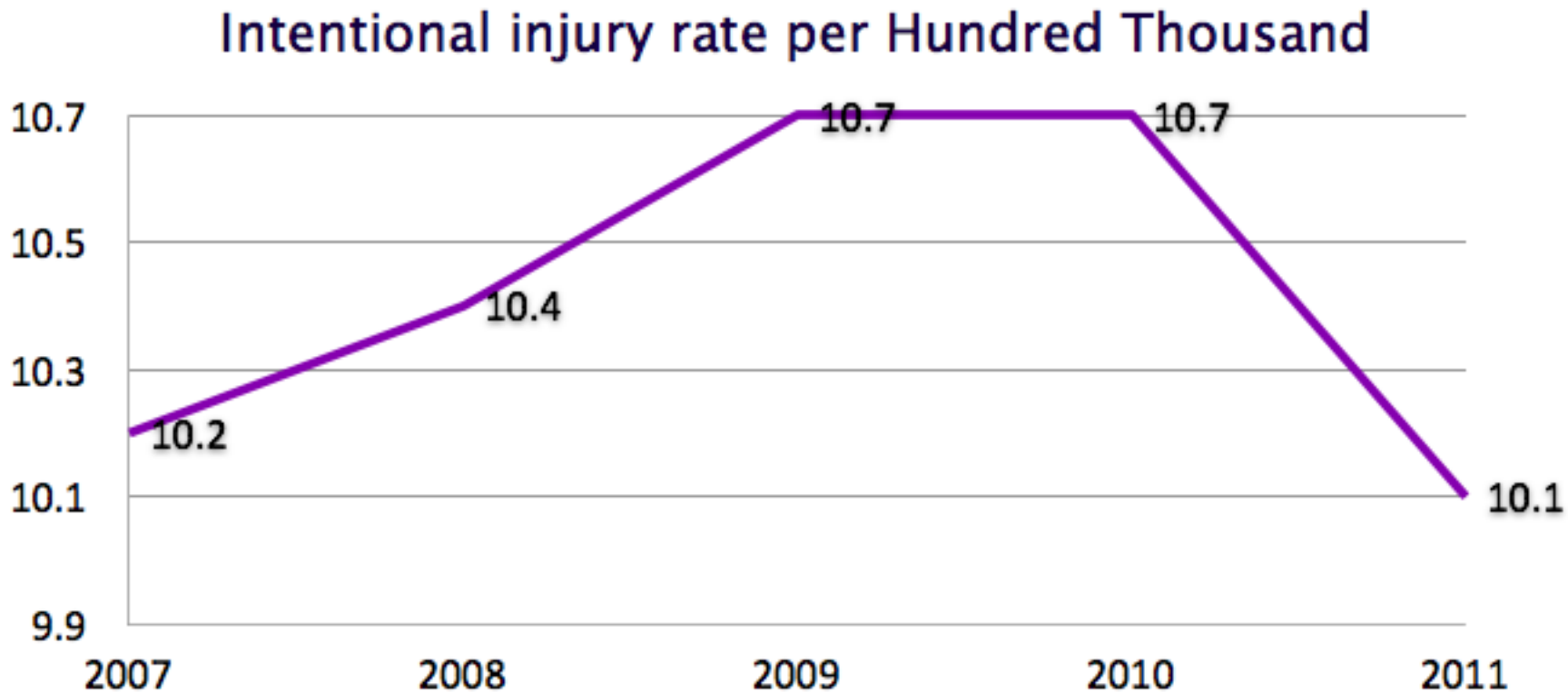
7th to 10th

Overall

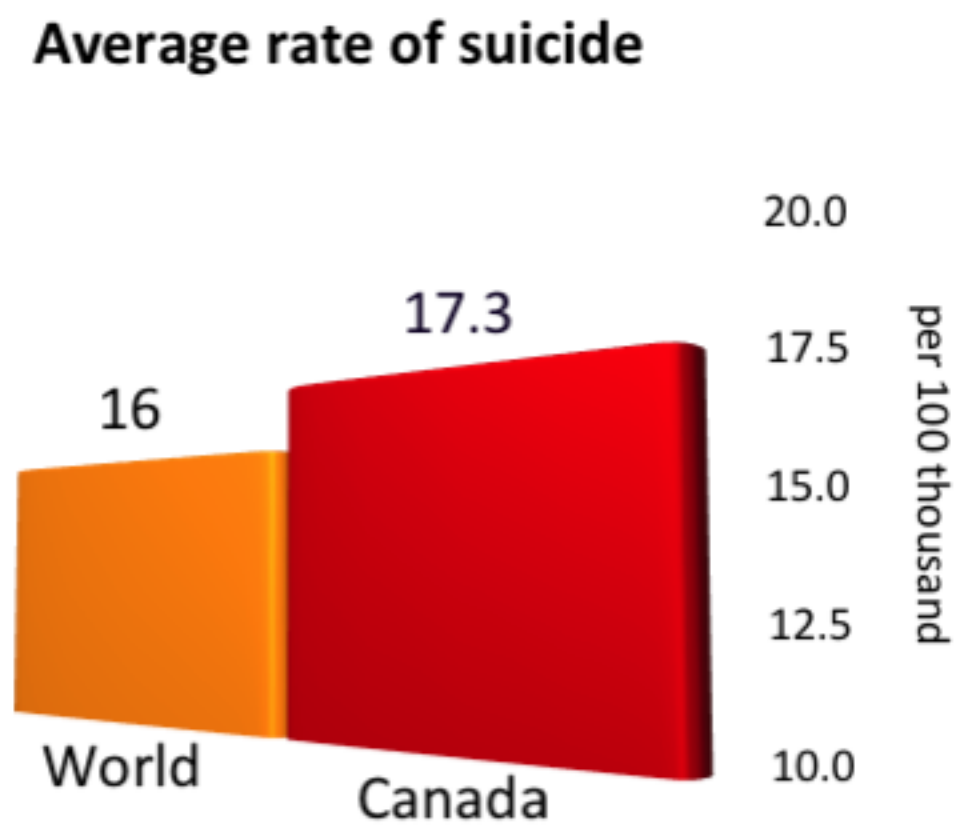
5th in age 10-24

2 end in age below 14 years

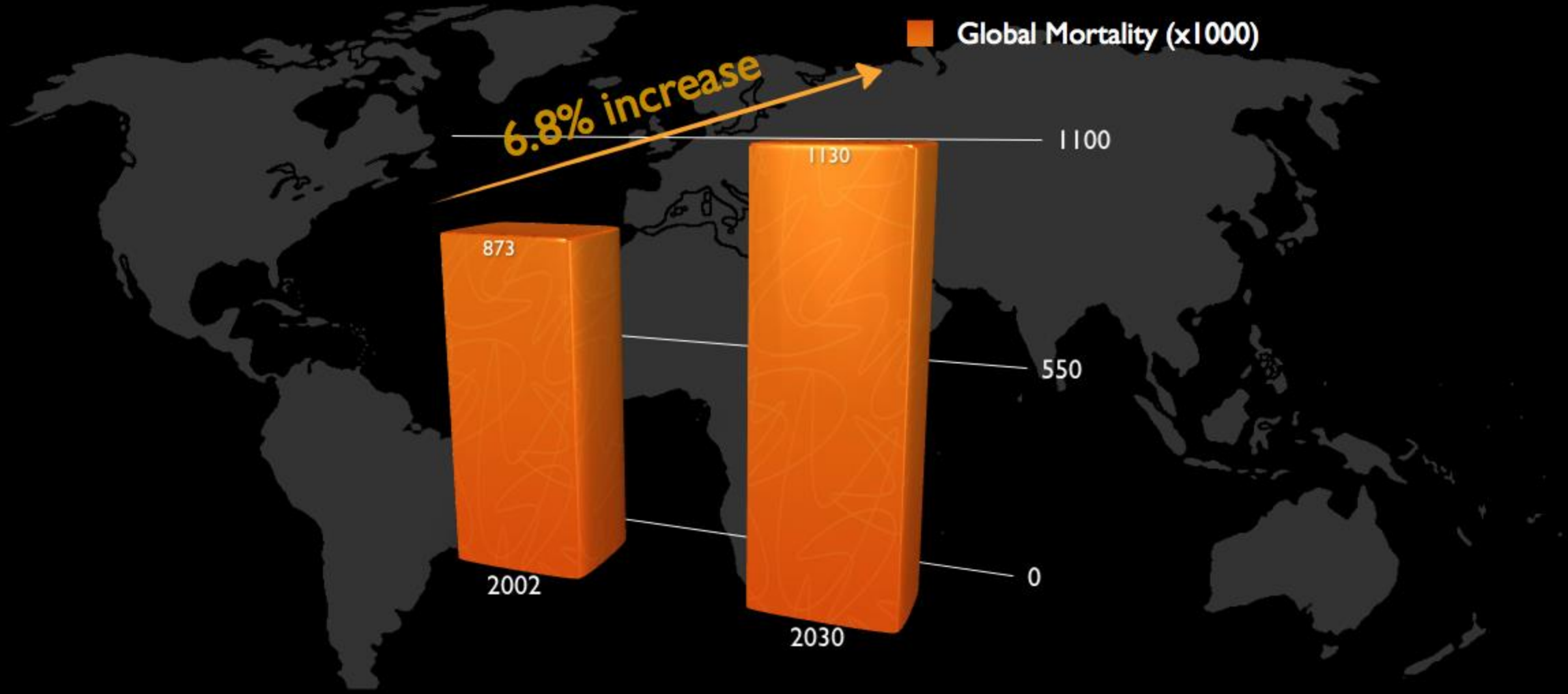
Suicide rate: Canada



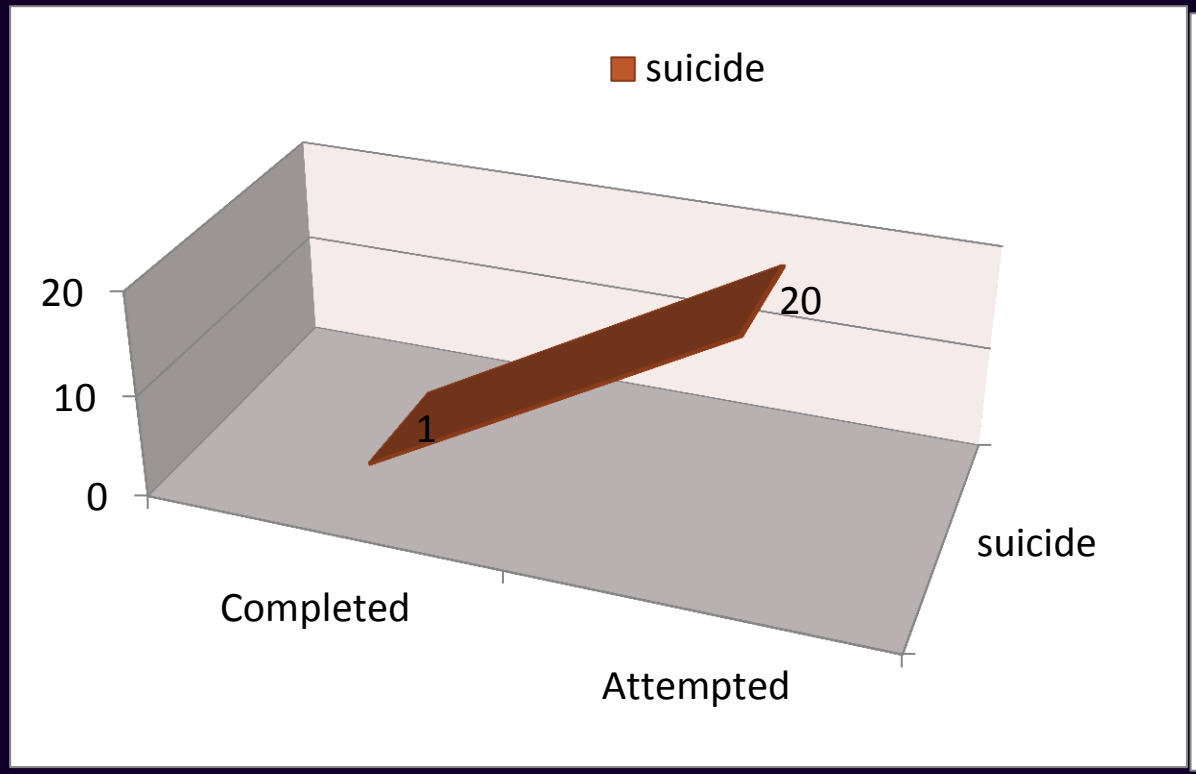
Suicide rate is closer to Global average in Canada: 2009 (WHO)

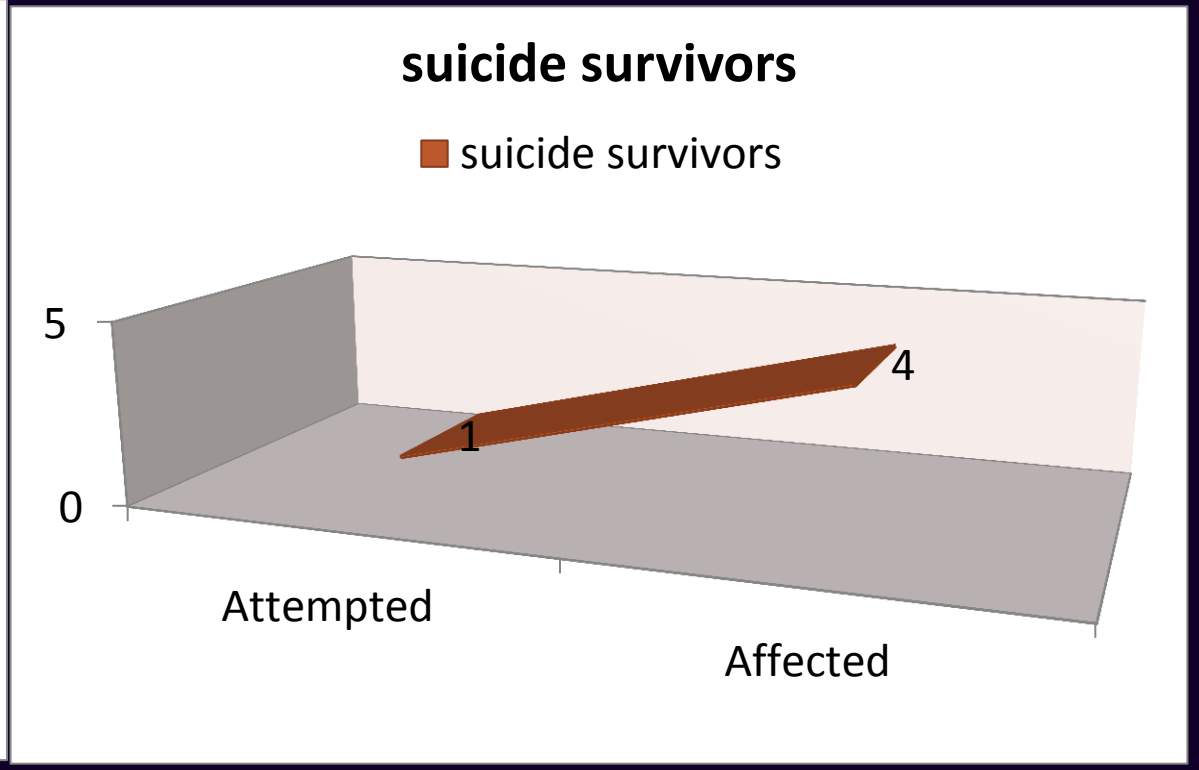


Global Projection

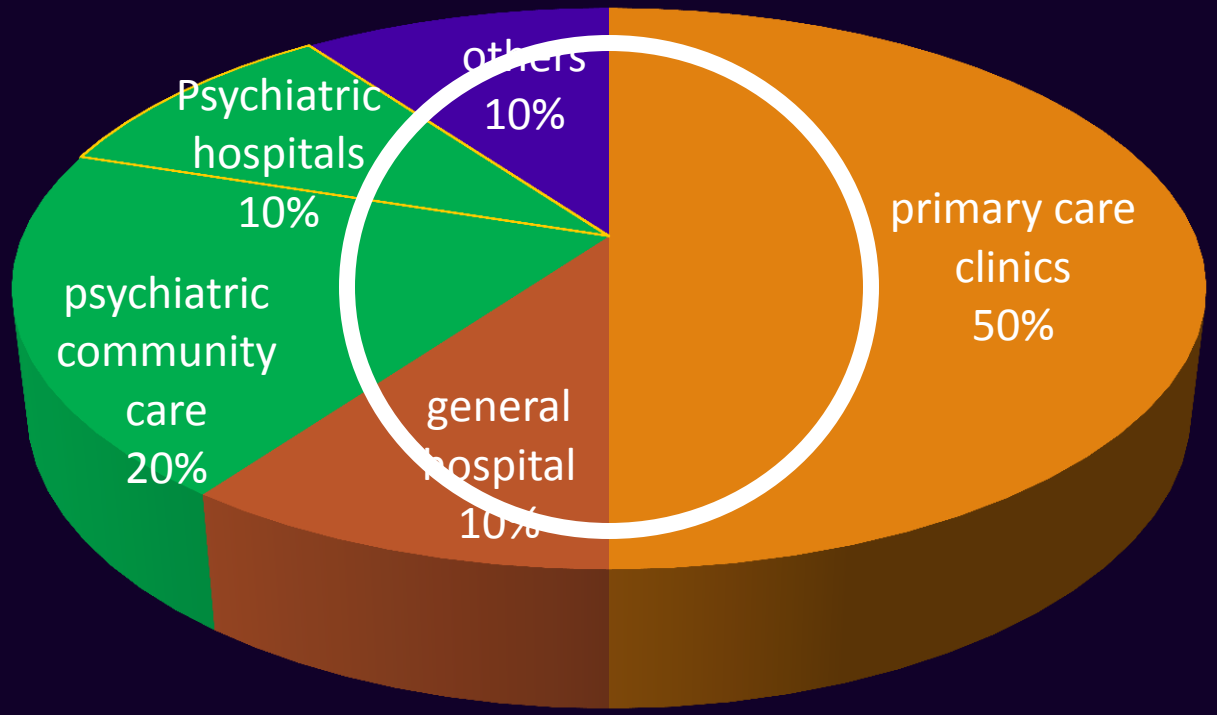


Completed: attempted suicide



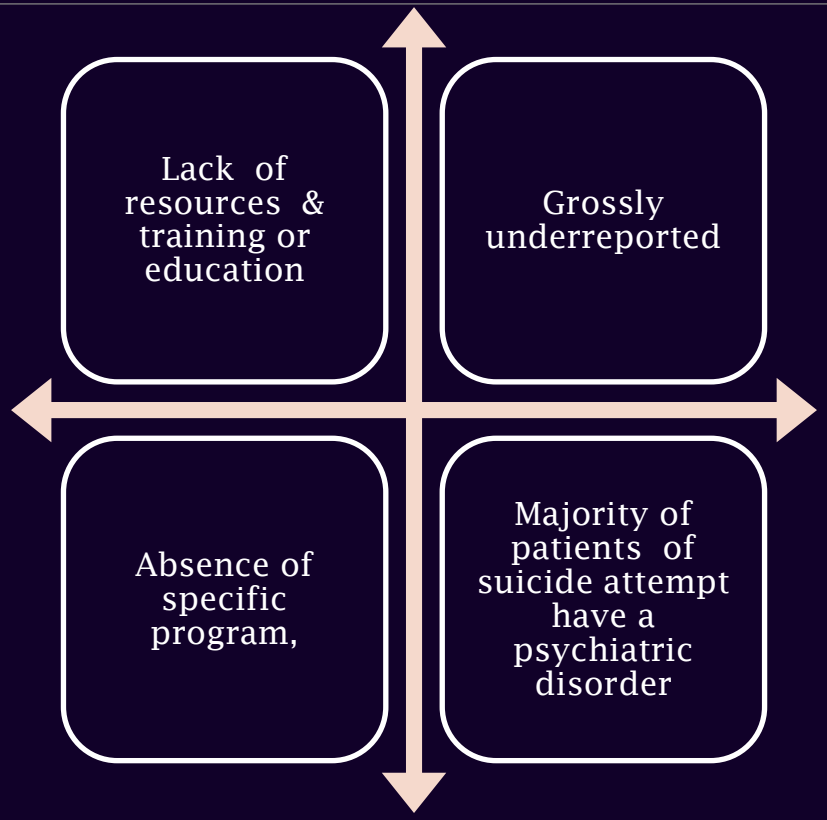


Where are these patients?



Treatment gaps

Access to care

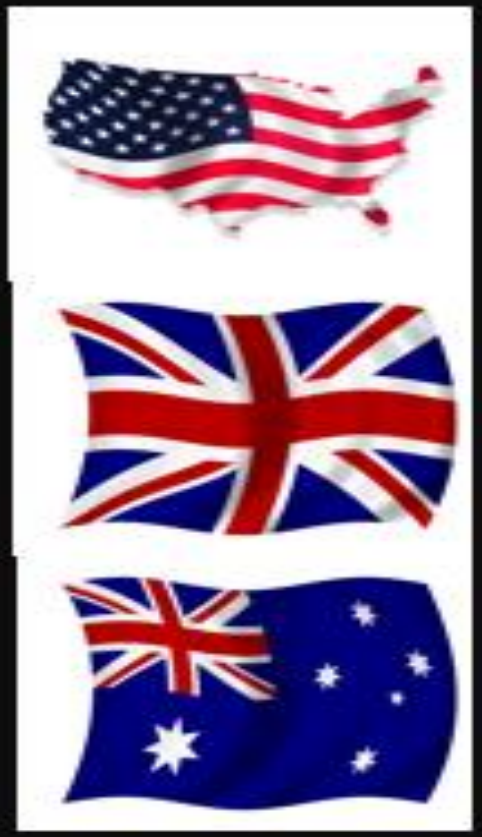


35 to 50% patients receive no treatment in high income countries

(Bresnahan et al., 2003, Lovisi et al., 2003).

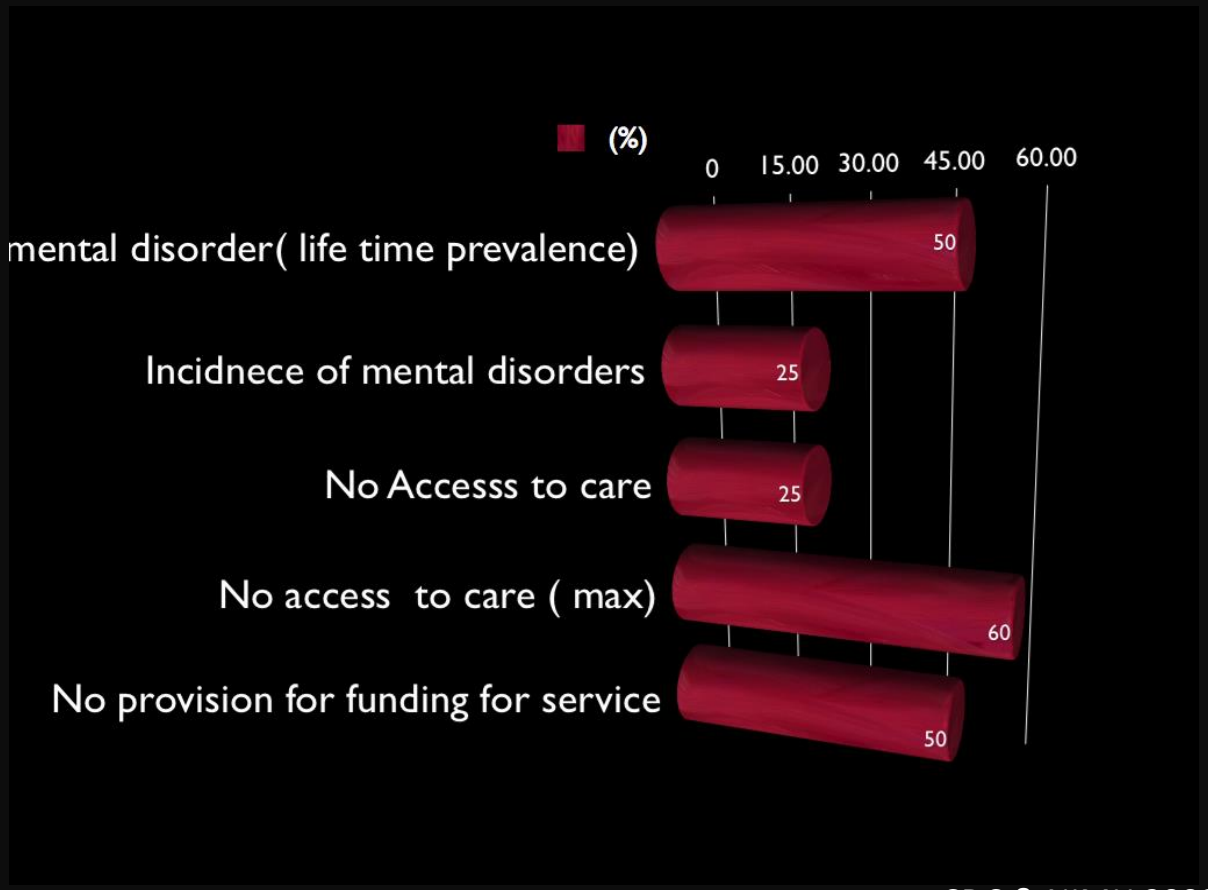
(Khurana et al., 2004, Kerfoot et al.

Access to care

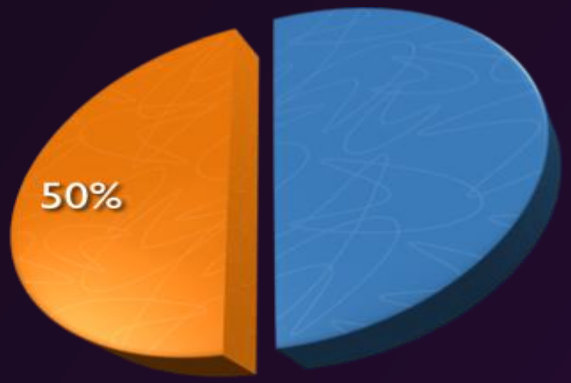


Rich Countries are not Rich For mentally ill patients

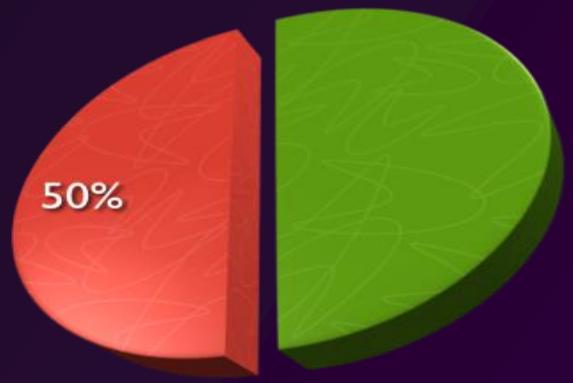
less than 1 in 3 adults receives services. In united states



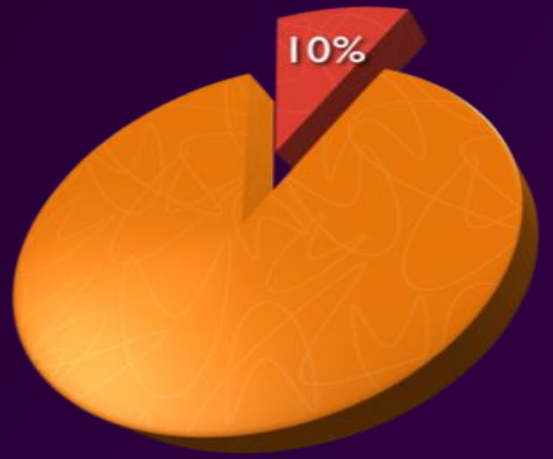
CDC & NIMH 2008



% Patients who repeated their suicide attempt



% Patients had seen a doctor in the last 6 months



% Patients were regular outpatients with their GP

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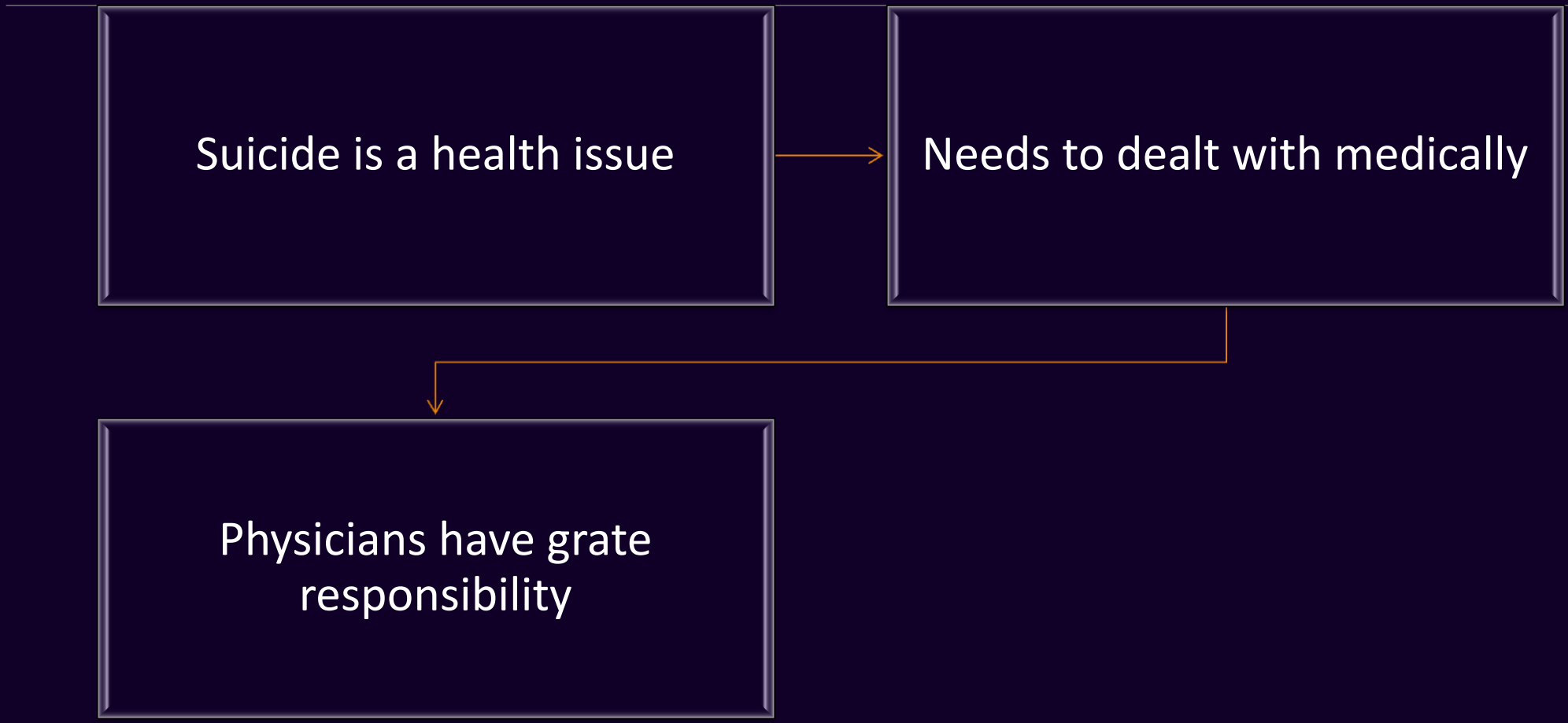
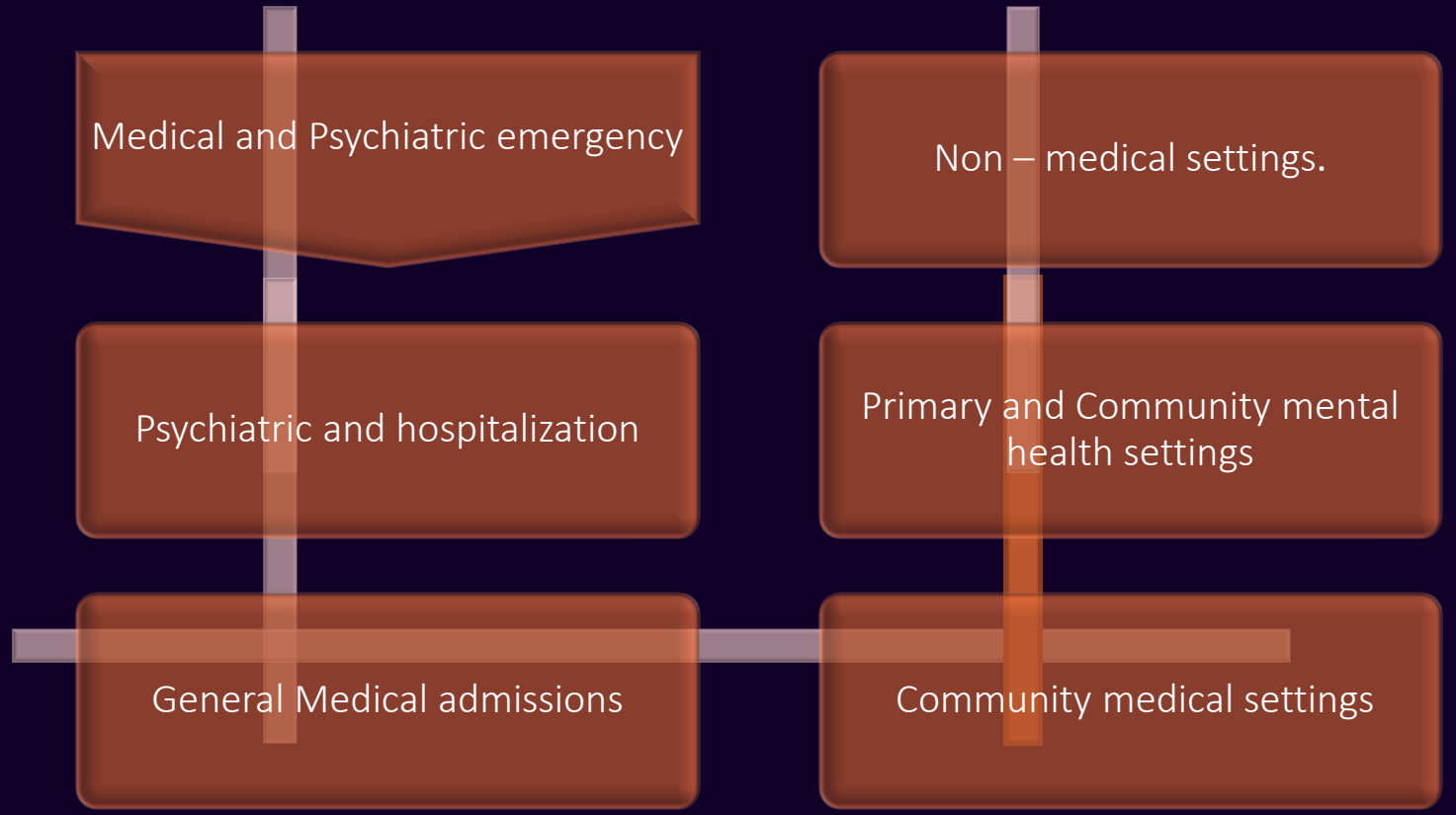
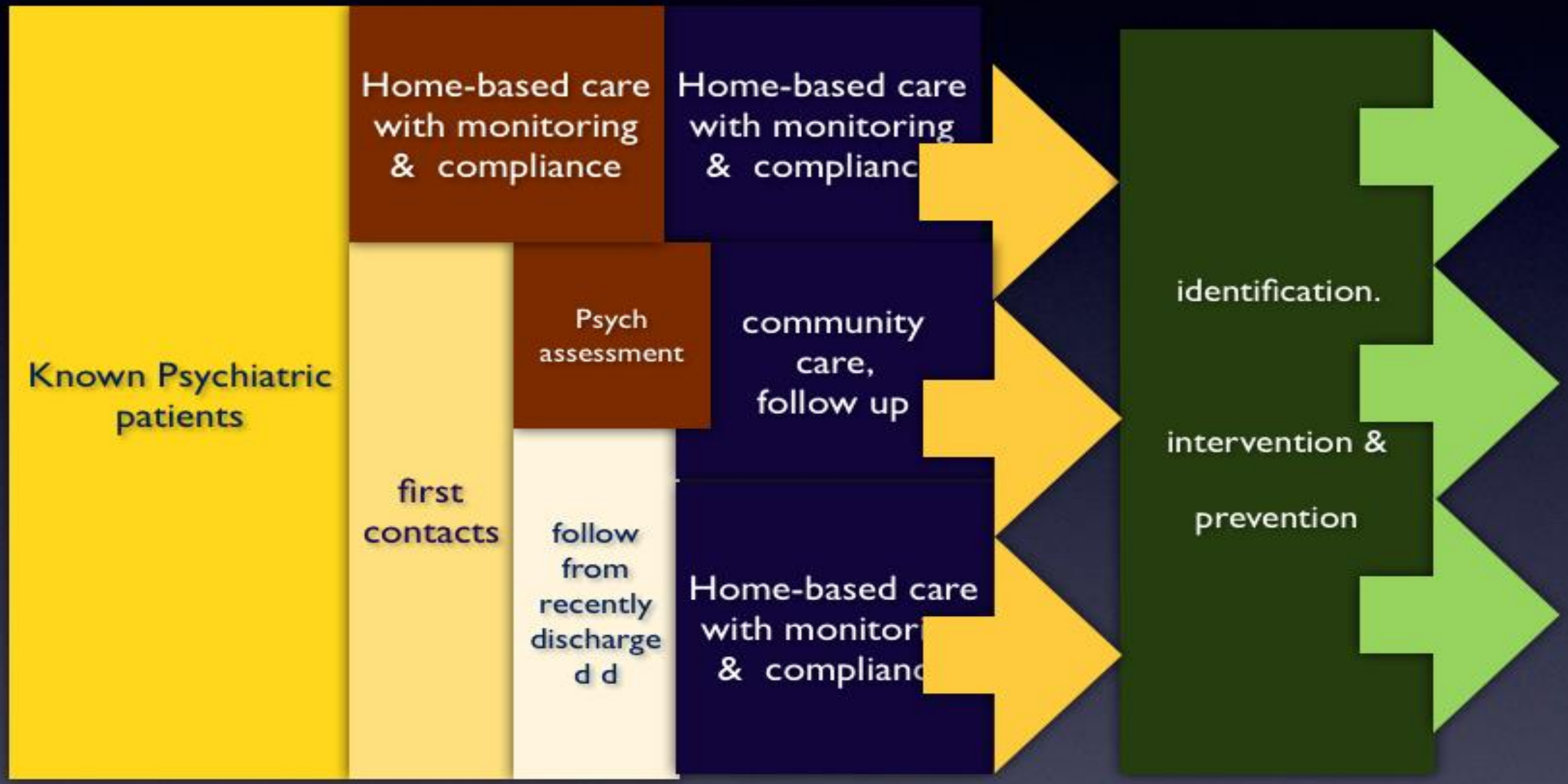
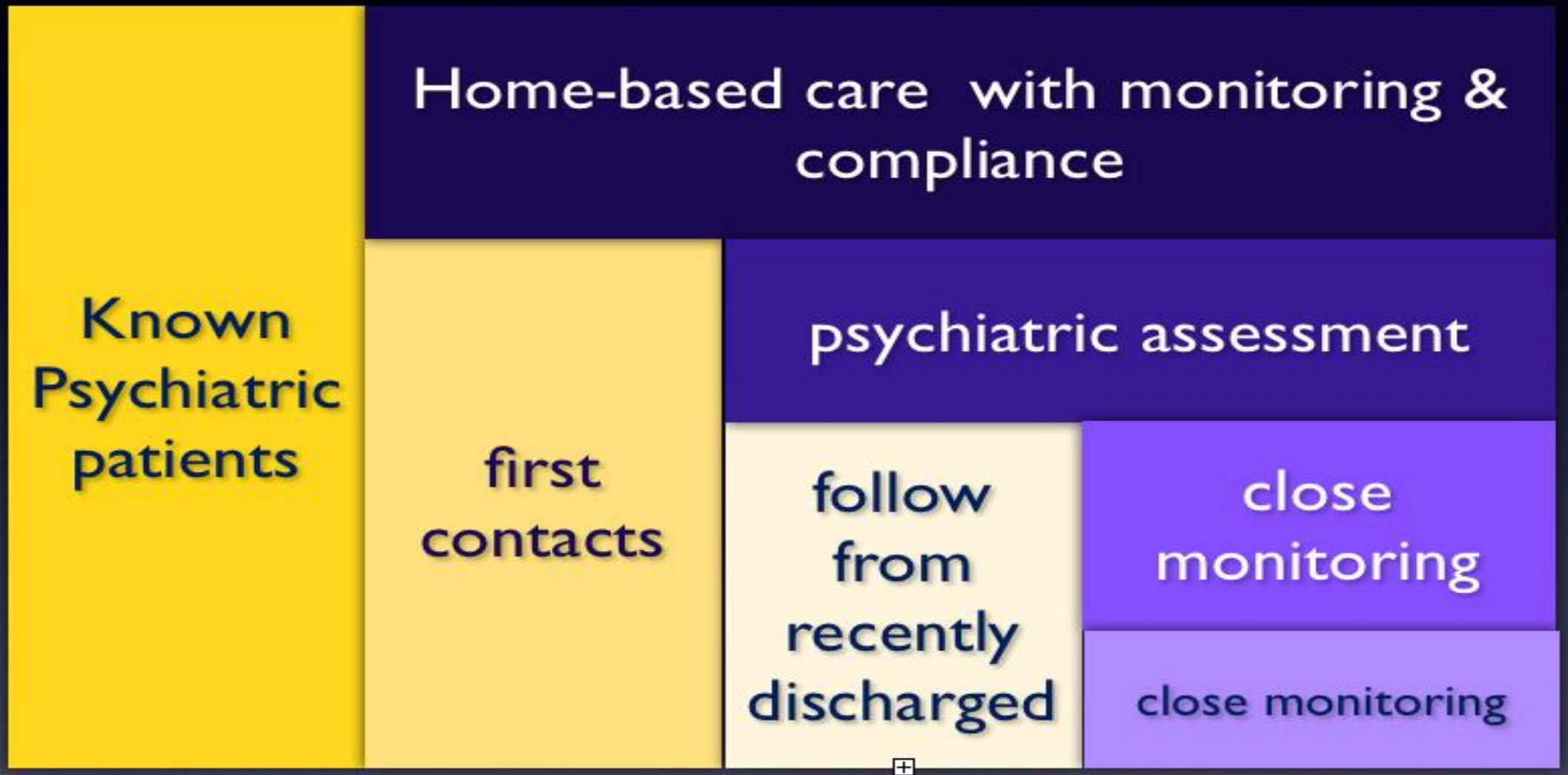
Suicide behavior is health issue



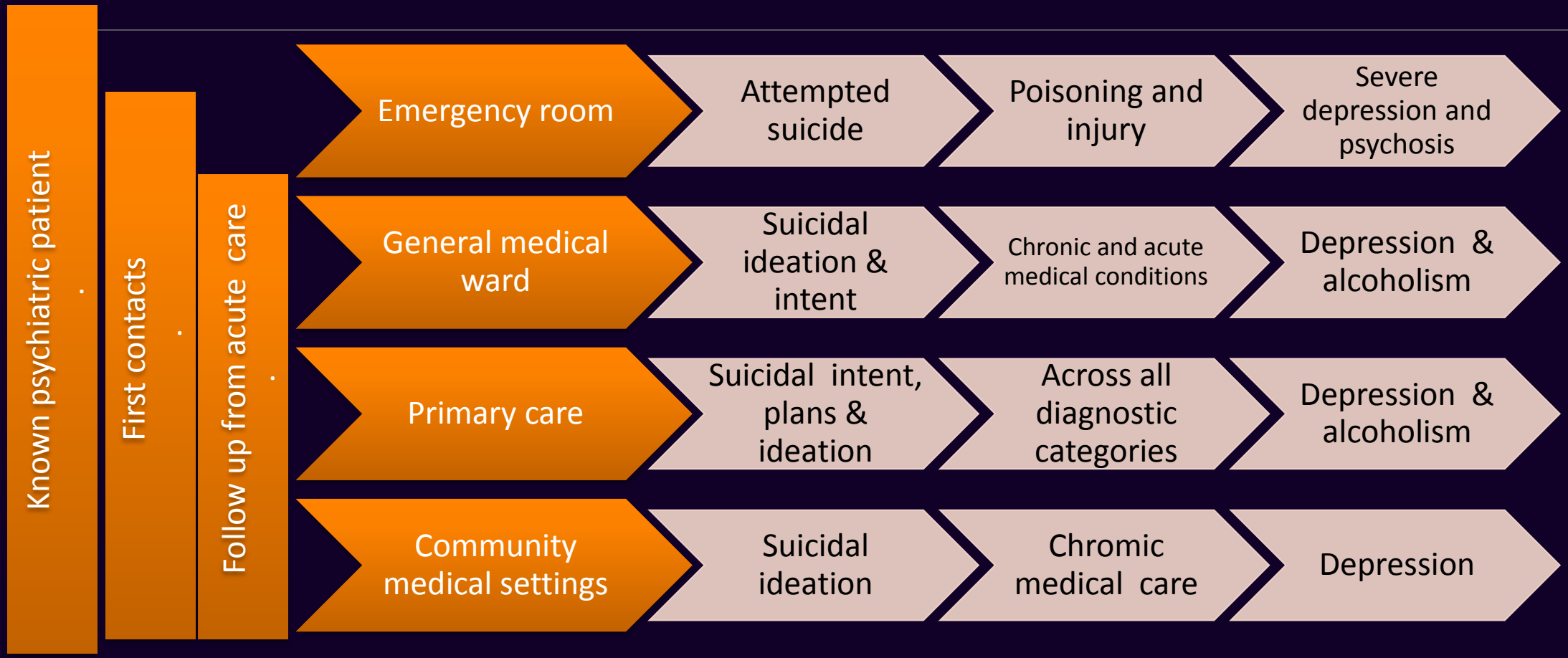
Suicide behavior is commonly seen across all settings




Known Psychiatric patients
first contacts
Home-based care with monitoring & compliance
Psych assessment
follow from recently discharge d d
Home-based care with monitoring & compliance
community care, follow up
Home-based care with monitor & compliance
identification.
intervention &
prevention


Home-based care with monitoring & compliance
Known Psychiatric patients
first contacts
psychiatric assessment
follow from recently discharged
close monitoring
close monitoring

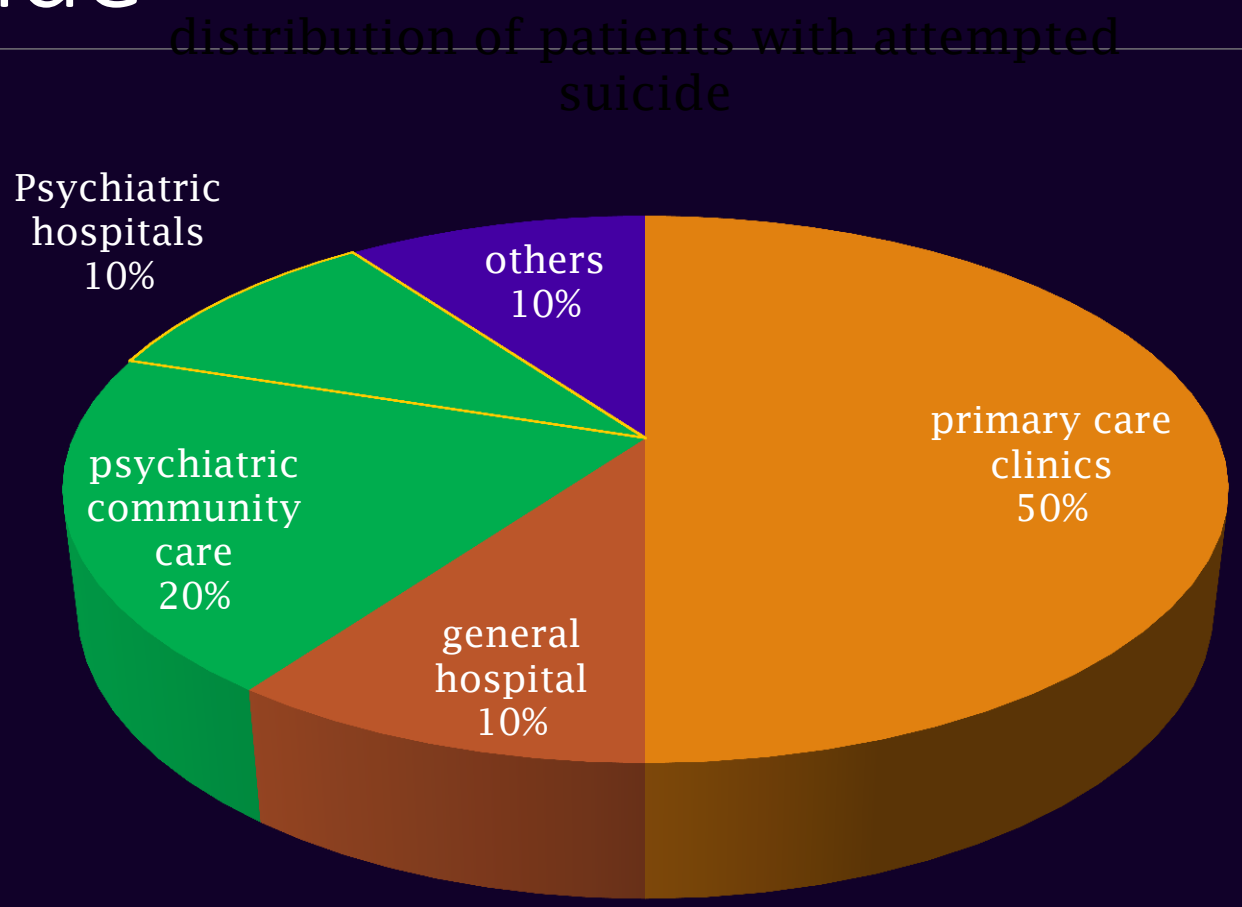
Main causes of suicide in different settings



Suicidal ideas are Strongest predictor of an attempt and occur frequently in patients population in various settings

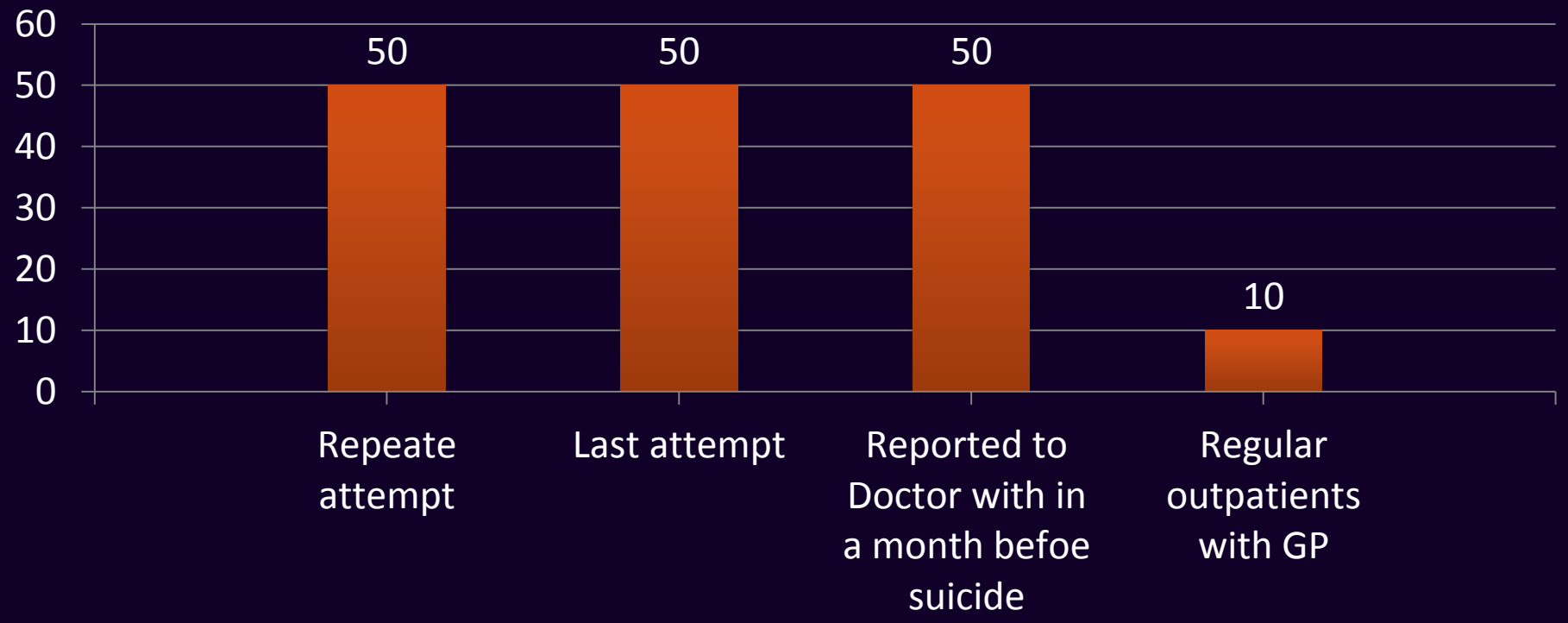
Psychiatric inpatients 60%	Substance abuse 50%	Medical Condition 40%	Family practice 35%

Attempted suicide



Repeated suicide

Suicide attempts



Ram D, Darshan MS, Rao TS, Honagodu AR**Suicide prevention is possible: A perception after suicide attempt.** Indian J Psychiatry. 2012 Apr;54(2):172-6. doi: 10.4103/0019-5545.99535.

42% of children aged 5 to 12 years reported suicidal ideation.

Prediction of suicide : Why is it difficult?

‘Pathways of suicide attempt is not clear.

- Small number of studies mainly with short follow-up
- Low incidence in community
- No definite Marker

Awareness

Stigma

Resources

There are two mjor challenges for suicide prevention

Adequate treatment

Adequate treatment of suicide behavior for those who are in health care system

To Bring more patient into treatment fold

Suicide prevention is everybody’s business

Perspective

It is a health issue

Physicians have grate responsibility for prevention of suicide because they have access to patients who need help and and opportunity utilize their skills

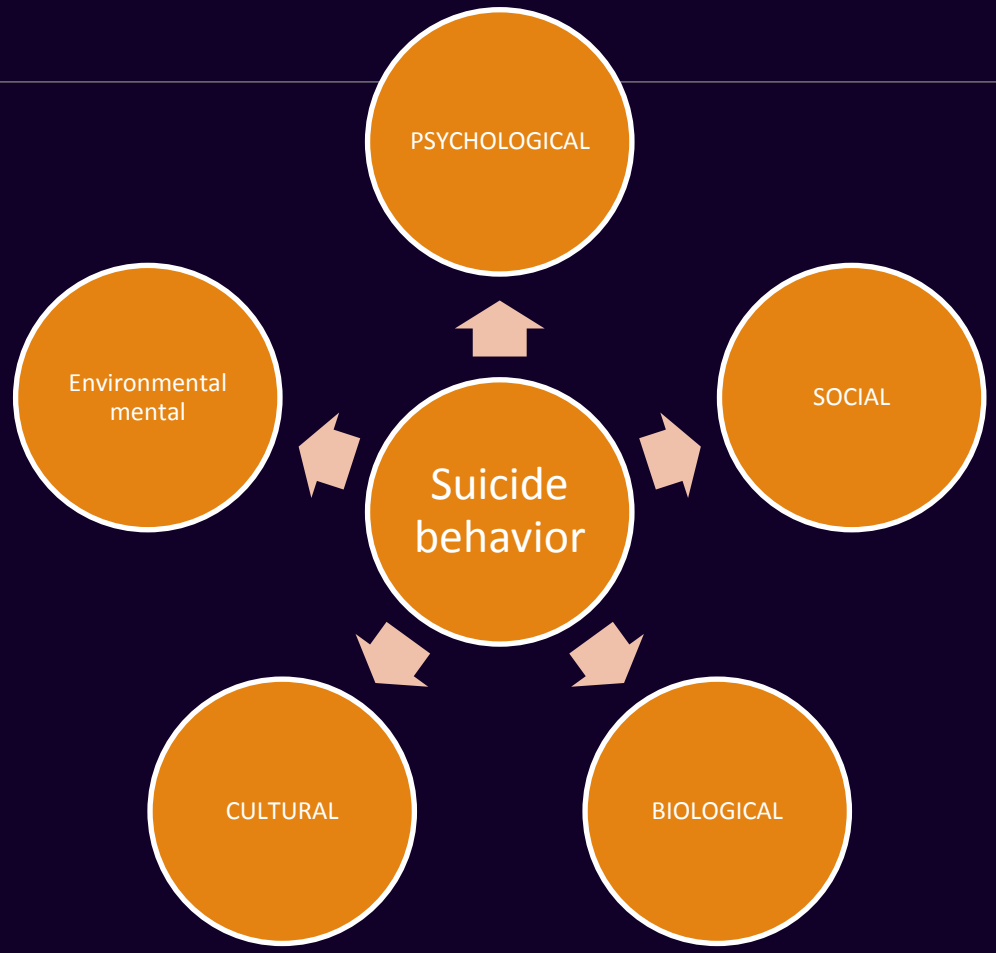
Itself not a disease,

Not necessarily the manifestation of a disease,

Mental disorders are a major factor associated with suicide

Psychosocial and environmental

Self -destructive behavior



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

Psychopathology and risk factors

History of Attempted suicide,

suicidal ideation and behavior

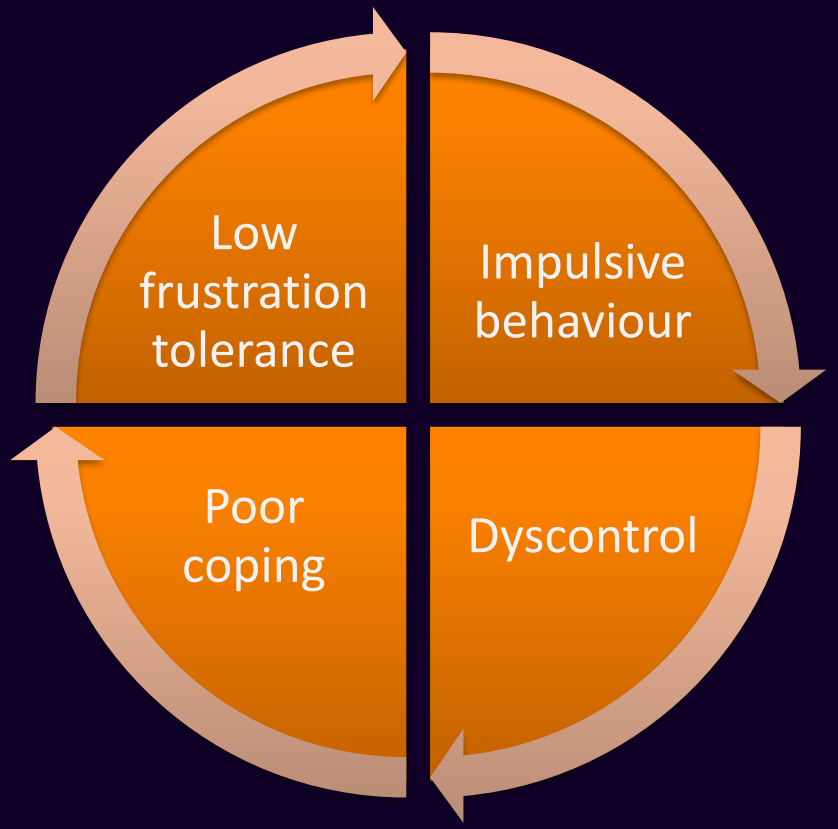
A Precursor to future suicide

repeated suicide is common in about 25 to 40% patients

Behavioral traits: related to genetics

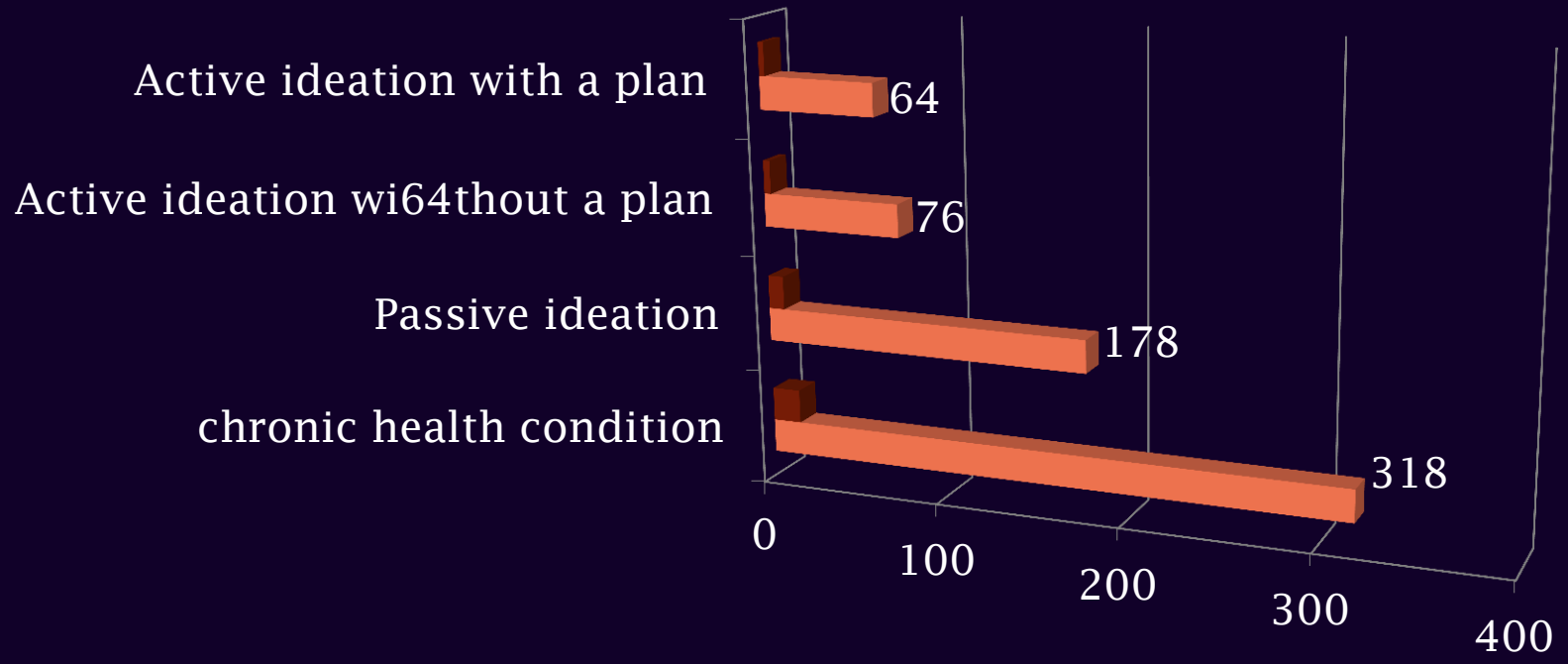
Common Psychopathological Traits .e.g

- Impulsivity
- Poor frustration tolerance
- Anger



Increased risk of suicide in family practice

Chronic health conditions =2068 Non-suicidal 1750, 15% had active suicidal ideation



Webb RT, Kontopantelis E, Doran T, Qin P, Creed F, Kapur N **Suicide risk in primary care patients with major physical diseases: a case-control study.** Arch Gen Psychiatry. 2012 Mar;69(3):256-64

Phenomenology

Completed suicide

Attention seeking suicide

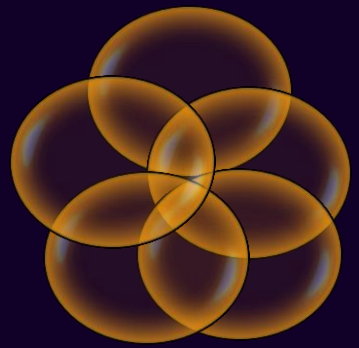
Cry for help

Attempted suicide

Developmental risk and parenting

Developmental risk and parenting

Early childhood parenteral separation & deprivation

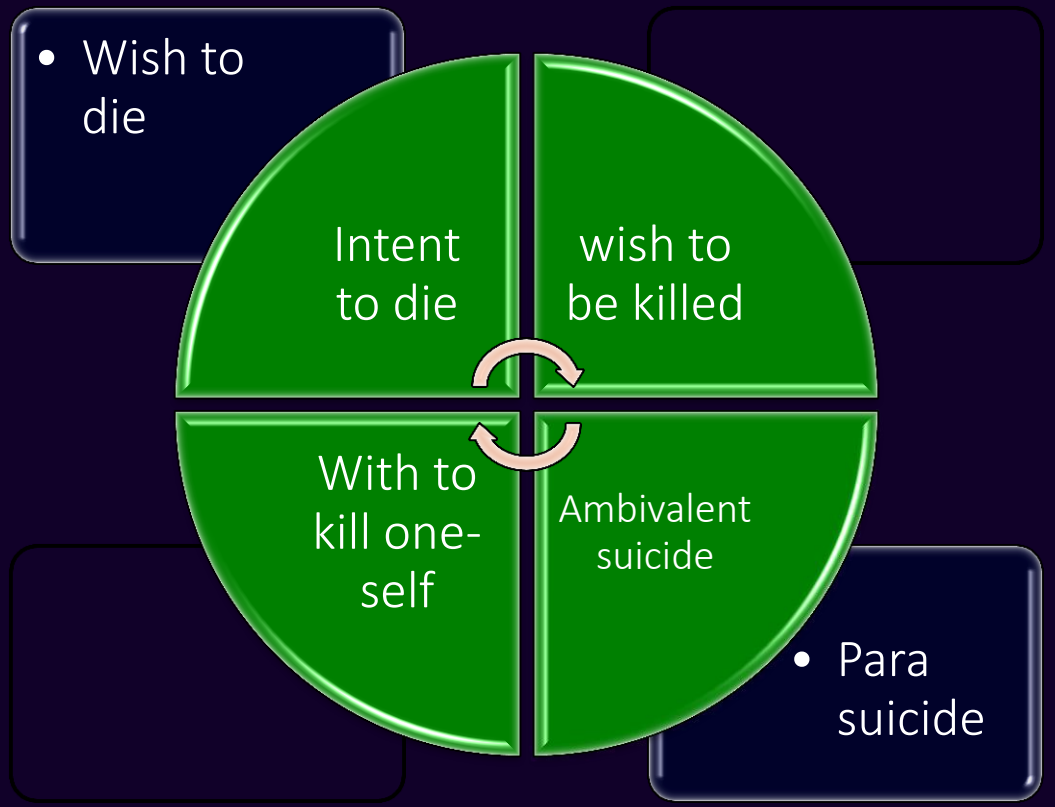


Cognitive development

Substance abuse in parents

Parenteral loss

Some of the common suicidal ideas and thoughts can be:



Biological factors

Serotonin

Agitation and psychotic symptoms

DA
++

Anxiety
Hopelessness
Psychomotor retardation

Neurobehavioral development

1. Events during brain maturation process during the period of growth
2. Cognitive development
3. Maturity

Developmental risk and parenting

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

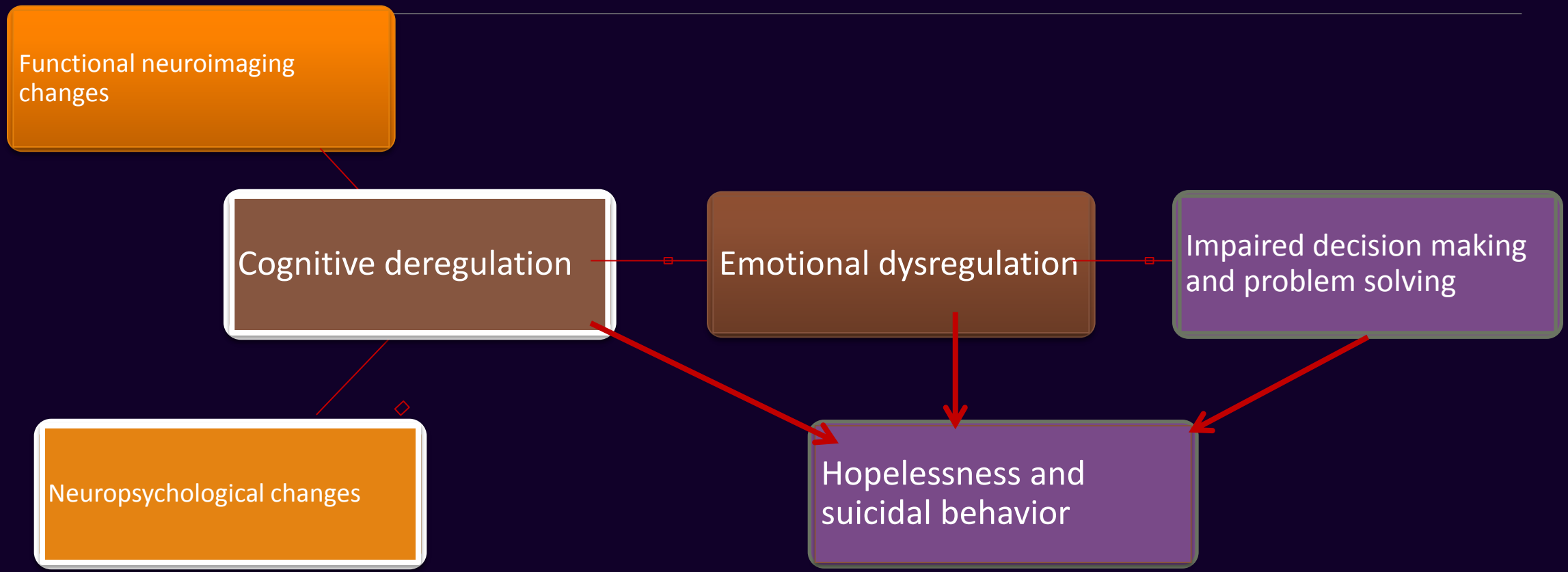
Past suicide attempts,

Pathways to suicide

Suicide and cognition: Confluence of brain and mind

A model of transition from ideas to attempt

Current Understanding



Underlying Pathophysiology

There is no known unifying underlying pathophysiology for either suicide or depression.[13]

It is however believed to result from an interplay of behavioural, socio-environmental and psychiatric factors.[58]

Prevention

Prevention	Risk factors	Assessment
Management	Treatment	Prevention

risk factors

Risk factors

Mental disorders	Physical disorders	Psychosocial stress
Childhood experience	Environmental conditions	

High rates of suicide – mental disorder

Multifactorial, complex behavior

Mental disorders: 80-90%

Mental disorders.

Schizoaffective

PTSD: 50%

Bipolar mood disorder

Ocd 30%

Major mood disorder

Schizophrenia

Stressful factors: 30-40%
of
attempted suicide

Generalized Clinical risk factors

Recent and past attempt	Family history & CSA	Psychiatric diagnosis	Substance & alcohol
Comorbidity & First episode	Dominant depressed mood	Hopelessness	Psychosocial stress

Risk factors

Modifiable (Dynamic risk factors)	Suicidal ideation, communication or intent	Hopelessness, active psychological symptoms	Substance abuse
Psychiatric admission and discharge	Problem solving deficit	treatment adherence	Lack of protective factors


Non-modifiable (Static / stable) risk factors
History of self harm
Seriousness of previous suicidality
Mental disorders
Substance abuse
Personality disorders or traits
Family history
Age and gender
Childhood adversity

Contributing Factors

- Presence of depression
- Presence of depression in mothers
- Depression during pregnancy and postpartum depression
- Social determinates of health
- Substance abuse

Contributing factors

Developmental	Environmental SDH
Childhood events	Genetic predisposition

Sexual violence involving forced Intercourse in Children under 18 years

73 million boys and 150 million girls.

Neurobiological changes

HPA axis, & Glucocorticoid

Amygdala and Hippocampus

Emotional dysregulation

Protective factors

Social support	Problem solving skills	Participation in treatment
Presence of hopefulness	Children present in the home	Pregnancy

Protective factors

Religious commitment

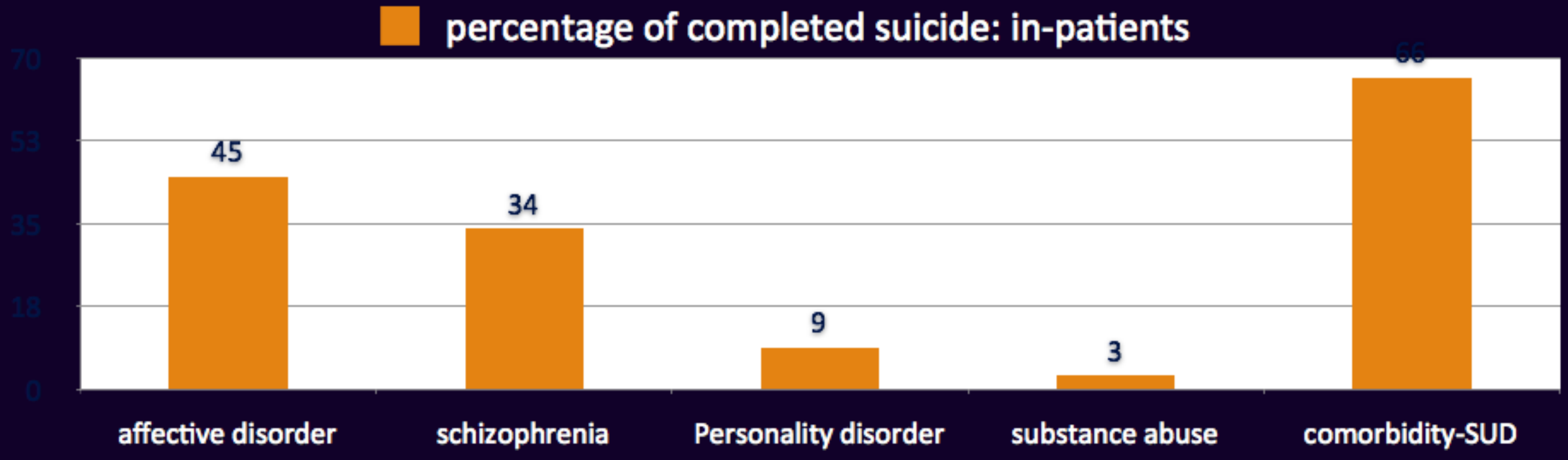
Life satisfaction

Intact reality testing

Fear of social disapproval

Fear of suicide or death

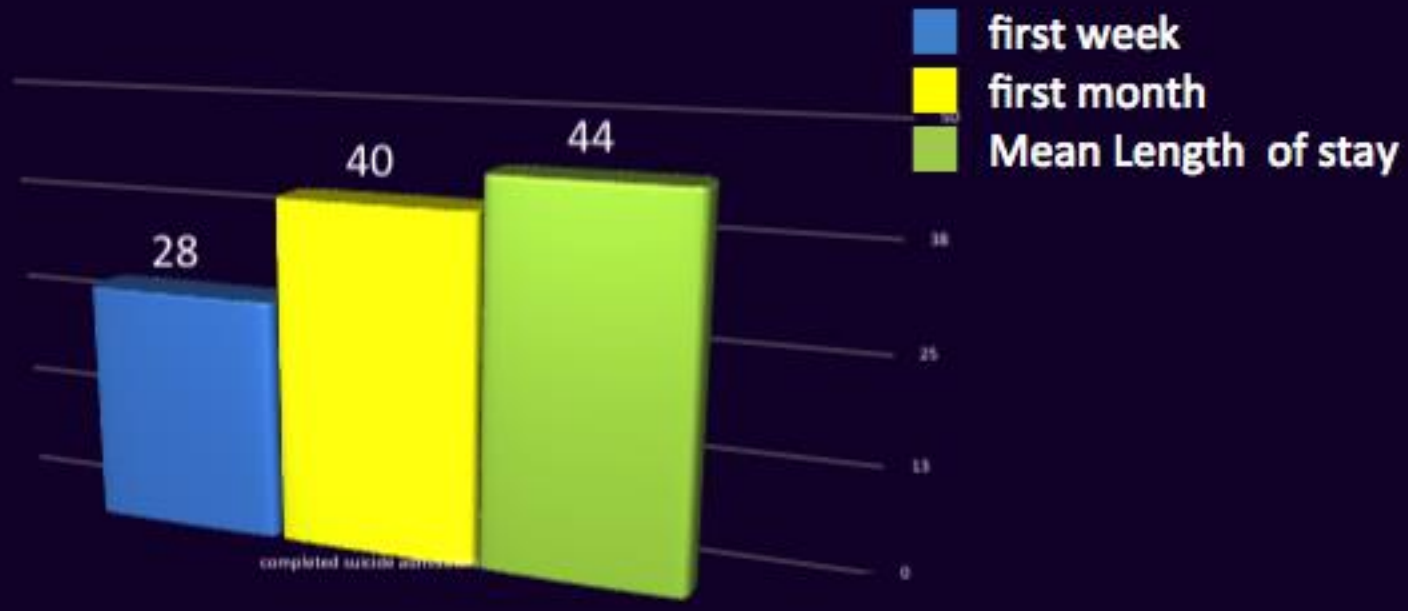
Co-morbid and severe mental illnesses are



SAFE MD, Practical applications and safe psychiatric practice.
Committee of patients,safety.APA,2008

In most cases it happens in first week or first

Post discharge period



Bower L et al, Suicide Inside, J.Nervous,mental Ds.May.2010.198

Childhood physical and sex abuse

Parental substance abuse,

Child abuse,

Family discord,

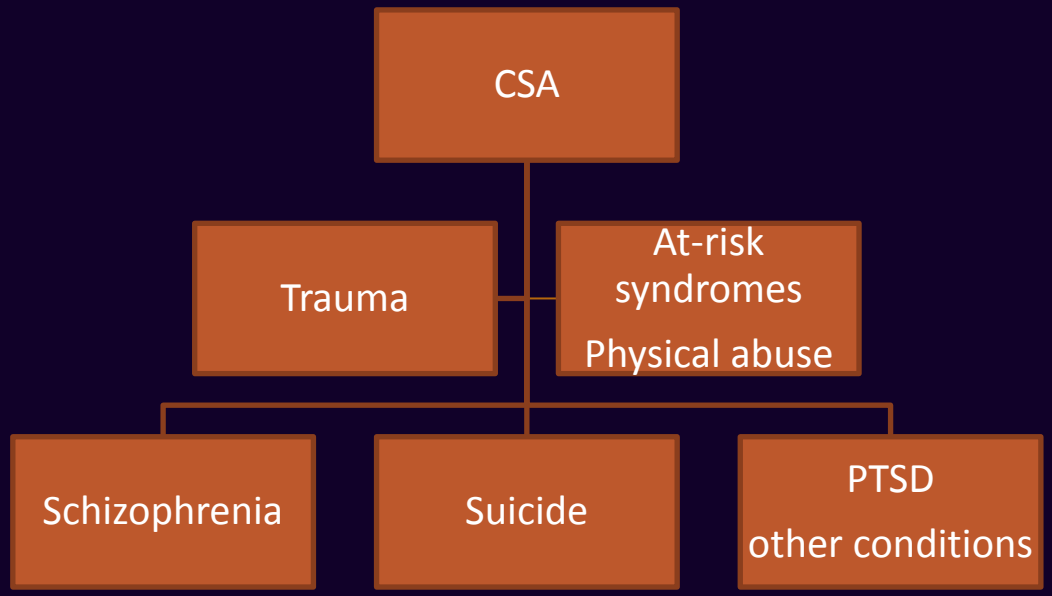
Parental loss and other

Negative life experiences.

Trauma and loss
Childhood physical and sexual abuse (CSA)

1. Negative life experiences. & Later consequences of abuse as suicide behaviour
2. Recent suicide attempt in presence of CSA
3. Parental substance abuse,
4. Child abuse, Family discord,
5. Parental loss due to separation or death,
6. Especially death of a parent before the child reaches the age of 12

Trauma and loss
Childhood physical and sexual abuse (CSA)



Predictors of suicide after a suicide attempt

- Age older than 45 years
- Living alone
- Unemployment
- Chronic physical diseases
- Psychiatric Axis I disorder
- Personality disorder
- “Hard” suicide method
- Repeated suicide attempts

Powell j et al, BJP,(2000), 176, 266-272

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

Substance abuse- risk behavior

Social determents of health

1.8 billion adolescents exposed to harmful alcohol consumption, sexually transmitted diseases, and other risks

Military

Relationship

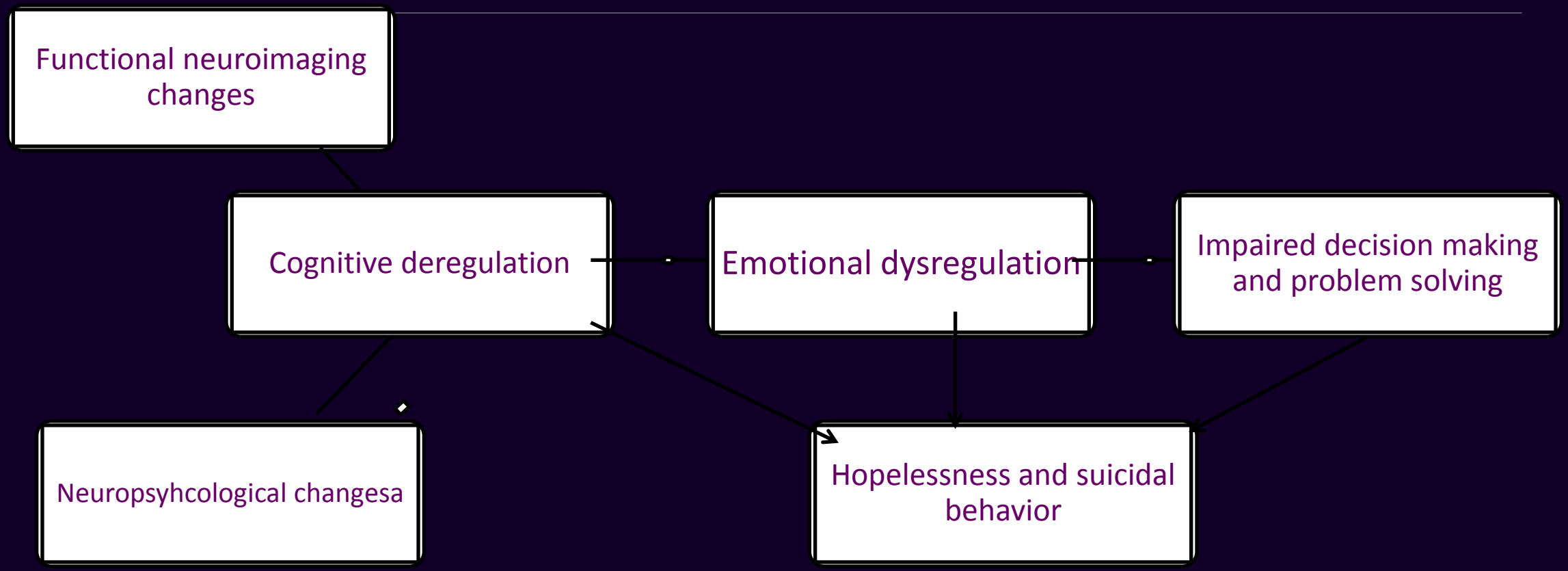
Economic :more debt more mental health problem and more suicide

Risk factors and psychopathology

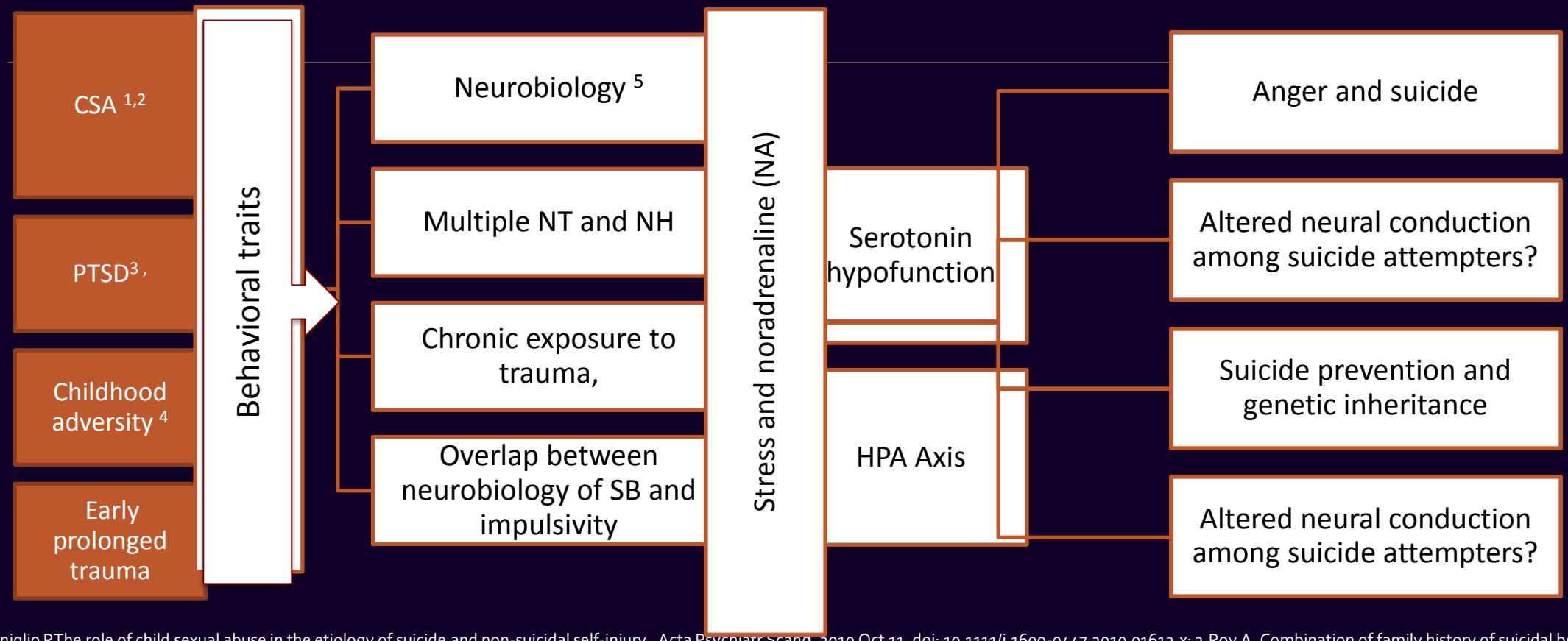
1. *Cognitive Development and Maturity*
2. Early childhood parental loss Substance abuse in parents
3. Negative Life Stressors/Environmental
4. Genetic predisposition: Family history of first-degree relatives having attempted suicide, especially mothers,

    5 times more common if mothers died by suicide and twice more common where father had committed suicide

Pathway for suicide behavior



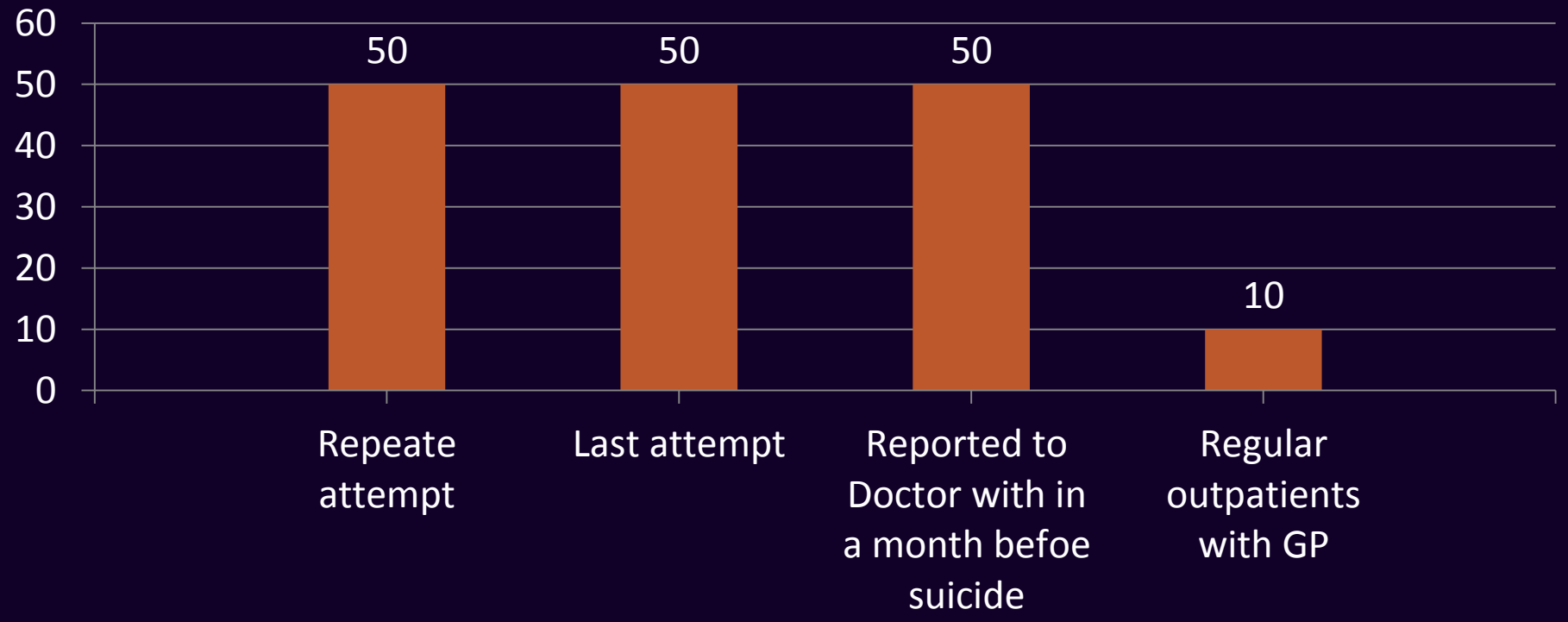
Impulsivity- Link with childhood experience and trauma
Nature and nurture in suicidal behavior, HPA response & NA response



1.Maniglio RThe role of child sexual abuse in the etiology of suicide and non-suicidal self-injury. Acta Psychiatr Scand. 2010 Oct 11. doi: 10.1111/j.1600-0447.2010.01612.x; 2.Roy A. Combination of family history of suicidal behavior and childhood trauma may represent correlate of increased suicide risk.
J Affect Disord. 2010 Oct 11; 4.Lentz V, Robinson J, Bolton JM. Childhood adversity, mental disorder comorbidity, and suicidal behavior in schizotypal personality disorder J Nerv Ment Dis. 2010 Nov;198(11):795-801.
Physiology & Behavior 92 (2007) 245 – 249
Braquehais MD, Oquendo MA, Baca-Garcia E, Sher L. Is impulsivity a link between childhood abuse and suicide? Compr.Psychiatry 2010 Mar-Apr;51(2):121-129

Repeated suicide

Suicide attempts



Ram D, Darshan MS, Rao TS, Honagodu AR**Suicide prevention is possible: A perception after suicide attempt.** Indian J Psychiatry. 2012 Apr;54(2):172-6. doi: 10.4103/0019-5545.99535.

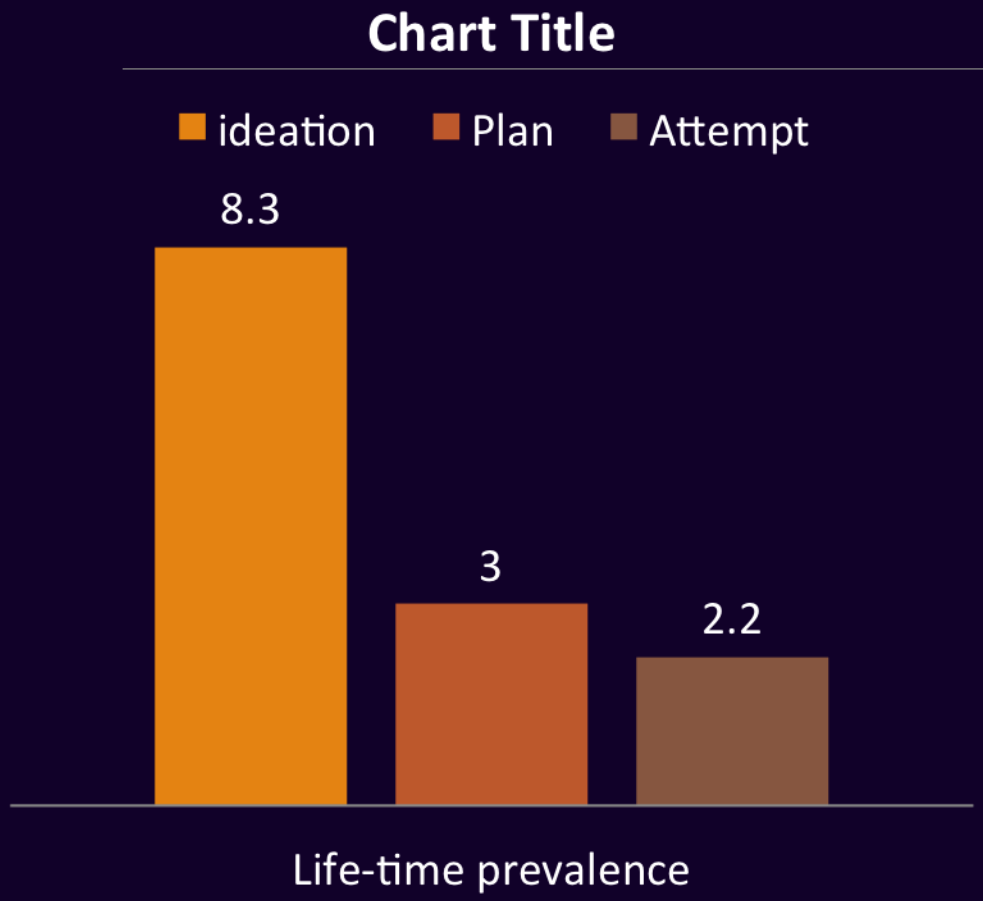
Suicide ideation and attempt

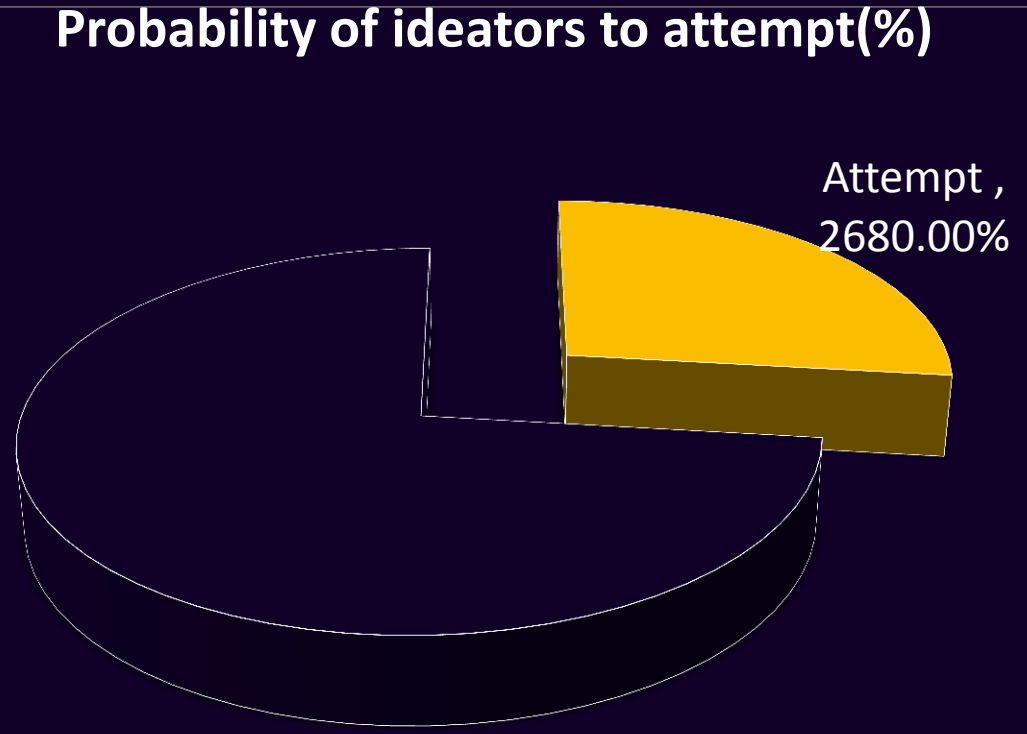
1. Only a small number of patients with suicide ideation attempt suicide
2. Presence of suicidal ideation is the strongest predictor of an attempt,
3. particularly in presence of a mental disorder
4. Pathways of suicide and suicide attempt from ideation is not clearly known

Suicidal ideation

1. At any given point of time suicidal ideation is present in
    1. About 30% subjects in family practice,
    2. 40% in chronic general medical condition
    3. 50% in substance abuse and
    4. 60% in a psychiatric ward have suicidal ideation at any given point of time

Ideation to attempt N=6646





Ten Have M, van Dorsselaer S de Graaf R ***Prevalence and risk factors for first onset of suicidal behaviors in the Netherlands Mental Health Survey and Incidence Study-2.*** *J Affect Disorder. 2013 May;147(1-3):205-11. doi: 10.1016/j.jad.2012.11.005. Epub 2012 Nov 27.*

Limitations in Risk Assessment

There are too many factors and

Too many variations on the subject.

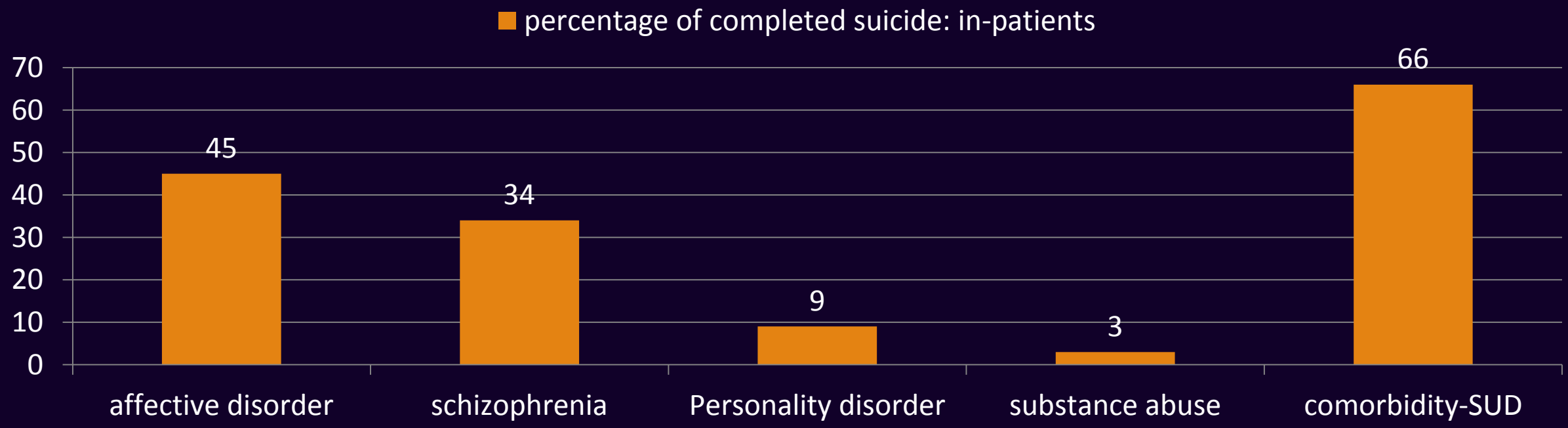
A new definition of suicide needs to be found. [5]

Several psychological & biological markers

Neither are free from false positive and false negative results

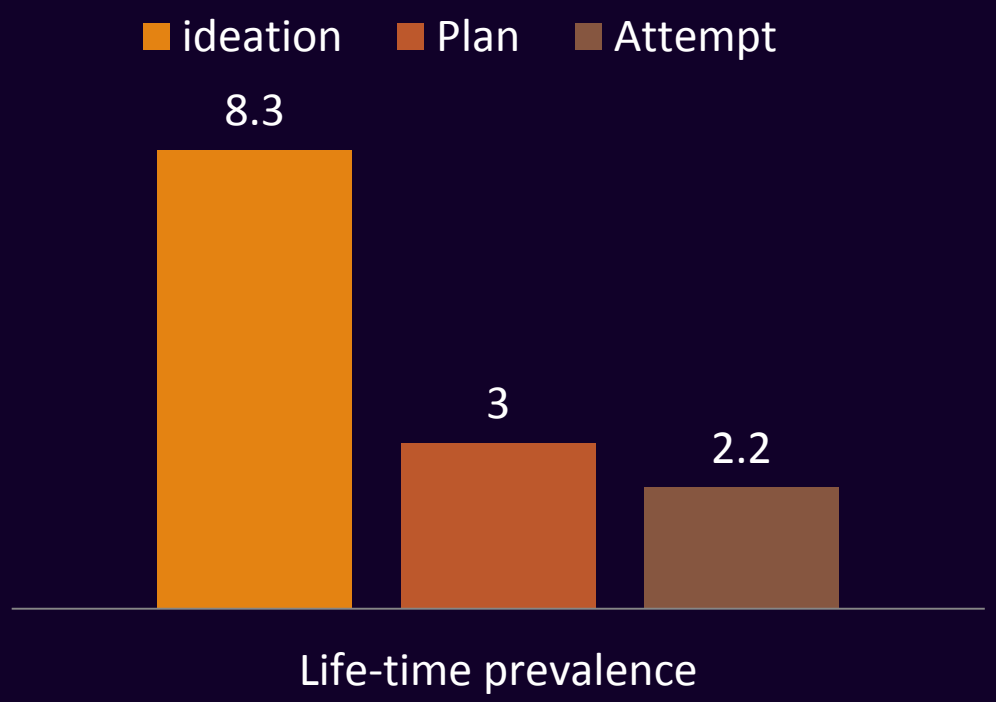
5.Soubrier JP.Beyond the scale: toward a new definition of suicide?Crisis. 1990 Nov;11(2):98-103.

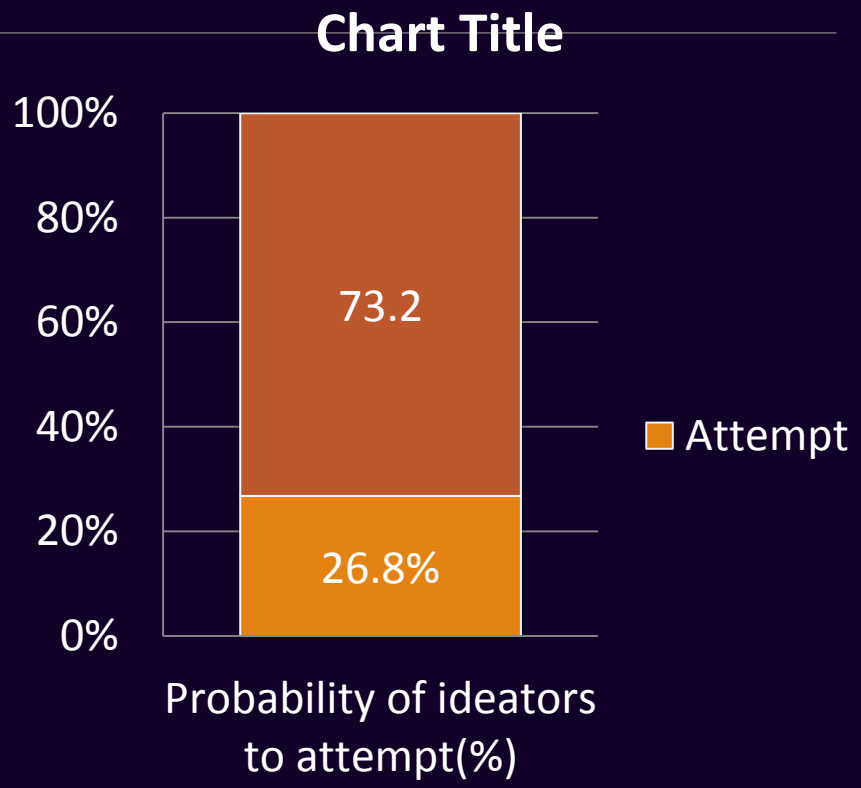
Co-morbid and severe mental illnesses are main challenge



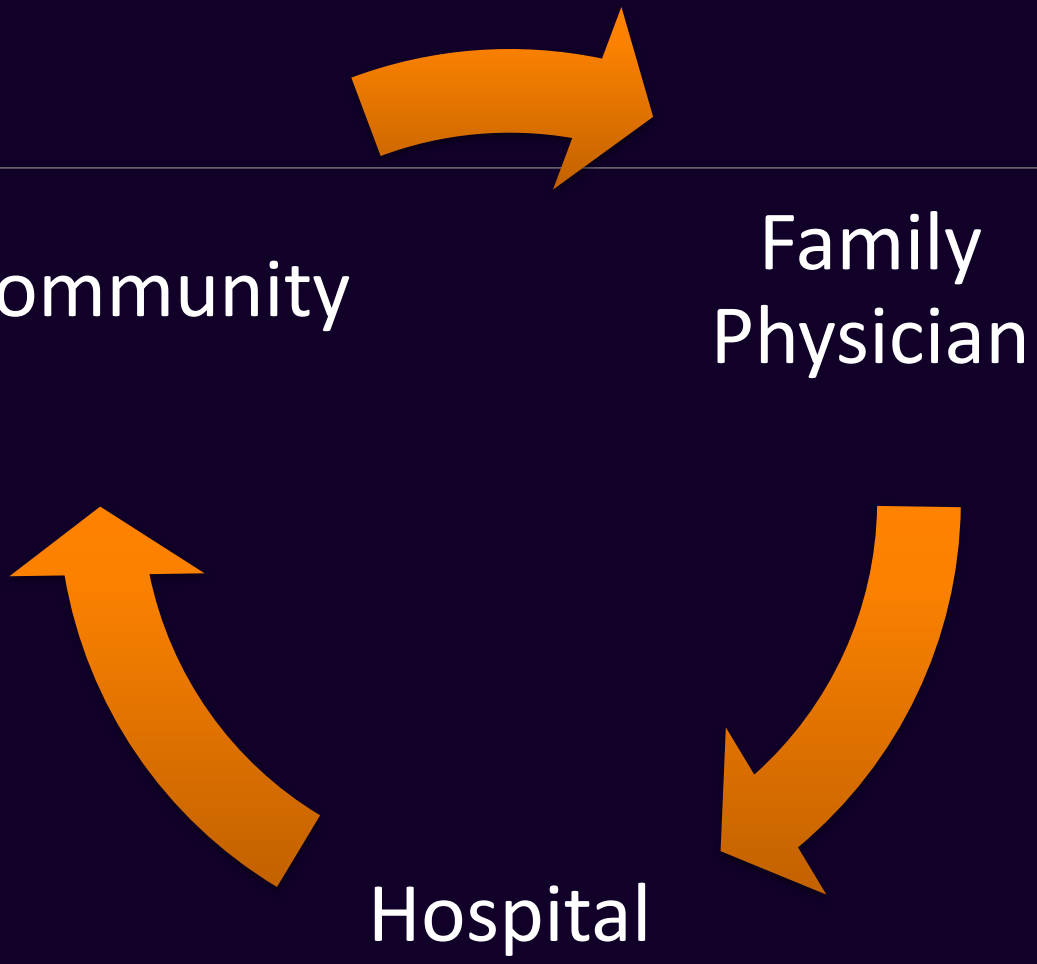
SAFE MD, Practical applications and safe psychiatric practice.
Committee of patients,safety.APA,2008

Ideation to attempt N=6646

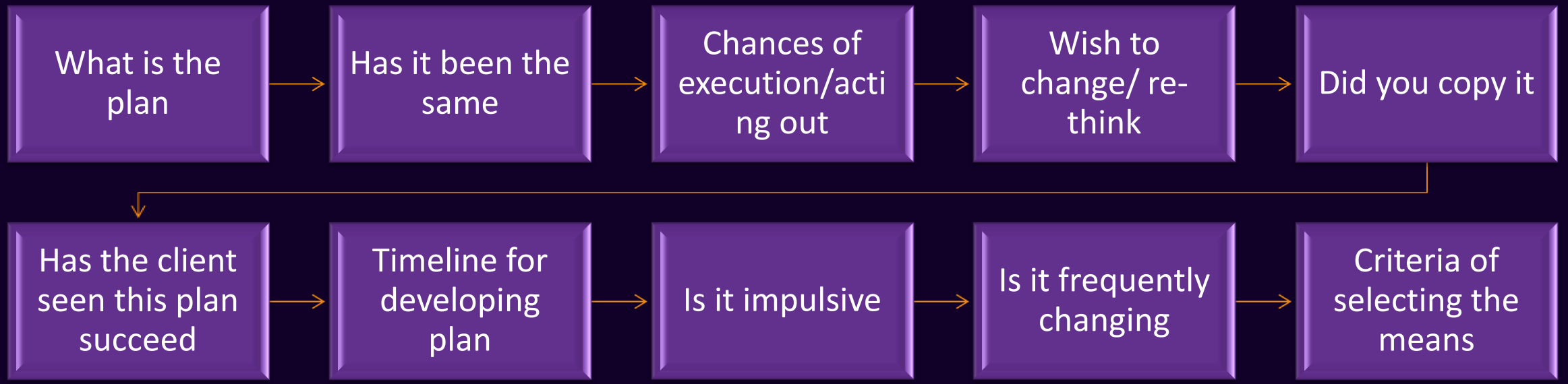


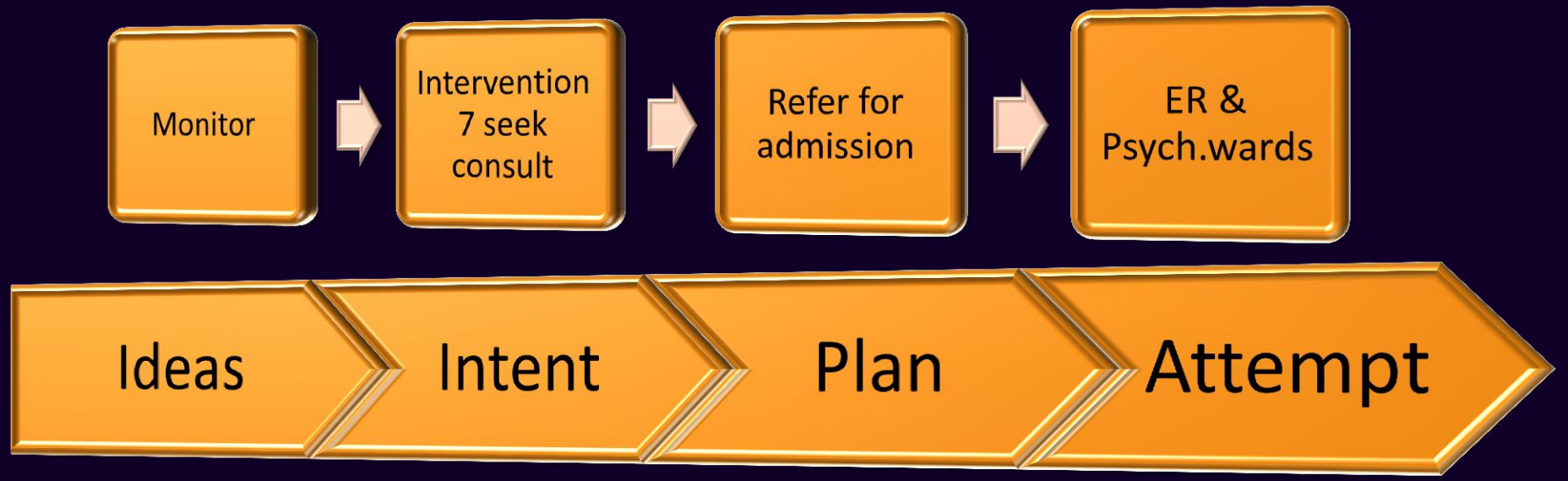


J Affect Disord. 2013 May;147(1-3):205-11. doi: 10.1016/j.jad.2012.11.005. Epub 2012 Nov 27.
Prevalence and risk factors for first onset of suicidal behaviors in the Netherlands Mental Health Survey and Incidence Study-2.
Ten Have M, van Dorsselaer S, de Graaf R


Community
Family Physician
Hospital

Assessment when patients has a Plan for suicide attempt




Monitor
Intervention 7 seek consult
Refer for admission
ER & Psych.wards
Ideas
Intent
Plan
Attempt

How do patients of suicide present?

Patients may present

Without Psychiatric symptoms

With Psychiatric symptoms

With an adverse life-situation

Anxiety, depression or abnormal behaviour

Presentation

Features of depression

Sudden change in behavior

Suicidal communication

Sudden increase in substance abuse

Withdrawn behavior

Agitation, anger and agitation

Early signs of psychosis

Frequent mood changes

Presentation

Depression

Unhappiness

Hopeless ness

Despair

Undiagnosed

low self esteem

Anxiety

Sexual identity

Physical abuse

Loss of purpose

HIV

Unwanted pregnancy

Isolation

Migration

Unemployment

Breakdown of intimate relationship

Alcohol

Illicit drugs

1. Persistent boredom, difficulty concentrating, or a decline in the quality of
2. Schoolwork
3. Frequent complaints about physical symptoms, often related to emotions, such as
4. Stomach-aches, headaches, fatigue, etc.
5. Loss of interest in pleasurable activities
6. Not tolerating praise or rewards
7. A teenager who is planning to commit suicide may also:

Common psychiatric symptom associated with suicide

Anxiety, depression, hopelessness or at-times an abnormal behavior, secluding themselves to make an attempt of suicide or even violence.

They may become mute or guarded and non-communicable.

Commonly patients suffering or harboring suicidal ideas are able to hide, despite the fact that they need to talk and discuss. In such situations they need time to connect and speak

Suicide in high risk groups

Prodromal stage

Post discharge

HIV AIDS

Geriatrics

Pregnancy

Risk factor/ antecedents

- Social determinants
- Migration
- Isolation
- Poverty
- Academic stress
- Economics and finance

Sudden desire to tidy up personal affairs

Writing a will etc.

Sudden resignation in presence of depression

Writing suicidal notes

Severe physical illness

Risk factors

Some of the symptoms may indicate presence of suicidal thoughts and such patients should be screened for high risk factors which are:

Psychiatric illness

Alcoholism

Withdrawn behavior

Anxiety or panic

Change in personality

Presence of depression Presence of depression

Change in eating of sleeping habits

Feeling of guilt or worthlessness

Feelings of hopelessness

Recent loss or severe stress e.g.death, divorce, separation etc.

How do I quantify risk?

There are several published scales which can help to quantify suicide risk, but they:

- Rely on the assumption (often false) that people will disclose suicidal ideas.
- Give little attention to social, environmental and background risk factors.

A good clinical interview should gain wider and more useful

How do I begin to ask about suicide?

It is not easy to ask about suicide ideas; it is helpful to lead into the topic gradually with due attention to the patient, and using a counseling approach.

For example:

1. do you feel unhappy and hopeless?
2. do you feel desperate?
3. do you feel unable to face each day?
4. do you feel life is a burden?
5. do you feel life is not worth living?
6. do you feel like committing suicide?

Protective Factors

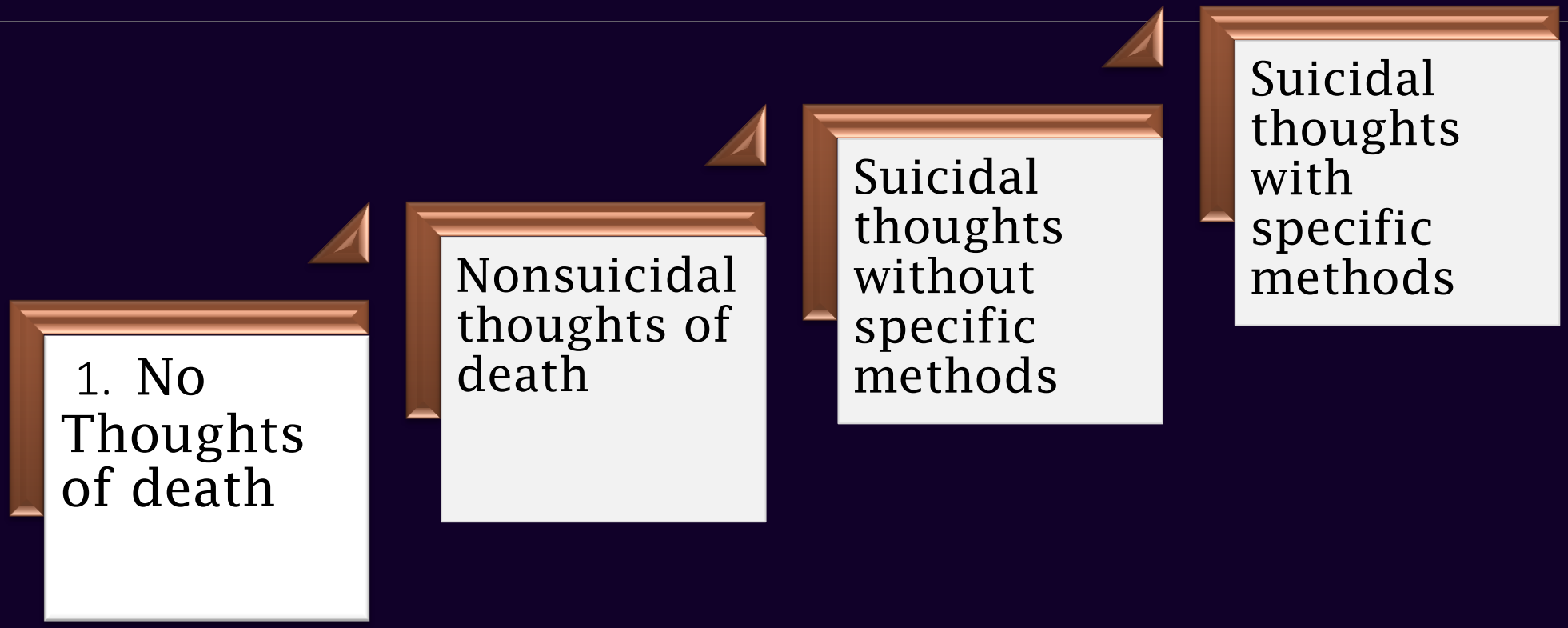
The absence of risk factors is protective. Additional protective factors are:

- Hopefulness.
- Receiving mental health care.
- Having responsibility for children.
- Having strong social supports and feeling supported.

Synthesis and formulation

Decision makinmg

Background



Arboleda-Florez J. What causes stigma?: World Psychiatry 2002;1:25–6.

Brohan E, Slade M, Clement S, Thornicroft G. Experiences of mental illness stigma, prejusdice and discrimination: a review of measures: BMC Health Serv Res 2010;10:80

Prediction and warning signs

Age older than 45 years

Living alone

Unemployment

Chronic physical diseases

Repeated suicide attempts

Hard” suicide method

Personality disorder

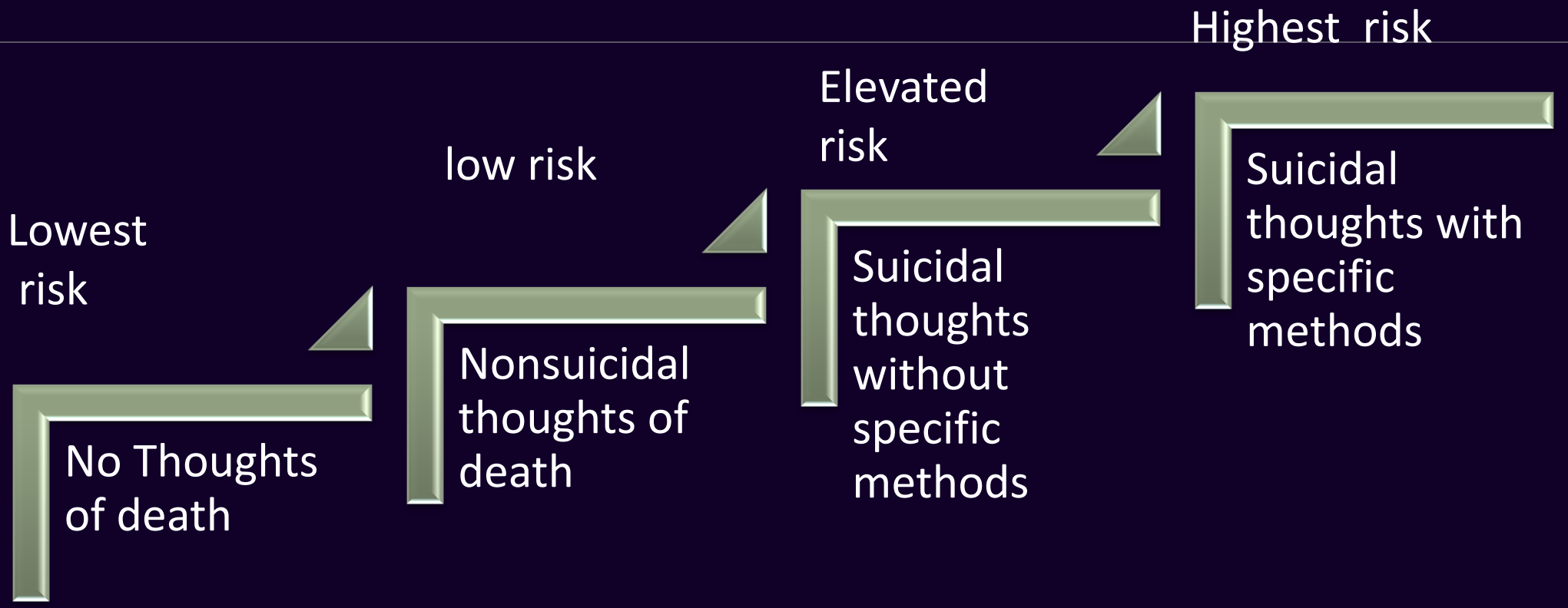
Psychiatric Axis I disorder

Powell j et al, BJP,(2000), 176, 266-272

Risk assessment

1. Identify or detect a predisposing factor
2. Elucidate potentiating factor
3. Conduct specific suicide inquiry
4. Determine the level of intervention
5. Document the assessment

Risk model and decision making



Prevention

Management

Treatment

Prevention

Prevention

1. Most prevention programs for suicidality 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

Family physicians

Question2: what is the role of primary care physician

98.5%

of doctors in community feel the need to be properly trained and oriented

Dr Amresh Shrivastava - dr.amresh@gmail.com

in suicide training in primary care specialties: a survey of training directors. Acad Psychiatry.**eficiencies** 2007 Sep-Oct;31(5):345-9.Sudak Roy ASudak , Lipschitz A Maltsberger J, Hendin H

Suicide prevention in primary care: General practitioners' views on service availability Pooja Saini[1], Kirsten Windfuhr[1*], Anna Pearson[1] Damian Da Cruz[1], Caroline Miles[2], Lis Cordingley[1], David While[1], Nicola Swinson[1], Alyson Williams[1], Jenny Shaw[1], Louis Appleby[1] and **Navneet Kapur[1]**

First contact

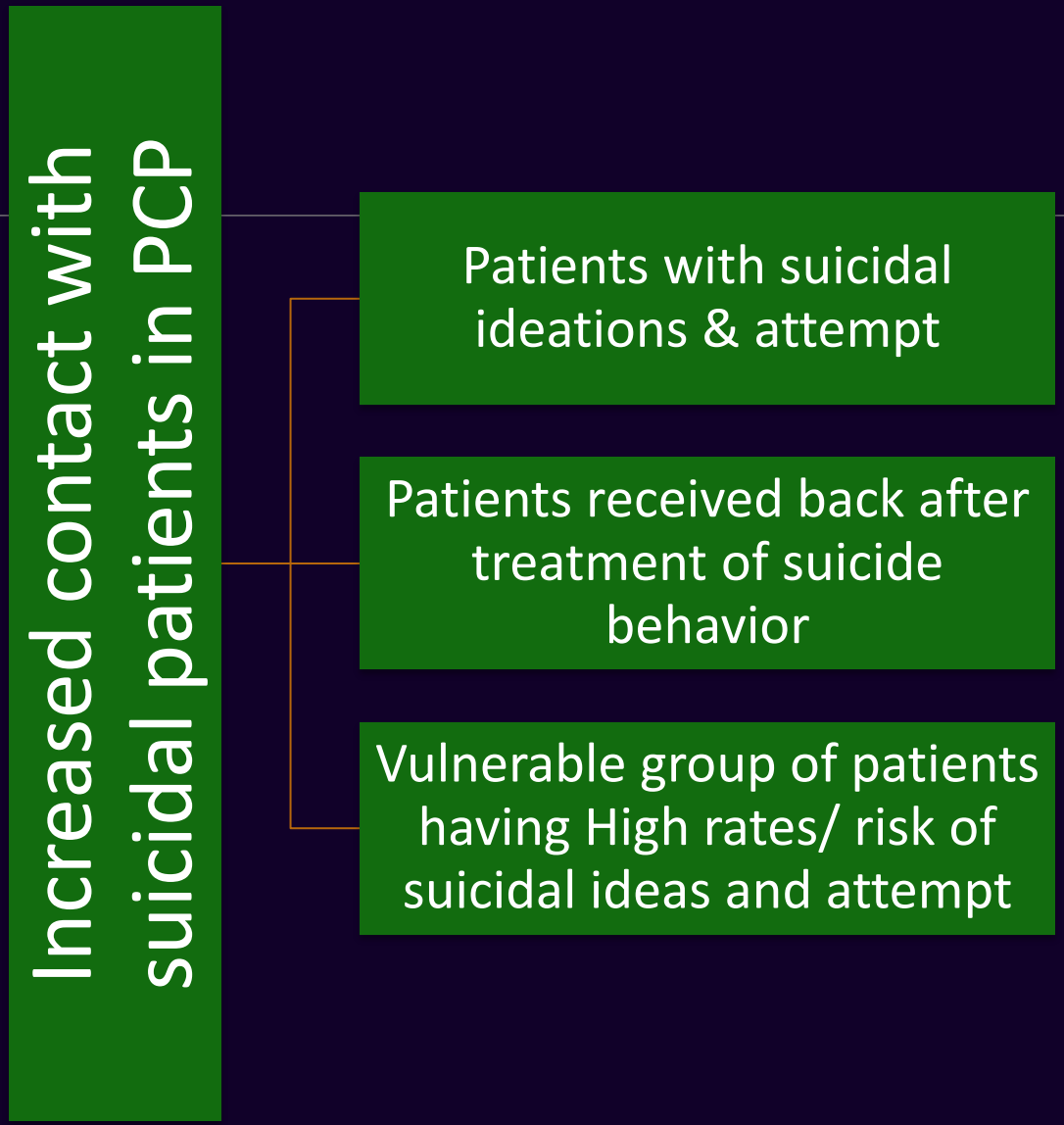
Physicians have skils and knowledge

Treatments for all

Easy access to care

Affordable care

String theraapeutic alliance


Increased contact with suicidal patients in PCP
Patients with suicidal ideations & attempt
Patients received back after treatment of suicide behavior
Vulnerable group of patients having High rates/ risk of suicidal ideas and attempt

High rates of suicide in patients seen in family practice

High rate of suicide in mental disorder	High rates of suicide and mental disorders in family practice	2 to 3 time increased risk of suicide in physical disorder in PCP	High rates of depression and suicide	High rates of suicd ein chronic physical disorder

Webb RT, Kontopantelis E, Doran T, Qin P, Creed F, Kapur N **Suicide risk in primary care patients with major physical diseases: a case-control study.** Arch Gen Psychiatry. 2012 Mar;69(3):256-64

Increased prevalence of mental disorders in primary care: 16 country WHO Study

26,422 persons aged 18 to 65 yr. 3 months follow up

Selected patients 5604

Follow up x 3 months & 12 months

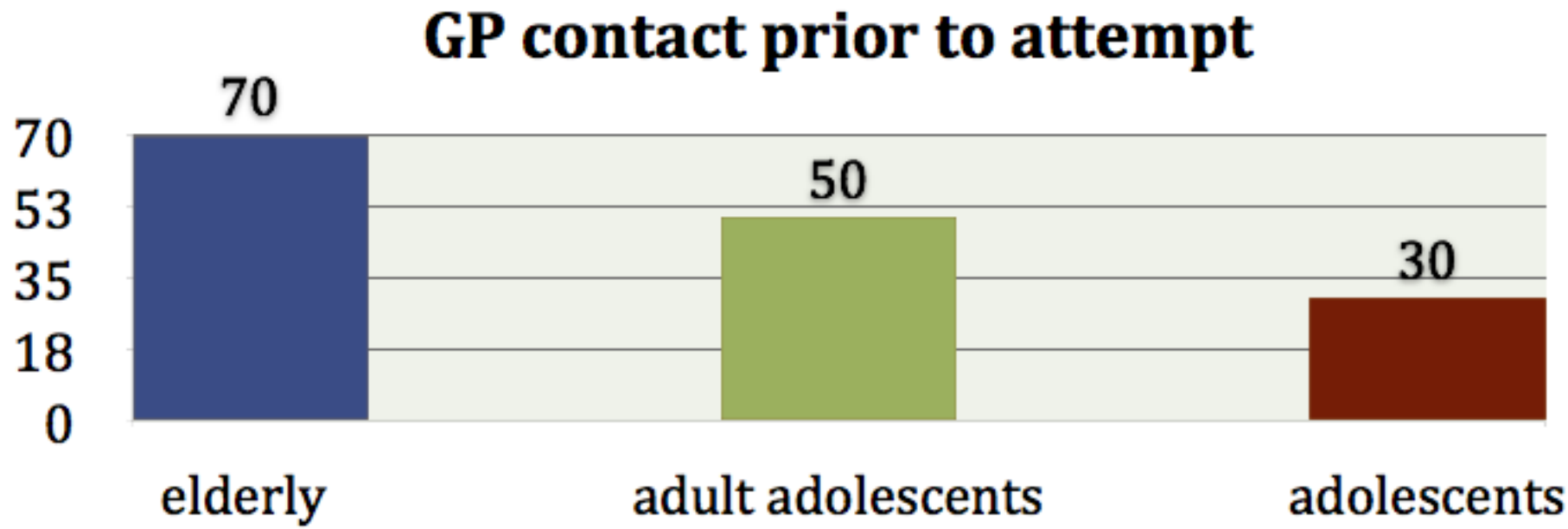
Sartorius N, Ustün TB, Costa e Silva JA Goldberg D, Lecrubier Y, Ormel J, Von Korff M, Wittchen HU
An international study of psychological problems in primary care. Preliminary report from the World Health Organization Collaborative Project on 'Psychological Problems in General Health Care'. Arch Gen Psychiatry. 1993 Oct;50(10):819-24.

Increased prevalence of mental disorders in primary care: 16 country WHO Study

1. 26,422 persons aged 18 to 65 yr. 3 months follow up
2. Selected patients 5604
3. Follow up x 3 months & 12 months
4. 40-60% patients attending primary care clinic had psychological disorder

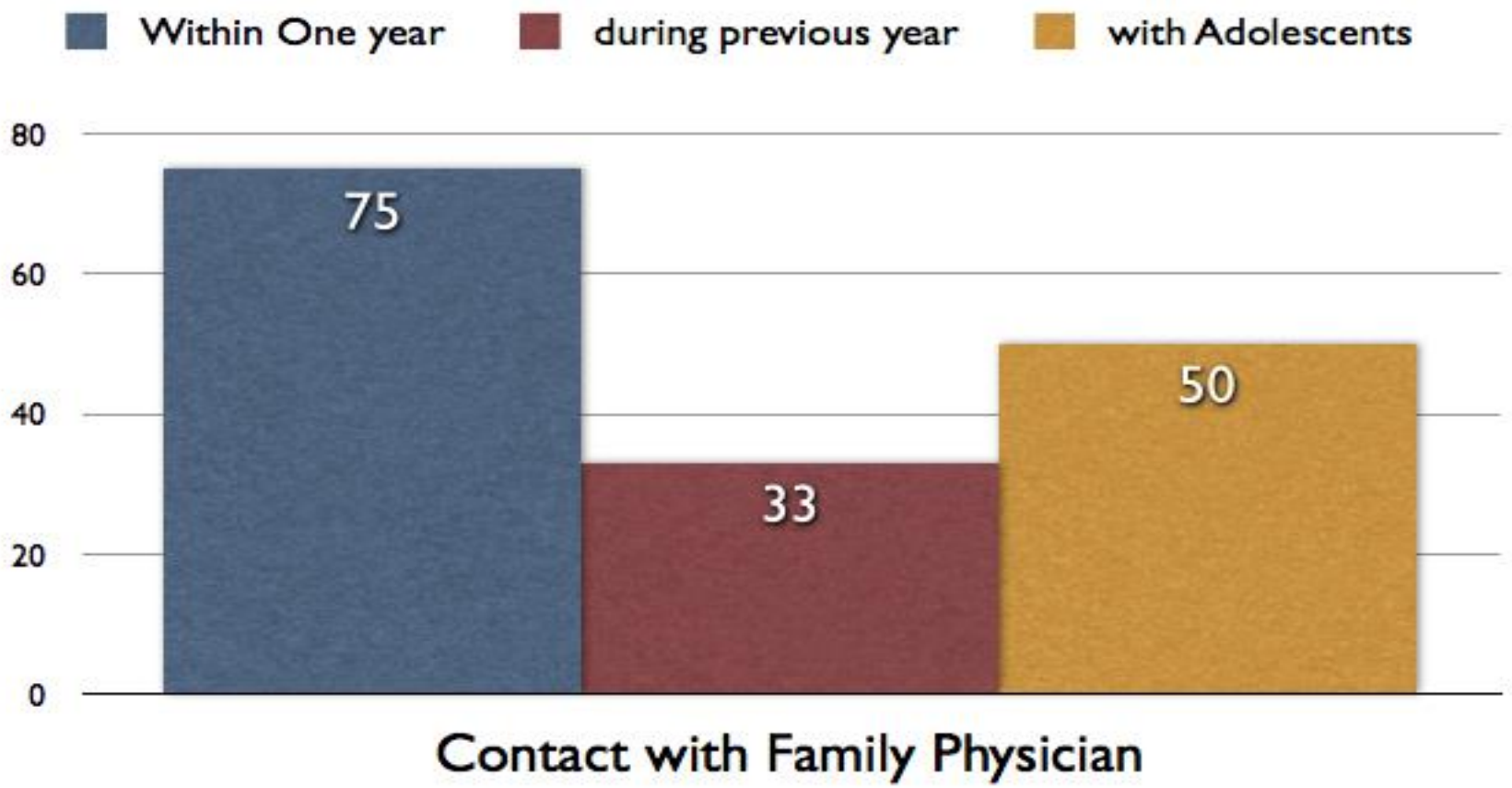
Sartorius N, Ustün TB, Costa e Silva JA Goldberg D, Lecrubier Y, Ormel J, Von Korff M, Wittchen HU
An international study of psychological problems in primary care. Preliminary report from the World Health Organization Collaborative Project on 'Psychological Problems in General Health Care'. Arch Gen Psychiatry. 1993 Oct;50(10):819-24.

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

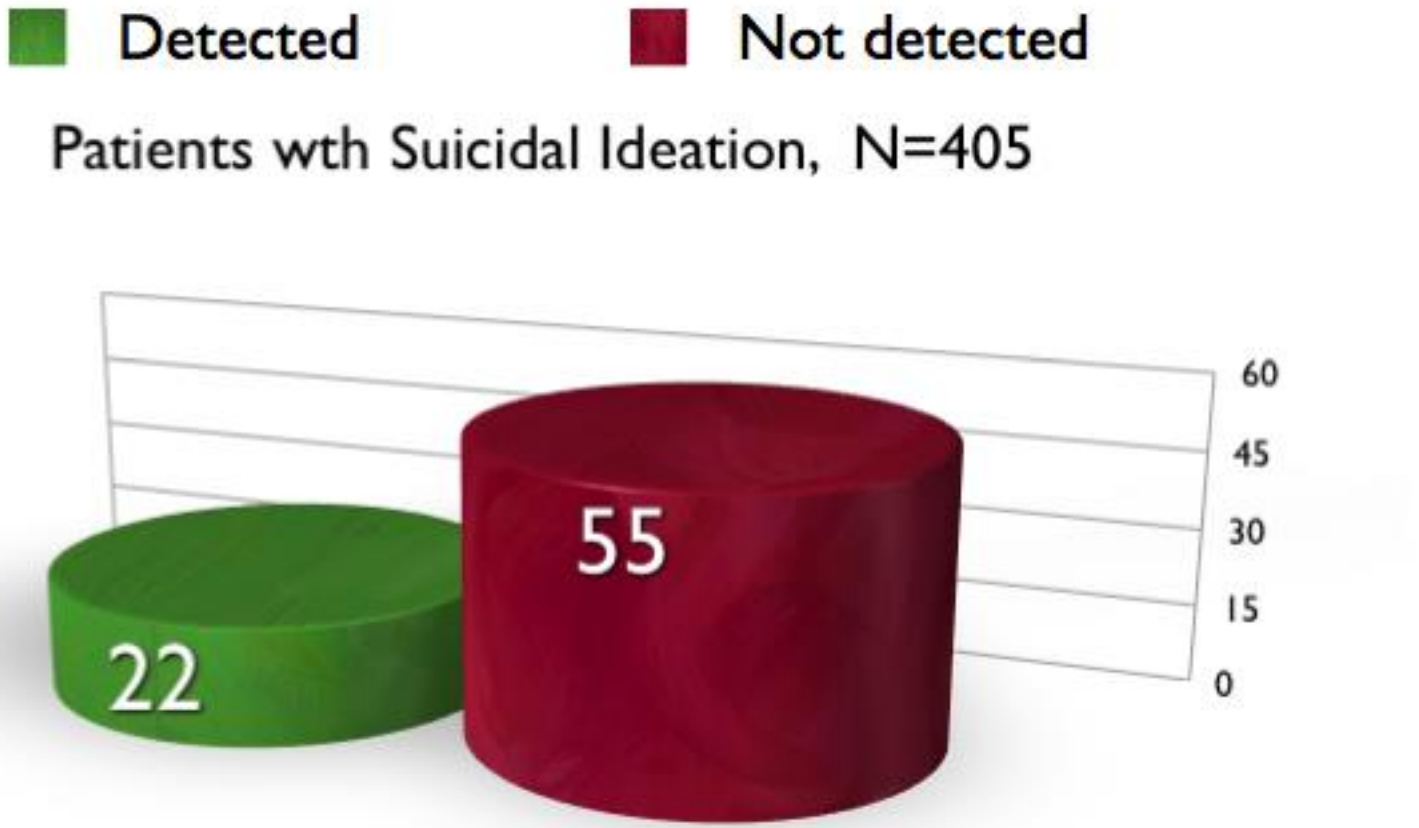


(Pfaff & Osvaldo, 2004; Luoma, et al., 2002;Vassilas & Morgan, 1994).

Contact with family physicians prior to suicide



Detection of suicide by General Practitioners



Suicide rate can be significantly reduced in primary care practice

QUESTION 3: CAN SUICIDE RATE BE REDUCED

Evidence of successful intervention

1. Identification and treatment of depression
2. Educational programs for general practitioners
3. Early intervention
4. Brief psychotherapeutic interventions are effective and feasible
5. Program based intervention
6. Involvement in public health programs

Rihmer Z, Gonda X.SourceDepartment]Pharmacological prevention of suicide in patients with major mood disorders Neurosci Biobehav Rev.2012 Sep 27. pii: S0149-7634(12)00162-5. doi: 10.1016/j.neubiorev.2012.09.009. of Clinical a

Campo JV. Youth suicide prevention: does access to care matter? Curr.Opin.Pediatr. 2009 Oct;21(5):628-634

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

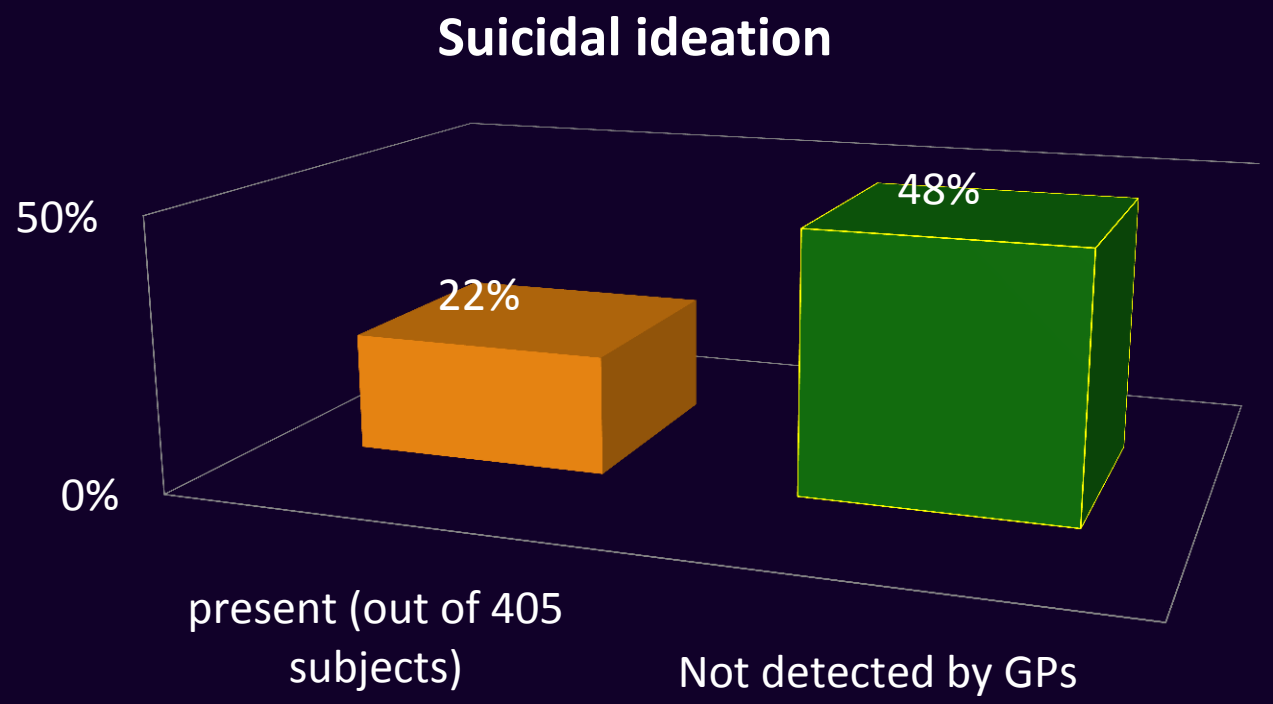
7. Administration and eveluation of programs

8. Resource development for placement of mental health professionals in family practice

9. Active involvement with advocacy groups and community agencies

10.To develop health system for delivery of care Administration and evaluation of the program

Treatment of depression effectively brings down suicide rates in primary care



1.Feldman MD, Franks P, Duberstein PR, Vannoy S, Epstein R, Kravitz RL. Let's not talk about it: suicide inquiry in primary care. Ann.Fam.Med. 2007 Sep-Oct;5(5):412-418

2.Goldberg DP, Gater R, **Sartorius N**, Ustun TB, Piccinelli M, Gureje O, Rutter C. The validity of two versions of the GHQ in the WHO study of mental illness in general **health care**. Psychol Med. 1997 Jan;27(1):191-7.

Treatment of depression effectively brings down suicide rates in primary care

1. Identification of depression and suicide can be increased
2. Outcome of treatment of depression is sustained over a period of time
3. Self-administered and clinician administered screening tools significantly improve identification
4. High incidence of resistant depression (TRD)

Rihmer Z, Dome P, Gonda X. The role of general practitioners in prevention of depression-related suicides. Neuropsychopharmacol Hung.2012 Dec;14(4):245-51.

Send to: Verger P, Brabis PA, Kovess V, Lovell ASebbah R Villani P, Paraponaris A, Rouillon F. Determinants of early identification of suicidal ideation in patients treated with antidepressants or anxiolytics in general practice: a multilevel analysis. J Affect Disord. 2007 Apr;99(1-3):253-7.

Treatment of depression reduces suicide in general Practice

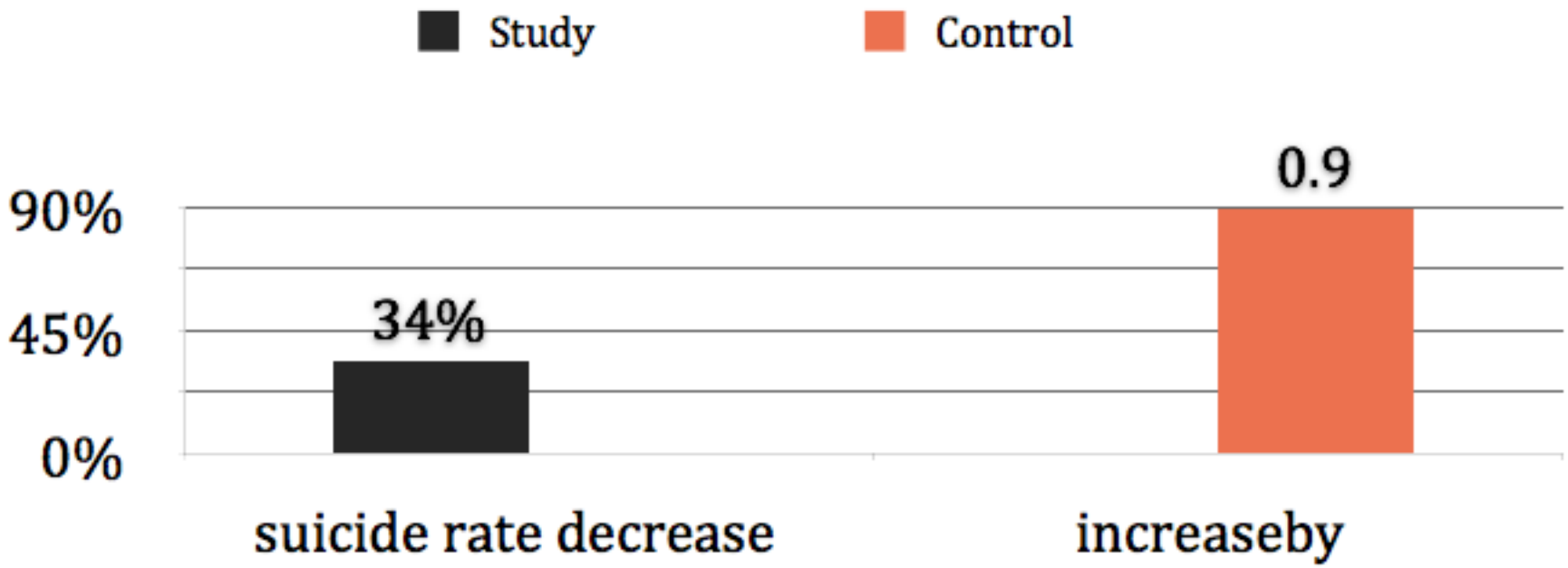
1. Five large-scale community studies
2. Combination with psycho-social interventions and public education improve the identification and treatment of depression and
3. Reduces the rate of completed and attempted suicide in the areas served by trained doctors.

Antidepressants can reduce suicidality

Verger P, Brabis PA, Kovess V, Lovell A, Sebbah R, Villani P, Paraponaris A, Rouillon F.
Determinants of early identification of suicidal ideation in patients treated with antidepressants or anxiolytics in general practice: a multilevel analysis. J Affect Disord. 2007 Apr;99(1-3):253-7.
Rihmer Z, Gonda X.
Prevention of depression-related suicides in primary care. Psychiatr Hung. 2012;27(2):72-81.

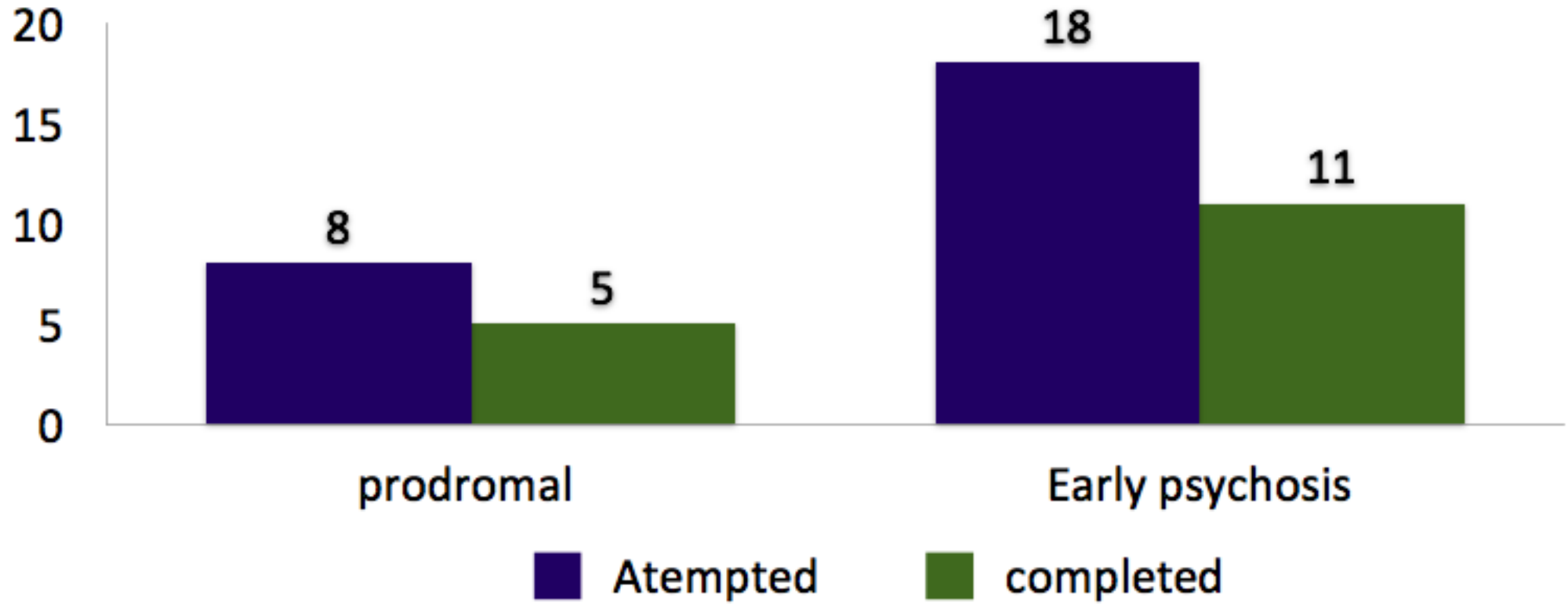
With education

Educational Intervention increases identification



Early intervention

Suicide rate in early phase of illness: Psychosis



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

Program based intervention

Suicide index reduction in Slovenia: the impact of primary care provision : Reduced Suicide index in Slovenia 1998–2008

Beškovnik L, Juričič NK, Svab V.Suicide index reduction in Slovenia: the impact of primary care provision. Ment Health Fam Med. 2011 Mar;8(1):51-5.

Challenges in managing suicide behavior in primary care

Challenges	Undetected	Untreated	Lack of resources	High stigma	unawareness
Responses	Educational and training program for identification Intervention and referral		Support from mental health system	Program involving patients and advocacy groups	

Evidence of success

1. Depression and suicide are closely related and about 17 to 20% patients are likely to attempt suicide during their life time
2. Identification and treatment of depression of depression is closely related to suicide prevention
3. Early intervention

Evidence of success

1. Educational programs for general practitioners brings down suicide rate, increases identification, intervention and referral, enhances skills and increases level of comfort
2. Brief psychotherapeutic interventions are effective and feasible
3. Their involvement in public health programs is effective and provides encouragement and empowerment

Parameters of effective intervention
evidence-based, effective interventions
New learning / training: about identification, intervention, referrals and continuity of care for prevention
Risk assessment of suicide potentials and decision making.
How to enhance skills of family physicians
Therapeutics
Developing community specific newer programs
Administration and evaluation of programs
Resource development for placement of mental health professonals in family practice
Active involvement with advocacy groups
Develop health care system for deliveray of care, administation and evaluation of the programs

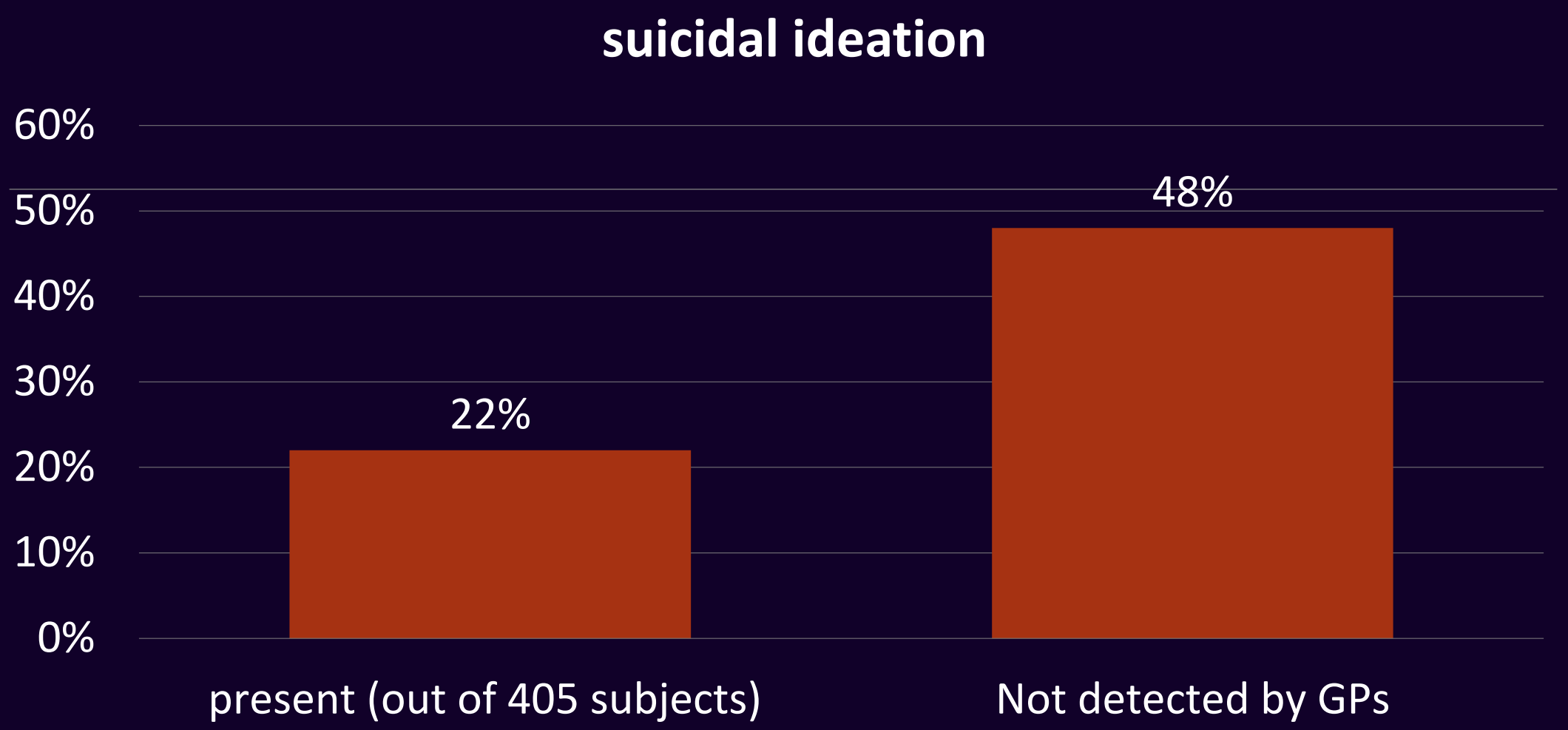
Developing suicide prevention strategy for suicide prevention in PCP

Evidence 1
Treatment of depression reduces suicide rate

Physicians ability to detect depression

Treatment of depression in family practice is elated to decrease in suicide

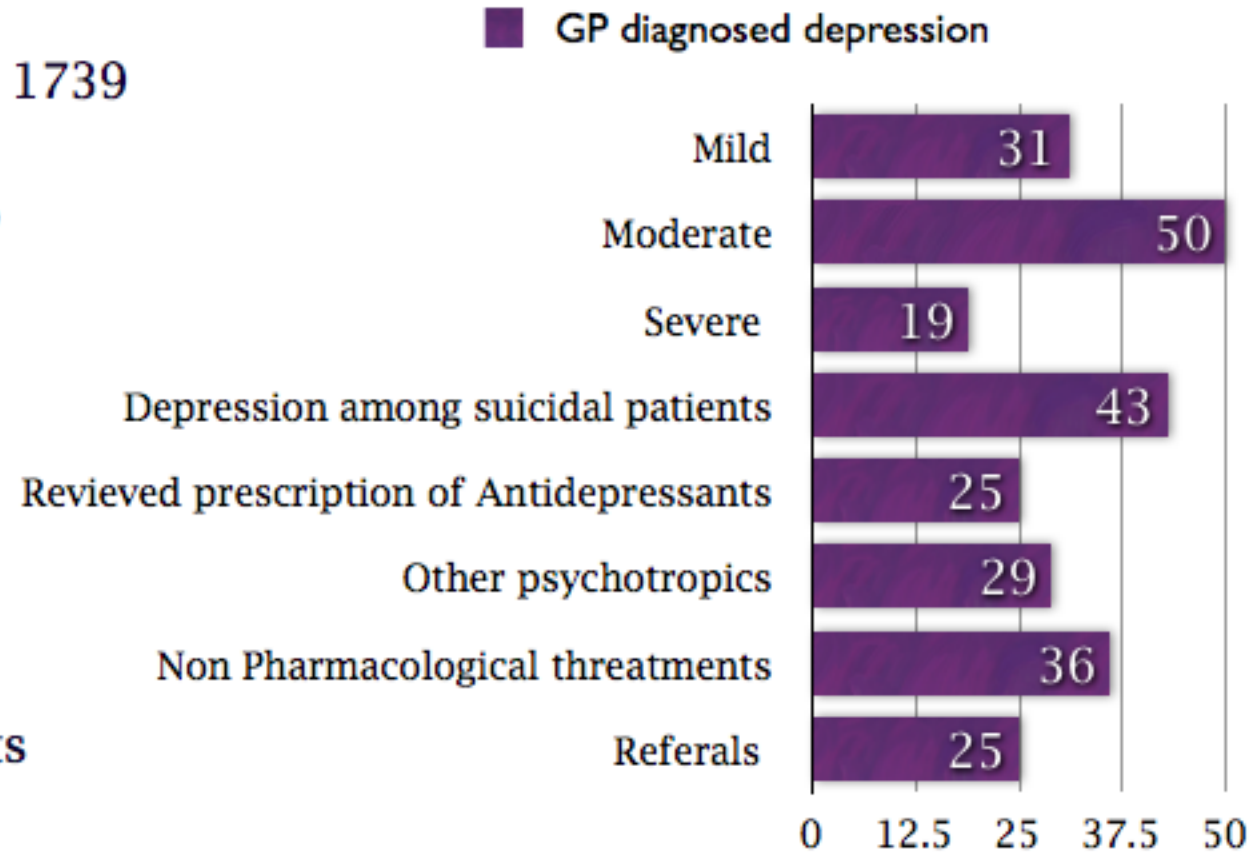
Increased compliance for management of depression


suicidal ideation
60%
50%
40%
30%
20%
10%
0%
22%
48%
present (out of 405 subjects)
Not detected by GPs

Grpah . Sui rate can be reduced by treatment of depression

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



2.Education increase identification

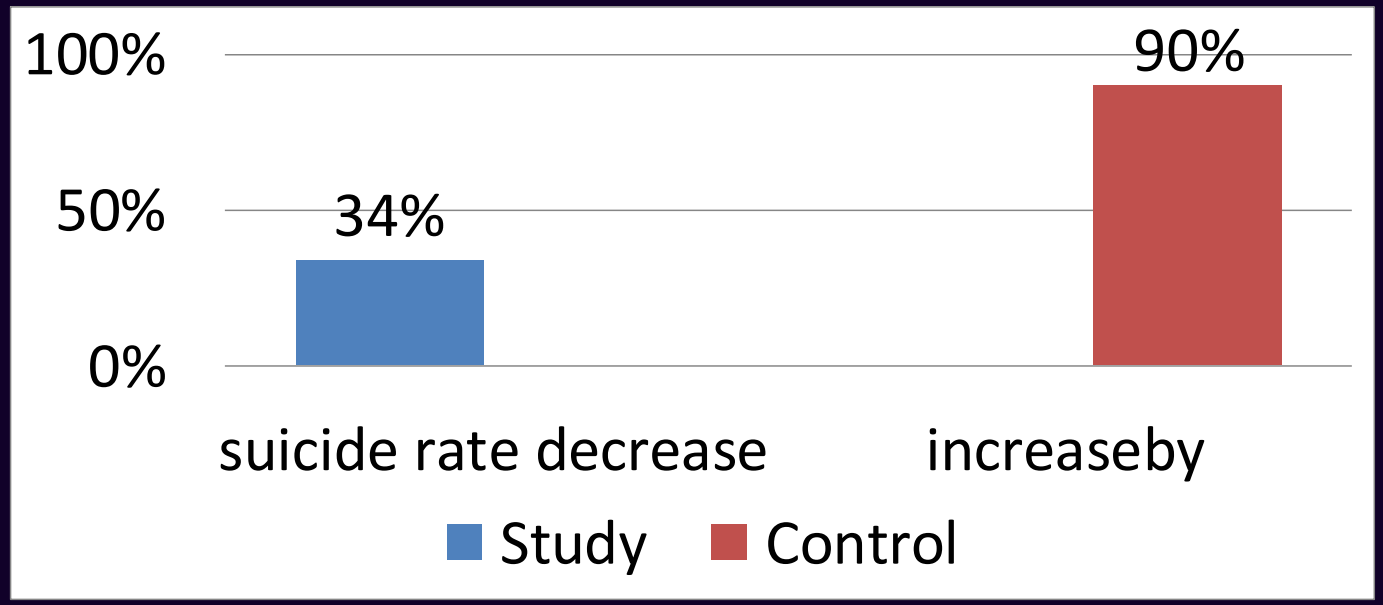
Evidence 2

Education and training: Merits

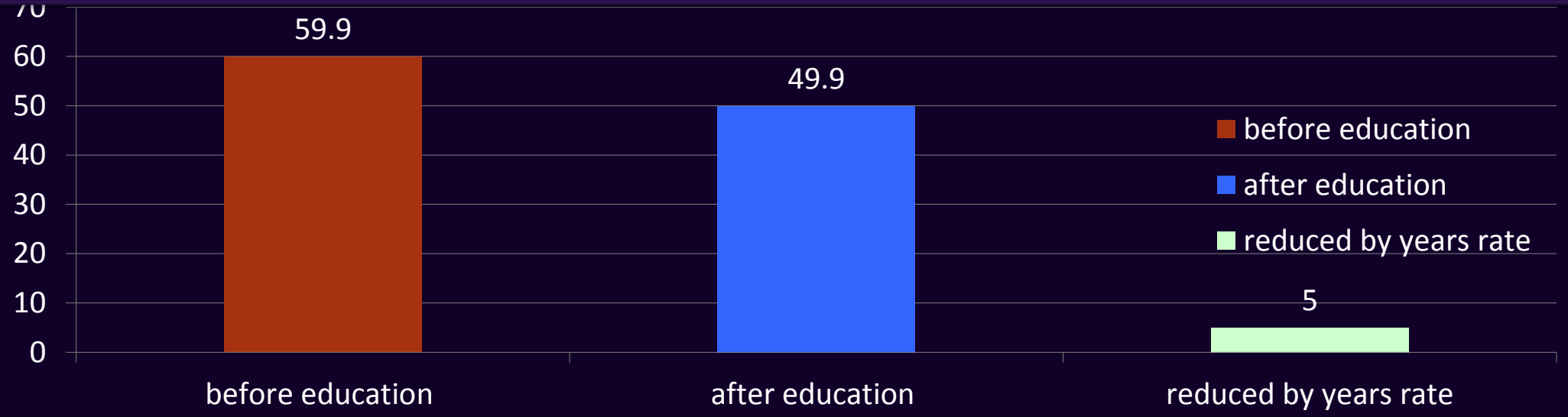
1. Increased ability for identification
2. Increased level of competency and comfort
3. Enhanced ability to provide accurate intervention and to make timely referrals
4. Role of training of trainers for community mental health workers

Evidence: Suicide rate decreased after education and training

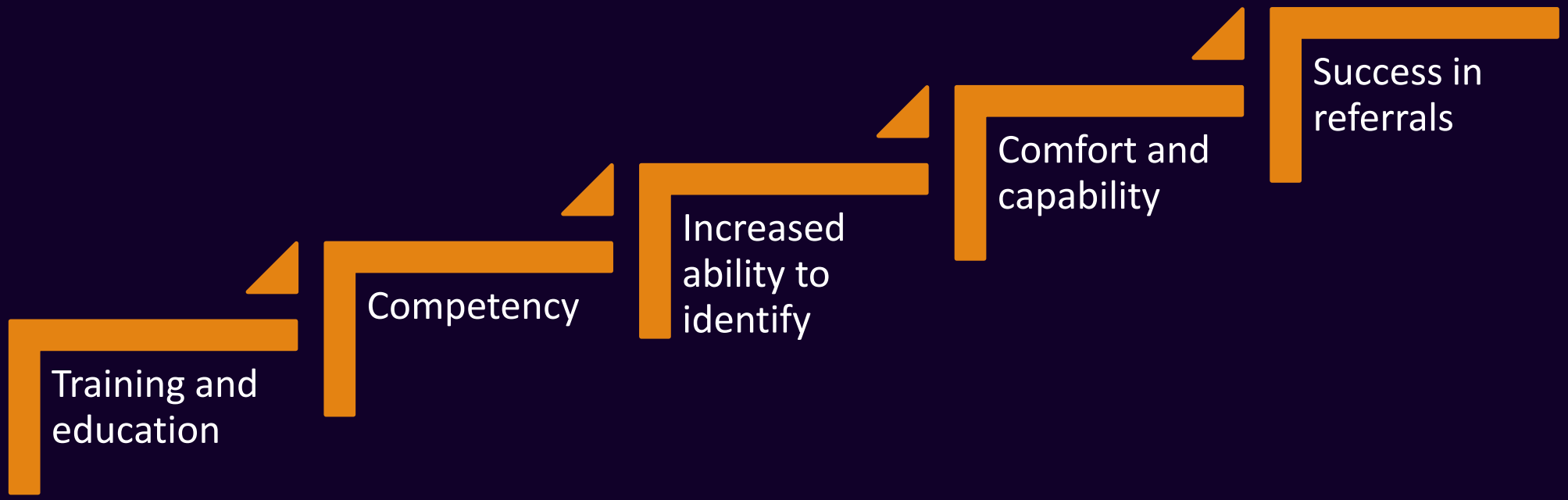
Successful intervention



Reduction in suicide rate after education

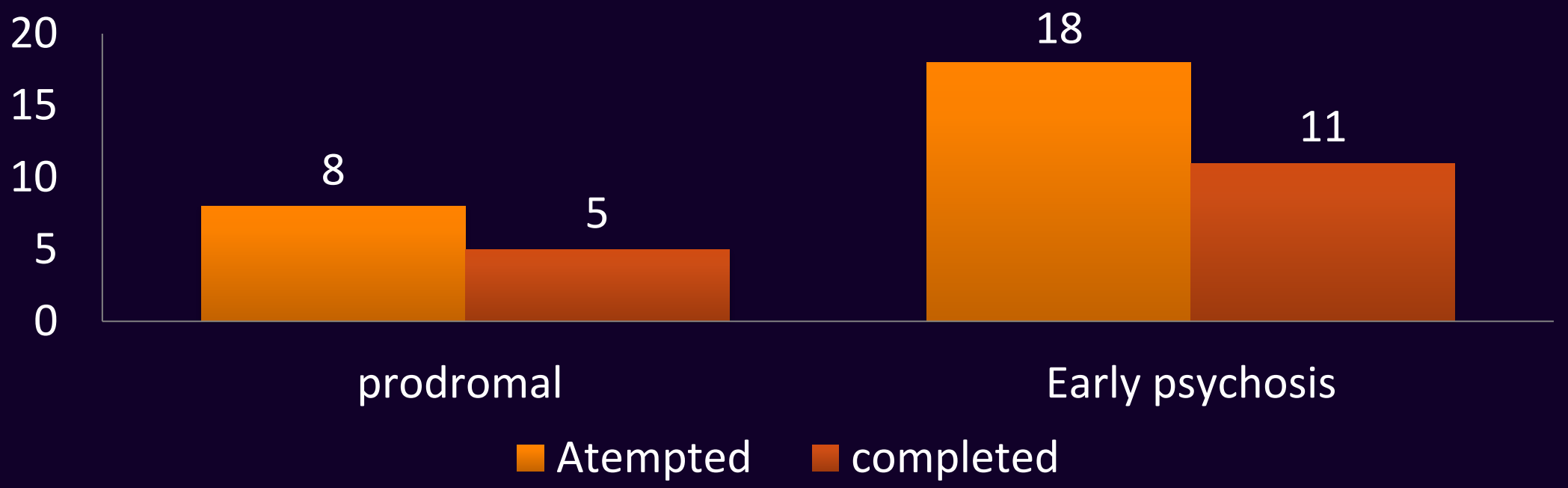


The decrease was comparable with the control region but greater than both the county and Hungary ($P < .001$ and $P < .001$, respectively).


Training and education
Competency
Increased ability to identify
Comfort and capability
Success in referrals

3.Program based intervention reduces suicide rate

Suicide rate in early phase of illness: Psychosis



About 8-11% patients in early phase of psychosis have attempted suicide.
These patients get an opportunity of prevention in such programs.

Program based intervention decreases suicide rate

	Community with EI	Community without EI
Rates of suicidal ideation & attempt	56%	39%
Previous attempt	16%	5%
Decrease in Rates after first clinical contact	Similar	Similar
SUD	High	Low
Suicidal behaviors	Low	High

4.Efficacy of empowerment

5.Brief psychotherapeutic programs

6.Involvement in national programs

Community innitiatives

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

Curriculum development: key topics to be covered

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

Curriculum development

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 cased based learning and
    3. one hour Q and 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

Conclusion

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 mubmer of means, most notably being treatment of depression
4. Education and training of family physician is the most effetive 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

Are the goals achievable?

Requirements for response to these challenges

1. education and training for identification and intervention
2. mental health support by innovative , need based programs.
3. administrative initiatives
4. treatment in clinics is itself an anti-stigma intervention
5. dialogue with family member

Depression and suicide in adolescents in primary care

Incidence of depression > 50%	Incidence of suicidal ideation > 30%	Incidence of depression in Physical illness seen in practice >20%	Detection rate : approximately 30%
Substance abuse with depression approximately 20%	Screening for depression and suicide in clinics	Development of community care programs	Antidepressant drugs may treat primary and comorbid depression and anxiety

Depression among youth: Primary care models for delivering mental health services

1. Outreach programs for those who do not attend the clinics
2. Mode accurate strategy for detection of depression
3. Developing newer interventions
4. Facilitating increased access to care
5. Strategies for increasing compliance
6. Collaborative model for care involving family physicians

Education-curriculum

curriculum	course	Screening
skill development		

Skill development

Education and training for primary care physicians

QUESTION4: WHAT EDUCATIONAL PROGRAM CAN BE UTILIZED

Course development

Review of literature

Development of curriculum

Peer review of curriculum

Methodology of conducting the training

Evaluation

Re-construction of curriculum based upon evaluation and feedback

Curriculum development: key topics to be covered

1. Clinical features
2. Psychopathology
3. Psychiatric disorders, environmental and development factors, violence abuse, trauma, substance abuse
4. Identification, risk assessment
6. Formulation and decision making

Curriculum development: key topics to be covered

7. Screening and structured interview, measurement tools
8. Intervention, medications
9. CBT
10. Monitoring
11. Long term management
12. Postvention
13. Care in community and network
14. Planning public health program

Conclusion

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 mubmer 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

1. Complain of being a bad person or feeling rotten inside
2. Give verbal hints with statements such as: I won't be a problem for you much
3. Longer, nothing matters, it's no use, and I won't see you again
4. Put his or her affairs in order, for example, give away favorite possessions, clean
5. His or her room, throw away important belongings, etc.
6. Become suddenly cheerful after a period of depression
7. Have signs of psychosis (hallucinations or bizarre thoughts)

Full day training following by half day repeat session)

First two session (full day)every 6 months

Didactic teaching	3 hours
Workshop	2 hours
FAQ and Q & A:	1 hours
Total	6 hours

Every year 6 months for 4 hours (half day)

Didactic lecture :	1 and half hours
Workshop	1 and half hours
Q and A	one hour
Total	4 hours

Principles of course development

Two options

1. As part of generalized mental health training

2. As a specific – ‘suicide prevention training’

Necessary merits:

Effective

comprehensive

Easy to administer

Physician –centric

Culture specific

Adequate contents

Curriculum development: key topics to be covered

1. Clinical features and Psychopathology
2. Risk factors, Identification, and risk assessment
3. decision making, intervention and referrals, Monitoring
4. Management: Crisis intervention, brief counselling, CBT
5. pharmacological treatment
6. Screening and structured interview, measurement tools
7. Long term management
8. Postvention
9. Care in community and network
10. Planning public health program

SIS MAP

Suicide risk Assessment scale developed and validated by us in Regional Mental Health Care

This scale is used for facilitating decision making for management

(Shrivastava A & Nelson Charles: SIS-MAP-24SR)

Scale for Impact of Suicidality - Management, Assessment and Planning of Care (SIS-MAP-24SR)
Brief Screener: Self-Report

NAME: _____

Shrivastava, A , Nelson, C.. (2013)

DATE: _____

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1. Are you an inpatient?	No ☐	Yes ☐
2. Do you think you would be better off dead?	No ☐	Yes ☐
3. Do you feel you are vulnerable to hurting yourself?	No ☐	Yes ☐
4. Do you often hurt yourself by cutting or overdose of pills?	No ☐	Yes ☐
5. When you have thoughts about hurting yourself or about death, can you control these thoughts?	Yes ☐	No ☐
6. Do you wish to die?	No ☐	Yes ☐
7. Do you fear losing control and attempting suicide?	No ☐	Yes ☐
8. Do you currently feel suicidal?	No ☐	Yes ☐
9. Do you feel helpless?	No ☐	Yes ☐
10. Have you attempted to kill yourself?	No ☐	Yes ☐
11. Do you think you will attempt suicide in the future?	No ☐	Yes ☐

11. Do you think you will attempt suicide in the future? No ☐ Yes ☐

12. Does drinking or drug use currently cause you any personal, legal, or work related problems? No ☐ Yes ☐

13. In the past, have you had problems with drug use or have you ever been addicted to drugs? No ☐ Yes ☐

14. In the past, has someone tried to touch you in a sexual way or tried to make you touch them without your consent? No ☐ Yes ☐

15. Have any of your family members (including siblings, parents, or grandparents) ever suffered from a mental illness? No ☐ Yes ☐

16. Is your family practically supportive of your problems and your recovery? No ☐ Yes ☐

17. Do you savour life's satisfying moments? No ☐ Yes ☐

18. Do people you know find that you are difficult to get along with, or have you experienced major problems in your relationships? No ☐ Yes ☐

19. Have there been times when you heard or saw things that other people couldn't? No ☐ Yes ☐

20. Have there been times when you believed that other people were deliberately trying to harm you or your interests? No ☐ Yes ☐

21. Do you feel like the atmosphere in your home is usually calm and organized? Yes ☐ No ☐

22. Do you ever feel like there is no meaning or purpose to your life? No ☐ Yes ☐

23. Do you find it difficult to maintain close relationships with friends and family No ☐ Yes ☐

(Shrivastava A & Nelson Charles: SIS-MAP-24SR)

24. Do you find it difficult to know where to find help or have problems assessing health care services? No ☐ Yes ☐

Scale for Impact of Suicidality - Management, Assessment and Planning of Care (SIS-MAP-scn) Brief Interview Screener

NAME: _____

Shrivastava, A. Johnston, M.,& Nelson, C (2013) **DATE:** _____

Demographics	*Item Scores (right column = 1)*	
	0	***1***
Inpatient	No ☐	Yes ☐
Psychological Domain		
Do you think you would be better off dead?	No ☐	Yes ☐
Do you feel you are vulnerable to hurting yourself?	No ☐	Yes ☐
Do you often hurt yourself by cutting or overdose of pills?	No ☐	Yes ☐
Can you control these (ideation) thoughts?	Yes ☐	No ☐
Do you wish to die?	No ☐	Yes ☐
Do you fear losing control and attempting suicide?	No ☐	Yes ☐
Do you currently feel suicidal?	No ☐	Yes ☐

Have you attempted to kill yourself? No ☐ Yes ☐
Do you think you will attempt suicide in the future? No ☐ Yes ☐

Comorbidities

Current alcohol abuse or dependence No ☐ Yes ☐
History of drug abuse No ☐ Yes ☐
History of sexual abuse No ☐ Yes ☐

Family History (including siblings, parents, or grandparents)

Family history of mental illness No ☐ Yes ☐

Protective factors for suicide risk

Is your family practically supportive of your problems and your recovery? No ☐ Yes ☐
Do you savour life's satisfying moments? No ☐ Yes ☐

Clinical ratings/observations

Is there evidence of a personality disorder or issues related to personality? No ☐ Yes ☐
Is there presence of psychosis? No ☐ Yes ☐
Would you consider client vulnerable due to a dysfunctional/chaotic home environment? No ☐ Yes ☐
Would you consider client vulnerable due to existential issues (i.e. no meaning in life)? No ☐ Yes ☐

Psychosocial and Environmental Problems

Problems with primary support group No ☐ Yes ☐
Problems with access to health care services No ☐ Yes ☐

(Shrivastava A & Nelson Charles: SIS-MAP-24SR)

Total of all above sections EXCEPT protective factors: _____
Protective Factors: (subtract): - _____
SIS-MAP Risk Index: _____

SIS-MAP
Clinical Cut-Offs for Level of Care Needed

Scores ≤ 12 = outpatient follow-up highly recommended

Scores 13 - 17 = consider psychosis, previous suicide attempts, and protective factors

Scores ≥ 18 = admit highly recommended

5 most frequent responses seen on assessment by the scale

Conclusion

There is a strong need for training and education of primary care physicians to enhance there skills for identification and intervention

There is strong evidence that this method is effective for prevention of suicide

It is afeasible and economical method for prevention.

A basic and effective curriculum can be used for carrying out the training

Further, there is huge scope of mordrnalizing and use modern technology to reach where generally face-to-face training is not possible

The trained physicians can also function as faculty for traininng of the training