Suicide prevention: Education and training for mental health professional

Amresh Srivastava

Available at: https://works.bepress.com/amreshsrivastava/152/
Management of suicide behavior in primary care

A PTCAP project
MENTAL HEALTH
RESOURCE FOUNDATION
Training and Education for Suicide Prevention
mhrf.ca
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SUICIDE PREVENTION
EDUCATION AND TRAINING FOR
HEALTH PROFESSIONALS IN PRIMARY CARE
Learning Objectives

- Overview of problem
- Discuss suicide as an everyday clinical problem
- Understand challenges in management and prevention of suicide
- Discuss evidence of successful intervention and prevention
- Explore the role of family physicians in suicide prevention
- Discuss significance of Education and Training for human resource development
20 MILLION Attempts
1 MILLION committed
873 thousand Deaths
1 death every forty seconds
One death every forty seconds.

90,000 suicide in adolescents.
Suicide prevention is everybody’s business
Challenges in management of suicide behavior

- Funding and manpower resources
- Poor access to care
- Stigma
- Unawareness
Suicide prevention is a life-saving measure
1. Poor identification
2. Lack of intervention
3. Lack of services
4. Poor public health measures for prevention

- **Patients & families**
  - Stigma
  - Unawareness

- **Professionals**
  - Training and education
  - Motivation & Involvement

- **Health systems**
  - Poor mental health support
  - Lack of funding, investment & priority
What are the problems in management of suicide behavior in family practice?

- Lack of training and skill development
- Poor resources and support
- Low identification
- Lack of intervention
effective, feasible and economic
carry forward training for health and non-health professionals
• 8 hours online course by experts

• Enhanced competence and confidence

• Health workers in cities, villages and slums can be trained in local languages
Suicide Prevention is everybody’s business

A commitment for social change
We believe that training and education for skill development can increase identification and intervention
Suicide prevention is everybody’s business
Challenges for management of suicide prevention in family practice
98.5% of doctors in community feel the need to be properly trained and oriented.
Training of physicians and counsellors can identify people who are suffering and successfully treat them.
Response to challenges of suicide prevention in family practice

1. Requirements for response to these challenges
2. Education & training
3. Mental health support
4. New and innovative experiments in Clinical practice
5. Health system development
6. Anti-stigma measures
Managing patients with suicide behavior in family practice: Challenges, responsibility and opportunities

family physicians are in best position to offer care for suicide behavior
Treatment by family physicians is effective & benefit of treatment is sustained
Advantages of family physicians

- Family practice offers easy access to care
- Physicians are the first contact for suicidal patients
- High rates of suicidal ideation, attempt and repeated attempt
- Physicians enjoy a good rapport with families
- Patients are more amenable to suggestion
- Care by family physicians has less stigma than treatment in psychiatric hospitals
- Physicians can monitor compliance, follow-up closely and manage underlying physical and mental disorders
Education and training for primary care physicians
Course is divided into 6 chapters

1. Chapter 1: Current understanding
2. Chapter 2: Working with family physicians
3. Chapter 3: Clinical psychiatry of suicide behavior
4. Chapter 4: Prevention of suicide in family practice
5. Chapter 5: Case-based learning
6. Chapter 6: Q & A – and - Self assessment
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
Contents of the Proposed Curriculum

1. Clinical features and presentations
2. Clinical examination, risk assessment and Decision making
3. Intervention in the clinic
   1) intervention in hospitals or specialists clinic
   2) Medications and monitoring
   3) CBT
   4) Outcome measurement, monitoring progress
   5) Treatment resistance
Curriculum: contents

4. Prevention
   1) Screening tools
   2) Prevention of first attempt
   3) Prevention of future attempt
   4) Long term management and compliance
   5) Family interaction and postvention
   6) Dealing with legality in suicide prevention
   7) Developing suicide prevention strategies
Design

1. On an average each section (1 to 12) will be of 500 words.
2. Total curriculum will be of 6000 to 10,000 words
3. Divided into 4 sessions / lectures, each covering 3 topics
4. Workshops and case based learning 4 cases for 30 minutes each either together with each section or in separate session.
5. Case-based learning will be focussed on identification, assessment and intervention
4. Q&A for one hour
5. 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 and A
## Schedule

<table>
<thead>
<tr>
<th>Contents</th>
<th>Half day course (4 hours)</th>
<th>Full day course (8 hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>clinical features &amp; presentations</td>
<td>30 min</td>
<td>60</td>
</tr>
<tr>
<td>Assessment &amp; decision making</td>
<td>30 min</td>
<td>60</td>
</tr>
<tr>
<td>Management Intervention</td>
<td>30 min</td>
<td>60</td>
</tr>
<tr>
<td>Prevention</td>
<td>30 min</td>
<td>60</td>
</tr>
<tr>
<td>Workshop-case based learning-1</td>
<td>30 min</td>
<td>60</td>
</tr>
<tr>
<td>Workshop-case based learning-2</td>
<td>30 min</td>
<td>60</td>
</tr>
<tr>
<td>Q &amp; A</td>
<td>30 min</td>
<td>60</td>
</tr>
<tr>
<td>Self-assessment</td>
<td></td>
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<tr>
<td><strong>Total time</strong></td>
<td><strong>210 min (approx. 3 &amp; 1/5 hours)</strong></td>
<td><strong>7 hours</strong></td>
</tr>
</tbody>
</table>
Design

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
Pre and post course evaluation using a structures format for assessment of knowledge, competency and capability
Recommendation (what should be done to promote the specialty?)

- Increased curriculum in medical education
- Training across all specialty
- Interdisciplinary collaborations for suicide prevention
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
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
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 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
Follow the following sections
Suicide behavior: Perspectives for intervention by Family physicians

Amresh Shrivastava
MBBS, MD, MRCPsych. FRCPC
Chapter 1: Current understanding
TRAINING
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.

Chapter 1. content and design of the course
Challenges for management of suicide prevention in family practice
Suicide prevention is everybody’s business
Section 1
background
Clinical features
Presentation
FROM PTCAP.
## Adolescent suicide

### Clinical features

#### Suicidal adolescents: Key differences from Adults

<table>
<thead>
<tr>
<th>Category</th>
<th>Differences from suicidal adults</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risk factors</strong></td>
<td>higher proportion</td>
</tr>
<tr>
<td></td>
<td>attempts are more common</td>
</tr>
<tr>
<td></td>
<td>ideation is more common</td>
</tr>
<tr>
<td></td>
<td>Increased risk in disruptive behaviour disorder</td>
</tr>
<tr>
<td><strong>Diagnostic differences</strong></td>
<td>Psychotic disorder is much less common</td>
</tr>
<tr>
<td><strong>Symptoms</strong></td>
<td>more common suicidal ideas are commonly denied</td>
</tr>
<tr>
<td></td>
<td>lethality of means is more commonly misjudged</td>
</tr>
</tbody>
</table>
# Adolescents suicide

<table>
<thead>
<tr>
<th>third leading cause of death</th>
<th>1500 / year in USA</th>
<th>6.87/100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>early adolescent suicide (10-14)</td>
<td>much less common</td>
<td>0.89/100,000</td>
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</tbody>
</table>

**Principles**
- Basic principles for assessment and intervention are almost same in adolescents and adults
- Some differences exist in psychopathology and management

**Clinical features**
### Risk factors

<table>
<thead>
<tr>
<th>Demographic factors</th>
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</thead>
<tbody>
<tr>
<td>Increased risk age &gt;14 years</td>
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<tr>
<td>Male, White, Unwed, unwanted pregnancy</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Family factors</th>
<th></th>
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<tr>
<td>Family history of suicidal behavior</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Abuse (Physical &amp; Sexual)</th>
<th></th>
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<tbody>
<tr>
<td>Parental psychopathology</td>
<td></td>
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</table>

<table>
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<tr>
<th>Violence</th>
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<tbody>
<tr>
<td>Fire arms at home</td>
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</table>

<table>
<thead>
<tr>
<th>recent stressors</th>
<th></th>
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<tr>
<td>Interpersonal loss &amp; legal problems</td>
<td></td>
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</tbody>
</table>
## Adolescent suicide

### Clinical features

<table>
<thead>
<tr>
<th>Leading risk factors</th>
<th>Individual factors</th>
<th>Psycjopathology</th>
<th>Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Explicit suicidality</td>
<td>Stated intent</td>
<td>Diagnosis</td>
</tr>
<tr>
<td></td>
<td>Stated intent</td>
<td>High intent</td>
<td>major depression</td>
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<tr>
<td></td>
<td>with or without plan</td>
<td>high lethality of methods</td>
<td>Bipolar disorder</td>
</tr>
</tbody>
</table>

- **Individual factors**
  - Explicit suicidality
  - Stated intent
  - with or without plan

- **Psycjopathology**
  - Previous suicide attempt
  - Diagnosis
  - Co-morbid substance abuse
  - Conduct or personality disorder

- **Symptoms**
  - Hopelessness and helplessness
  - Conflict over same-sex or bisexual orientation
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%
### Depression and suicide in adolescents in primary care

<table>
<thead>
<tr>
<th>Substance abuse with depression approximately 20%</th>
<th>Screening for depression and suicide in clinics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Development of community care programs</td>
<td>Antidepressant drugs may treat primary and comorbid depression and anxiety</td>
</tr>
</tbody>
</table>
**Treatment gaps**

1. Poor access to care, stigma, and lack of resources besides unawareness

2. Grossly underreported and difficult to predict

3. Life-threatening psychiatric emergency.

4. Suicide accounts for about 70 to 75% of acute hospitalization

5. Majority of patients have a psychiatric disorder

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35 to 50% patients receive no treatment in high income countries
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
Background & current concept
Optimizing mental health contributes to ‘capacity-building for real-life’ Challenges
One million suicide every year globally

- Global Challenge
- Life threatening condition
- A preventable death
- Public health issue
- Under-reported
Adolescent suicide, Canada

- Rate 0.6/100k < 14 years
- 4.8/100K 15-25 years
- 28 suicide 2 to 14 age
- 480 suicide 15 to 25 age
- Total suicide 3613

Marginal decrease from 1.6 to 1.5 from 2006 to 2011
Suicide statistics

Suicide in children and adolescents

1. Depression increases the risk of first suicide attempt by at least 14-fold

2. One half of all kids with depression attempt suicide at least once, and more than 7% will die as a result

3. Four times as many men as women die by suicide, but young women attempt suicide 3 times more frequently than young men

4. Firearms are used in a little more than half of all youth suicide
Suicide statistics

Suicide in children and adolescents

5. Suicide is among the top 10 causes of death in every country, and

6. Suicide accounts for 6% of all death due to suicide death for adolescents,

7. rates are rising faster than among other age groups.

8. Suicide rate in Canada = 0.7 <14 years &

9. 4.8 15-25 years, national average??

10. Overall rate 17.3. World average is 16
90000 Adolescent suicide every year globally

Death due to suicide 5th in age 10-24

Death due to suicide 2 end in age below 14 years
Suicide behavior

- Lack consensus in concept
- Multifactorial in origin
- Strong psychosocial factor
- A general health issue
- No specific treatment
- High genetic loading

Background
Main barriers

- Stigma
- Unawareness
- Poor financial and human resources
- Poor access to care
- Lack of demonstrable example of success
- Lack of training and education

Background
Suicidal patients are seen across all health settings

![Graph showing the distribution of patients with attempted suicide across different health settings.]

- **Primary care clinics**: 50
- **General hospital**: 10
- **Psychiatric community care**: 20
- **Psychiatric hospitals**: 10
- **Others**: 10

**Background**
Itself not a disease,

Mental disorders are a major factor associated with suicide

Not necessarily the manifestation of a disease,

Psychosocial and environmental

Background
Hereditary predisposition

Genetics

Family history

Five times more common in case of suicide happened mothers

Twice more common in cases where suicide happened in fathers
Self-destructive behavior

Background

Suicide behavior

- Biological
- Social
- Cultural
- Psychological
- Environmental mental
Pathways to suicide and cognition: Confluence of brain and mind

A model of transition from ideas to attempt

- Functional neuroimaging changes
- Cognitive deregulation
- Emotional dysregulation
- Impaired decision making and problem solving
- Neuropsychological changes
- Hopelessness and suicidal behavior

Hopelessness and suicidal behavior
Serotonin

Agitation and psychotic symptoms

Anxiety
Hopelessness
Psychomotor retardation

DA ++
<table>
<thead>
<tr>
<th>Itself not a disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not necessarily the manifestation of a disease</td>
</tr>
<tr>
<td>Mental disorders are a major factor associated with suicide</td>
</tr>
<tr>
<td>Psychosocial and environmental play a pivotal role</td>
</tr>
</tbody>
</table>
Multiple domains involved in complex suicide behaviour

Psychopathology

- Psychological factors
- Biological factors
- Environmental factors
- Social factors
- Cultural factors
A complex behavior: Hypothetical graphic

Psychopathology

Lethality Spectrum

Psychosocial

Biological factors

Environment

Genetic/Hereditary factors
Underlying Pathophysiology

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

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

CAUSES, IDEATION, ATTEMPT, REPEATED ATTEMPT, & COMPLETED SUICIDE
Suicide behavior is commonly seen across all settings

- Medical and Psychiatric emergency
- Psychiatric and hospitalization
- General Medical admissions
- Non-medical settings
- Primary and Community mental health settings
- Community medical settings
Causes

Mental disorders in > 80% cases

Only psychosocial stress in 39-40% cases

Psychosocial stress in almost all cases

In a large number of suicide causes remain unexplained
MENTAL DISORDERS IN SUICIDE
SUICIDE: A HEALTH ISSUE

Physical illnesses
First call for treatment
Medications
Adequate management of physical illness
• Sizeable number attempt suicide
• Seen across all health settings
• Medications to treat physical disorders lead to depression
• Adequate management of physical illness improves outcome
PHYSICAL ILLNESS & SUICIDE

- General health
- Distress
- Ideation
- Attempt

- Physical disorder
- Depression
- Hopelessness
- Intent
- Suicide attempt

Contact:
dr.amresh@gmail.com
CHRONIC HEALTH CONDITIONS [N=2068]

- Non-Suicidal: 85%
- Suicidal Ideation: 15%

Suicidal Ideation:
- Active ideation with plan: 20%
- Active ideation no plan: 24%
- Passive Ideation: 56%
PHYSICAL ILLNESS - A SIGNIFICANT RISK FACTOR

<table>
<thead>
<tr>
<th>Danish study</th>
<th>27,262 suicide cases, and 468,007 live controls</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of hospitalization for physical illness</td>
<td>Index 63.5%</td>
</tr>
<tr>
<td></td>
<td>Control 44.5%</td>
</tr>
<tr>
<td>Physical illness-total</td>
<td>24.4%</td>
</tr>
<tr>
<td>Male</td>
<td>21%</td>
</tr>
<tr>
<td>Female</td>
<td>31%</td>
</tr>
<tr>
<td>Risk of subsequent suicide</td>
<td>Was two times</td>
</tr>
<tr>
<td>High Risk ratio</td>
<td>All organs &amp; comorbidity</td>
</tr>
</tbody>
</table>
HIGH RATES OF MEDICAL CONDITIONS IN SUICIDE & MENTAL DISORDERS
MEDICAL DISORDERS WITH SIGNIFICANTLY INCREASED RISK FROM SUICIDE

- renal disease - haemodialysis: 14.49
- Malignant neoplasm - Head & Neck: 11.39
- HIV/AIDS: 6.65
- Epilepsy: 5.11
- SLE: 4.35
- Renal transplant: 3.83
- Spinal cord injury: 3.82
- Brain injury: 3.5
- Chorea: 2.9
- MS: 2.36
- Peptic Ulcer: 2.1

dr.amresh@gmail.com
Successful management of medical disorders improves depression and suicide ideation.

Deterioration in general medical condition worsens depression, suicide and bipolar symptoms.
Severe Mental Illnesses And Suicide Co-Exist With Physical Disorders
Suicidal ideation

Suicide attempt

Suicide
Stressful factors: 30-40% of attempted suicide
Multifactorial, complex behavior

Mental disorders: 80-90%
High rates of suicide - mental disorder

- Suicide in mental disorder
- Mental disorder in suicide (attempted & completed)
- High rates of suicide in comorbidity
- In at-risk or prodromal states
Psychiatric disorders and comorbidities

<table>
<thead>
<tr>
<th>Present in more than 90% patients of suicide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approximately in 60 to 70% in attempted</td>
</tr>
<tr>
<td>Depression</td>
</tr>
<tr>
<td>Mood and anxiety disorder commonest risk factor:</td>
</tr>
<tr>
<td>Eating disorder, PTSD, bipolar disorder and schizophrenia</td>
</tr>
<tr>
<td>Substance abuse is a common comorbidity</td>
</tr>
</tbody>
</table>
1. Mental disorders have disproportionately higher rates of disability

2. Globally, more than 350 million people of all ages suffer from depression.

3. Depression: chances of premature death is 40-60% greater due to physical illness, if left untreated and suicide

4. Early onset in young age

5. 1 or 3 out of 10 have depression after child birth
Mental disorders.

- Schizoaffective
- Bipolar mood disorder
- PTSD
- Major mood disorder
- OCD
- Schizophrenia
50% Patients who repeated their suicide attempt

50% Patients had seen a doctor in the last 6 months

10% Patients were regular outpatients with their GP
Behind every suicide at least 6 more are affected.

Most patients do not access the health care system.
Suicidal ideation

- Strongest predictor of an attempt,
  - 60% in a psychiatric ward
  - 40% in chronic general medical condition
  - 30% subjects in family practice (2 to 3 times increase)
  - 50% in substance abuse and

Pathways of suicide attempt

In a study of 2068 patients with chronic health conditions, 1750 were non-suicidal and 350 had suicidal ideation.

Suicidal ideation

- Suicidal Ideation with a plan: 21%
- Suicidal ideation without a plan: 56%
- Passive suicidal ideation: 24%

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

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
Suicidal ideas

Wish to dies
Wish to be killed
Wish to kill one self
Ambivalent ideas
Prevalence of suicidal thoughts and Behavior in US Adults

<table>
<thead>
<tr>
<th>Suicidal Thoughts</th>
<th>Percentage</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Serious thoughts</td>
<td>3.7</td>
<td>8.3 Million</td>
</tr>
<tr>
<td>Made plan</td>
<td>1.0</td>
<td>2.3 Million</td>
</tr>
<tr>
<td>Suicide attempt</td>
<td>0.5</td>
<td>1.1 Million</td>
</tr>
<tr>
<td>Suicide deaths</td>
<td>0.01</td>
<td>34,598</td>
</tr>
</tbody>
</table>

Data for suicide deaths are for 2007 and are from the Centers for Disease Control and Prevention. Adapted from the 2008 National Survey on Drug Use and Health Report: Suicidal Thoughts and Behaviors among Adults.
Only a small number go on to attempt

From ideation to attempt

- Attempt: 27%
- No Attempt: 73%

Suicide attempts

Ram D, Darshan MS, Rao TS, Honagodu AR
Completed: attempted suicide

- Completed: 1
- Attempted: 20
- Affected: 4

Graphs showing the comparison between completed and attempted suicide.
Prediction of suicide attempt is difficult

Only a small percentage of people with suicidal ideation go on to make an attempt

prevalence of suicidal ideation is very low in Community
Some of the common suicidal ideas and thoughts can be:

- Wish to die
- Ambivalent suicide
- With to kill oneself
- Wish to be killed
- Para suicide

Some of the common suicidal ideas and thoughts can be:
Chapter 3: Clinical psychiatry of suicide behavior
A: presentation, risk and risk assessment
How do patients of suicide present?

Patients may present
Without Psychiatric symptoms
With Psychiatric symptoms
With an adverse life-situation
Anxiety, depression or abnormal behavior
## Presentation

<table>
<thead>
<tr>
<th>Features of depression</th>
<th>Sudden increase in substance abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sudden change in behavior</td>
<td>Withdrawn behavior</td>
</tr>
<tr>
<td>Suicidal communication</td>
<td>Agitation, anger and agitation</td>
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<tr>
<td></td>
<td>Early signs of psychosis</td>
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<tr>
<td></td>
<td>Frequent mood changes</td>
</tr>
</tbody>
</table>
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
<table>
<thead>
<tr>
<th>Presentation</th>
<th>Depression</th>
<th>Anxiety</th>
<th>Isolation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unhappiness</td>
<td></td>
<td></td>
<td>Migration</td>
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<tr>
<td>Hopelessness</td>
<td></td>
<td></td>
<td>Unemployment</td>
</tr>
<tr>
<td>Despair</td>
<td></td>
<td></td>
<td>Breakdown of intimate relationship</td>
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<tr>
<td>Undiagnosed</td>
<td></td>
<td></td>
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<tr>
<td>low self esteem</td>
<td></td>
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<td>Alcohol</td>
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<td></td>
<td>Anxiety</td>
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<td>Illicit drugs</td>
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</tbody>
</table>
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:
Section 2
Risk and risk assessment, decision making
Chapter 3. Risk factors and assessment of level of risk, severity and potential for suicide
Risk factors, risk assessment & decision making
 Trait factors

 State factors

 Modifiable risk

 Non-modifiable risk

 Absolute risk

 Risk factors & factors increasing risk

 Protective factors & factors decreasing risk
Classifying risk factors

Protective factors | Risk factors

Vulnerability | Resilience
1. Demography
2. Family history
3. Biological
4. Protective Factors
5. Comorbidities
6. Clinical Ratings
7. Psychological
8. Social and Environmental

Risk for suicide
Current absolute risk:

State Risk:

Trait risk:
Risk factors: Modifiable (Dynamic risk factors)

- Modifiable (Dynamic risk factors)
-Suicidal ideation, communication or intent
-Hopelessness, active psychological symptoms
-Substance abuse,
-Psychiatric admission and discharge
-Psychological stress
-Problem solving deficit
-treatment adherence
-Lack of protective factors
## Non-modifiable (Static / stable) risk factors

<table>
<thead>
<tr>
<th>Non-modifiable (Static / stable) risk factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of self harm</td>
</tr>
<tr>
<td>Seriousness of previous suicidality</td>
</tr>
<tr>
<td>Mental disorders</td>
</tr>
<tr>
<td>Substance abuse</td>
</tr>
<tr>
<td>Personality disorders or traits</td>
</tr>
<tr>
<td>Family history</td>
</tr>
<tr>
<td>Age and gender</td>
</tr>
<tr>
<td>Childhood adversity</td>
</tr>
</tbody>
</table>
# Risk for suicide

<table>
<thead>
<tr>
<th>Vulnerable individuals</th>
<th>Vulnerable events</th>
<th>Vulnerable situation</th>
</tr>
</thead>
<tbody>
<tr>
<td>with defined risk factors</td>
<td>exposure to stressful situation</td>
<td>post hospitalization</td>
</tr>
<tr>
<td>lack of protective factors</td>
<td>trauma</td>
<td>First week</td>
</tr>
<tr>
<td>Presence of mental disorders</td>
<td>Sub-human condition</td>
<td>First month</td>
</tr>
<tr>
<td>presence of substance abuse</td>
<td>sexual violence</td>
<td>First year</td>
</tr>
</tbody>
</table>
Risk factors

- Mental disorders
- Physical disorders
- Psychosocial stress
- Childhood experience
- Environmental conditions
Past and recent suicide attempt
Psychiatric diagnosis
Lack of treatment adherence
Substance abuse
Past and recent suicide attempt
Psychiatric diagnosis
Chronic physical disorders
Hopelessness
Childhood sex abuse
Trauma & Abuse
<table>
<thead>
<tr>
<th>Male gender</th>
<th>First episode &amp; Ultra high risk candidates for mental disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric hospitalization</td>
<td>Domonent Depressed mood</td>
</tr>
<tr>
<td>Suicidal ideation</td>
<td>Suicidal ideas communication</td>
</tr>
</tbody>
</table>

**Comorbidity & First episode**

**Psychosocial stress**
# Risk factor/ antecedents

<table>
<thead>
<tr>
<th>Social determinants</th>
<th>Sudden desire to tidy up personal affairs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Migration</td>
<td>Writing a will etc.</td>
</tr>
<tr>
<td>Isolation</td>
<td>Sudden resignation in presence of depression</td>
</tr>
<tr>
<td>Poverty</td>
<td>Writing suicidal notes</td>
</tr>
<tr>
<td>Academic stress</td>
<td>Severe physical illness</td>
</tr>
<tr>
<td>Economics and finance</td>
<td></td>
</tr>
</tbody>
</table>
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
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
Contributing Factors

Presence of depression
Presence of depression in mothers
Depression during pregnancy and postpartum depression
Social determinates of health
Substance abuse
<table>
<thead>
<tr>
<th>Contributing Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurobehavioral and Brain development</td>
</tr>
<tr>
<td>Violence (to children, partner violence)</td>
</tr>
<tr>
<td>Witness to marital violence in family and</td>
</tr>
<tr>
<td>Partner violence</td>
</tr>
<tr>
<td>Bullying Sex abuse.</td>
</tr>
<tr>
<td>Sub threshold illnesses</td>
</tr>
<tr>
<td>Transitioning from also descent to adulthood</td>
</tr>
</tbody>
</table>
# Antecedents factors

<table>
<thead>
<tr>
<th>Social determinants</th>
<th>Sudden desire to tidy up personal affairs</th>
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</thead>
<tbody>
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<tr>
<td>Academic stress</td>
<td>Severe physical illness</td>
</tr>
<tr>
<td>Economics and finance</td>
<td></td>
</tr>
</tbody>
</table>
Symptoms/Triggers

withdrawn behaviour
illness
alcoholism
anxiety
personality change
previous suicide attempt
self-hatred

recent loss
family history
desire to tidy personal affairs
loneliness
‘goodbye’ notes
physical ill-health
repeated mentions of death/suicide
CONTRIBUTING FACTORS

- psychological distress
- adverse social conditions
- presence of mental disorders
- faith
- conviction
- beliefs
- general health
- medical illnesses
- mental disorders
Risk Situation

- Early phase of illness
- Before admission
- During admission
- Early days in the ward
- When discharge is close.
- After discharge
Factors that increase suicide risk in depressed people

- § Aged below 25 years
- § Aged over 65 years
- § Male
- § Misuse of alcohol
- § Manic-depression
- § Feelings of hopelessness
- § Self-neglect
- § Persistent insomnia
- § Severe depression
- § Impaired memory
- § Agitation
- § Anxiety
- § Panic attacks
- § Late onset of depression
## Protective factors

<table>
<thead>
<tr>
<th>Social support</th>
<th>Problem solving skills</th>
<th>Participation in treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presence of hopefulness</td>
<td>Children present in the home</td>
<td>Pregnancy</td>
</tr>
</tbody>
</table>
## Protective factors

<table>
<thead>
<tr>
<th>Religious commitment</th>
<th>Life satisfaction</th>
<th>Intact reality testing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fear of social disapproval</td>
<td>Fear of suicide or death</td>
<td></td>
</tr>
</tbody>
</table>

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.
## Protective factors

<table>
<thead>
<tr>
<th>Social support</th>
<th>Problem solving skills</th>
<th>presence of optimism</th>
<th>Presence of children at home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnancy</td>
<td>Religious commitment</td>
<td>Life satisfaction</td>
<td>Fear of social disapproval</td>
</tr>
<tr>
<td>Fear of suicide or death</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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 |
### 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
Prediction and warning signs

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

Powell j et al, BJP,(2000), 176, 266-272
<table>
<thead>
<tr>
<th>Relationship to suicide</th>
<th>Warning signs</th>
<th>Risk factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evidence basis</td>
<td>Clinically derived</td>
<td>Empirical research</td>
</tr>
<tr>
<td>Applicable group</td>
<td>Individuals</td>
<td>Populations</td>
</tr>
<tr>
<td>Clinical implications</td>
<td>Intervene to resolve</td>
<td>Limited ability to address</td>
</tr>
<tr>
<td>Time basis</td>
<td>Transient</td>
<td>Often static</td>
</tr>
<tr>
<td>Examples</td>
<td>Threats to harm self</td>
<td>White</td>
</tr>
<tr>
<td></td>
<td>Planning for suicide</td>
<td>Male</td>
</tr>
<tr>
<td></td>
<td>Talking or writing about suicide</td>
<td>History of a suicide attempt</td>
</tr>
<tr>
<td></td>
<td>Hopelessness</td>
<td>Family history of suicide</td>
</tr>
<tr>
<td></td>
<td>Rage, anger, seeking revenge</td>
<td>Psychiatric diagnosis</td>
</tr>
<tr>
<td></td>
<td>Impulsive or reckless actions</td>
<td>Smoker</td>
</tr>
<tr>
<td></td>
<td>Feeling trapped</td>
<td>Firearms access</td>
</tr>
<tr>
<td></td>
<td>Increasing alcohol or drug use</td>
<td>Physicians</td>
</tr>
<tr>
<td></td>
<td>Withdrawing from others</td>
<td>Prisoners</td>
</tr>
<tr>
<td></td>
<td>Anxiety or agitation</td>
<td>History of sexual abuse</td>
</tr>
<tr>
<td></td>
<td>Increased or decreased sleep</td>
<td>History of psychiatric admission</td>
</tr>
<tr>
<td></td>
<td>Dramatic mood changes</td>
<td>Increasing age</td>
</tr>
<tr>
<td></td>
<td>No purpose or reason for living</td>
<td>Divorced</td>
</tr>
</tbody>
</table>

Adapted from *Suicide and Life Threat Behav*, with permission.
Data from *J Clin Psychiatry*.37
Presentation
<table>
<thead>
<tr>
<th>Depression</th>
<th>Anxiety</th>
<th>Isolation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unhappiness</td>
<td>Sexual identity</td>
<td>Migration</td>
</tr>
<tr>
<td>Hopelessness</td>
<td>Physical abuse</td>
<td>Unemployment</td>
</tr>
<tr>
<td>Despair</td>
<td>Loss of purpose</td>
<td>Breakdown of intimate relationship</td>
</tr>
<tr>
<td>Undiagnosed</td>
<td>HIV</td>
<td>Alcohol</td>
</tr>
<tr>
<td>Low self esteem</td>
<td>Unwanted pregnancy</td>
<td>Illicit drugs</td>
</tr>
</tbody>
</table>
Risk assessment
Assessing Risk of Suicide

The best way to find out whether individuals have suicidal thoughts is to ask them.

Contrary to popular belief, talking about suicide does not plant the idea in people’s heads. In fact, they are very grateful and relieved to be able to talk openly about the issues and questions they are struggling with.
Asking the question

Do you feel sad?
Do you feel that no one cares about you?
Do you feel that life is not worth living?
Do you feel like committing suicide?
When to ask the questions
What to ask

Is there a plan?

Are there the means?

Is there a time frame?
How do patients of suicide present?

- Without Psychiatric symptoms
- With Psychiatric symptoms
- With an adverse situation
- Anxiety, depression or abnormal behaviour
- Guarded behaviour
- Seclusion
How do patients of suicide present?

- Muteness
- Violence
- Agitation
- Command hallucinations
- Stressful situations
- Suicidal crisis
Identification

Promptly Check

Incorporate Risk Assessment in Practice

Warning Signs
Threatening to hurt or kill themselves
Looking for ways to kill themselves
Talking or writing about death, dying, or suicide
Hopelessness
Rage, anger, seeking revenge
Acting reckless
Feeling trapped
Increasing alcohol or drug use
Withdrawing from friends, family, or society
Anxiety, agitation, unable to sleep, or sleeping all the time
Dramatic changes in mood
Presentation of depression

- depressed mood
- medically unexplained symptoms
Symptoms in depression

Hopelessness
Sadness of mood
loss of interest
inability to experience pleasure
weight loss
loss of appetite

Suicidal ideas
Helplessness
Sleep disturbance
Memory problems
Anxiety
Somatic symptoms
Loss of libido
<table>
<thead>
<tr>
<th>High-Risk Factors in Assessing Suicide Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Past suicide attempts</strong></td>
</tr>
<tr>
<td><strong>Social isolation</strong></td>
</tr>
<tr>
<td><strong>Seriousness of previous attempts</strong></td>
</tr>
<tr>
<td><strong>Personal or family history of psychiatric disorders</strong> (e.g., major depression, bipolar disorder)</td>
</tr>
<tr>
<td><strong>Family history of suicide</strong></td>
</tr>
<tr>
<td><strong>Burden of physical health problems</strong></td>
</tr>
<tr>
<td><strong>Feelings of hopelessness</strong></td>
</tr>
<tr>
<td><strong>History of loss</strong></td>
</tr>
<tr>
<td><strong>Substance abuse</strong></td>
</tr>
<tr>
<td><strong>Preoccupation with death</strong></td>
</tr>
</tbody>
</table>
Thought of death

Suicidal idea

Plan of suicide

Means available

Intent
<table>
<thead>
<tr>
<th>No.</th>
<th>Step</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Identification</td>
</tr>
<tr>
<td>2</td>
<td>Monitor</td>
</tr>
<tr>
<td>3</td>
<td>Detect &amp; assess to manage</td>
</tr>
<tr>
<td>4</td>
<td>Assess and consult or admission</td>
</tr>
<tr>
<td>5</td>
<td>Hospitalization</td>
</tr>
<tr>
<td>6</td>
<td>Treatment of mental disorders &amp; psychological factors</td>
</tr>
<tr>
<td>7</td>
<td>Remove the means and ensure safety during hospitalization</td>
</tr>
<tr>
<td>8</td>
<td>Remove the means and ensure safety during hospitalization</td>
</tr>
<tr>
<td>9</td>
<td>Consider intensive treatment</td>
</tr>
<tr>
<td>10</td>
<td>Remove the means and ensure safety during hospitalization</td>
</tr>
<tr>
<td>11</td>
<td>Comprehensive care with post-discharge plan</td>
</tr>
</tbody>
</table>

**Opportunities for prevention**

- **At-risk vulnerability**
- **Suicidal ideas**
- **Plans for suicide with low severity**
- **Plan of suicide with high severity**
- **Suicide intent**
- **Access to means**
- **Persistence of ideas**
- **High lethality**
- **Attempt with certainly of suicide**

1. Identification
2. Monitor
3. Detect & assess to manage
4. Assess and consult or admission
5. Hospitalization
6. Treatment of mental disorders & psychological factors
7. Remove the means and ensure safety during hospitalization
8. Remove the means and ensure safety during hospitalization
9. Consider intensive treatment
10. Remove the means and ensure safety during hospitalization
11. Comprehensive care with post-discharge plan
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?
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
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

- No Thoughts of death
- Nonsuicidal thoughts of death
- Suicidal thoughts without specific methods
- Suicidal thoughts with specific methods

Lowest risk
Lowest risk
Elevated risk
Highest risk
Risk assessment stepwise.

1. Identify the multiple contributing factors,
2. Conduct a thorough psychiatric examination,
3. Identify risk factors and protective factors,
4. Distinguish modifiable and non-modifiable factors,
5. Ask directly about suicide, determine level of suicide risk (low, moderate, high),
Contents of assessment

1. Determine treatment setting and plan, i
2. Investigate past and present suicidal ideation,
3. Plans, behaviors, intent; methods;
4. Hopelessness, anhedonia, anxiety symptoms;
5. reasons for living;
6. Associated substance use; homicidal ideation.
Contents of assessment

ideation, ➔ severity, ➔ intent, ➔ lethality,

Plans, ➔ Availability of means and ➔ certainty of carrying out the
Lethality

How strong are the ideas

Planning

What is the plan, when and how it will be executed

Attempt

Will an attempt take place
Before attempt

Risk factors

Social stress

After attempt

Transit

Treatment

Monitoring

Treatment
Assessment when patients has a Plan for suicide attempt

- What is the plan
- Has it been the same
- Chances of execution/acting out
- Wish to change/re-think
- Did you copy it
- Has the client seen this plan succeed
- Timeline for developing plan
- Is it impulsive
- Is it frequently changing
- Criteria of selecting the means
Remember and always suspect

• Milder symptoms are equally significant

• Even in low risk It can always happen

• In general suicide is difficult prevent

• Partial remission is more lethal

• Denial of suicidal ideation is no criteria for modifying plan
Remember and always suspect

• Trusting denial gives more surprises

• Evaluate psychological perspective ie patients emotions, perception of crisis, attitude, rationality and insight

• Transition to good insight is a risk situation

• Do not believe "I will never do it"
Remember and always suspect

• Be very judicious for voluntary status.

• It does not prevent but increases level of care an observation

• It's more for staff than for patient.

• It indicates your perception of level of risk

• Transition of symptoms or transition states are more serious situation

• Pay attention to risk situation

• Evaluate therapeutic alliance and psychological intervention
Remember and always suspect

• Protective factors are not always protective, particularly in early phase of illness and psychotic states

• Special care in following states

• Hallucinations are not sways reported but often "observed"

• Emotional apathy, Bewilderedness, Anxiety

• Pre psychotic states

• Confusional states delirious states withdrawal states

• Organic syndromes "aura"
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

Chapter 4. Working with family physicians, intervention and management of suicide behavior
Why work with family physicians?

Care provided by family physician is available to all people at an affordable cost.
• Future of management of mental disorders lies in community medicine and primary care which provides easy and rapid access to care and integration of mental and physical disorders.

• A robust health care system has certain well-defined characteristics.
Requirements for integrated health care services

Services by family physicians offers great benefit to the patients
• Health system in primary care has most of these features and therefore lot more can b expected in terms of management of suicide behaviour.

• Family physicians play an important role in identification, intervention and prevention of suicide primarily because more than 50 to 60% patients approach and talk to (or try to talk) with their physician.
• Role of family physicians is not only limited to urban and metro regions but it is equally important for rural communities which have definite scarcity of services.

• Significant number of people living is rural and under-serviced areas also have problems related to suicide.

• More innovative services are required to provide care to this population.
Patients with suicide behaviors approach a number of settings and therefore health care professional is such facilities require skills for identification and intervention.
Advantage of family physicians for suicide prevention

1. Care provided by family physician is available to all people.
2. Care is available free. (instate managed centers.
3. It is affordable most cases.
4. Most of the people before attempting suicide contact their physicians.
5. Physicians are also the first person to whom the patient reaches out
6. Physicians have the opportunity to offer long-term care wherever necessary
A number of patients see their family physicians prior to an attempt.

(Pfaff & Osvaldo, 2004; Luoma, et al., 2002; Vassili & Morgan, 1994).
Advantage of family physicians for suicide prevention

7. A number of patients stop treatment after some time, in such cases family physicians can re-enforce and increase their compliance.
8. Suicidal ideation is present in 30% of all the patients seen in their practice.
9. Risk of suicide is 2-3 times higher among those suffering from a physical disorder.
• Serious thoughts of suicide, plans for suicide, and suicide attempts are surprisingly common in the general population.
• Suicide is still a low base-rate occurrence and impossible to predict accurately.
• First, patients dying by suicide visit primary care physicians more than twice as often as mental health clinicians.\textsuperscript{10}

• Second, generalists (internists, pediatricians, family physicians) write most antidepressant prescriptions (62\%) in the United States.

• When these 2 facts are considered together, it becomes clear that primary care clinicians provide most antidepressant treatment and are the group most likely to see patients at risk of suicide in the month before their death
Some research shows that educating primary care clinicians can help protect against suicide, primarily by improving the recognition of depression and leading to the increased prescribing of antidepressants.12-15

These effects are stronger when collaborative care models of depression treatment are used.16,17

management

• Antidepressant
• Suicide risk management
• Treatment of anxiety and agitation
• Suicide risk assessment
Practical management

• 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.
• Particularly for patients being released from their office or during discharge from the hospital or emergency department, clinicians should recommend that family or friends secure or remove firearms, large quantities of medication, or other obvious means of self-harm and involve family and significant others in crisis planning and treatment.
• Clinicians should ensure that patients know how to use their on-call phone numbers in the event of a suicidal crisis.

• If patients call outpatient offices in suicidal crises, clinicians or office staff should call 911 or law enforcement as needed to ensure that patients are safe and that they are being transported safely to receive more intensive treatment.
• Environmental factors may be even more relevant in management than usual.

• For patients in the emergency department, general hospital, or outpatient offices, the potential of medical equipment (e.g., intravenous tubing) or the patients’ own belongings being used in a suicide attempt should be carefully evaluated.
• Great efforts may be made to ensure a patient is referred for evaluation to an emergency department, while immediate safety needs may be missed (e.g., patients may overdose on medications they have in their possession or on their person).

• If evaluation in the emergency department or hospitalization is thought to be necessary, patients should be transferred by ambulance.
• Although family or friends may offer (and desire) to provide transport, patients should be transferred safely using trained personnel following standard protocols.

• Clinicians should consider the possibility that some patients being evaluated for suicide risk may have overdosed or harmed themselves immediately before seeking care.
• Clinical situations should be reassessed as needed and the level of physiologic monitoring increased on the basis of changing presentations.

• Patients should be monitored closely both before and during their transitions between care settings during emergency evaluations.

• Although uncommon, suicides can occur in the emergency department, general hospital, and outpatient offices.

MANAGING CONTINUITY PATIENTS WHO HAVE ATTEMPTED SUICIDE

• The primary care physician may not be the one to immediately treat and stabilize the patient following the suicide attempt.
• However, responsibility may be turned over to them at some point, and special considerations and guidelines will aid the primary care physician in the patients care.
• A close working relationship between the patient and physician will foster the patients recovery and minimize the chance of another suicide attempt.
• Failure to adhere to discharge recommendations is common in patients who have attempted suicide.4
• his tendency may be reduced by a good therapeutic relationship with the primary care physician.23
• In particular, the physicians knowledge over time not only of the patients physical condition but also of their psychosocial circumstances may alert the physician to levels of patient stress and warning signs.
• Because of the high incidence of chronic health problems in depressed and suicidal patients, especially among the elderly,24 knowledge of the patients attitudes and feelings about their illness may be very relevant.
• Several studies have reported that between 20% and 76% of patients who commit suicide have seen their primary care physician in the prior month.25
• Frequent monitoring of suicidal thoughts in high-risk patients, especially those who have made recent attempts, may reduce the number of completed suicides.
• Knowledge of high-risk factors (Table 1)2123,26 will make the primary care physician more effective in identifying vulnerable patients.
• It has been suggested that no-suicide contracts may be helpful in managing suicidal patients.27
• Basically, this approach asks the patient to commit either verbally or in writing to not act on suicidal impulses but instead contact a source of help, such as a suicide hotline or the primary care physician, if they feel suicidal.
• This approach not only conveys the concern and regard of the primary care physician but also gives the patient a concrete plan to follow when feeling in crisis and despondent.
• Agreement to a no-suicide contract does not ensure patient safety, but if the patient cannot agree to this contract, hospitalization should be seriously considered.
• The potential for substance abuse, history of impulsive behaviour, and social isolation all might limit the value of such contracting.
• Close follow-up is important when treating a patient who has recently made a suicide attempt.
• While office visits will be the basic intervention, brief telephone calls can provide support contact and help identify if an urgent appointment needs to be scheduled.
• If hospital discharge planning did not include psychiatric referral, this should be a priority.
• Prompt communication and coordination with the mental health professional will promote efficient and effective care.
• Since many patients are still averse to seeing a psychiatrist because of misconceptions and fear of stigma, encouragement and education from the primary care physician about the importance of treatment will make it more likely the patient will follow through on the referral.
• Medication may play an important role in the ongoing management of patients who have attempted suicide.
• The pharmacologic treatment depends on the underlying psychiatric diagnosis.
• Most clinicians choose a selective serotonin reuptake inhibitor as first-line treatment of depressive disorders.28
• These medications are generally well tolerated and safe for use in the depressed patient and have been found to decrease suicidal ideation.29
• There are many choices available for depression, and a review of these medications is outside the scope of this article.
• Many excellent reviews of pharmacotherapy are available.28
• Patients who fail first-line treatment or have other psychiatric disorders, such as bipolar disorder or schizophrenia, may benefit from consultation with a psychiatrist.
• It has been suggested that antidepressant medications may activate depressed individuals, thus increasing the risk of suicidal behaviour.30
• Close monitoring of the patient recently started on any antidepressant will help the primary care physician assess whether suicidal risk has been increased as a result of activation effects from the medicine.
Conclusion

• When evaluating a suicidal patient, first and foremost, keep the patient safe. Stabilize the presenting medical condition and treat any comorbid conditions. Ask for collateral information from police, emergency medical staff, and any witnesses to the suicidal events. When the patient is able to participate in an interview, the physician should ask the question, Why now? and listen intently for any clues to the patients current situation. Perform a thorough and detailed physical examination. After consultation and/or contact the patients existing physician(s) and make sure a follow-up plan is in place. If the primary care physician sees the suicidal patient on a continuity basis, the therapeutic patient-physician relationship as well as attention to suicidal risk factors and general health status will be important. Finally, coordination with and support for specialized psychiatric care by the primary care physician is recommended.
Decision making
Figure 1. Algorithm for the Management of Patients With a Recent Suicide Attempt

Initial Evaluation

Is Patient Medically Stable?

No → Stabilize Medical Conditions

Yes → Toxicology Screen (+) → Detox Protocol

Toxicology Screen (-)

Ensure Patient Is In Safe Environment 24-Hour Observation With Suicide Precautions

Take Careful History, Including Suicide Risk Factors (Table 1)

Complete Physical Examination

Mental Status Examination

→ Coordinate Care With Subspecialists

→ Admission to Appropriate Facility

→ Observation

Risk assessment
Client in suicidal behaviour or ideation

- Presence of agitation, hallucination or delusion
  - Hospitalise

- No psychotic feature
  - Start assessment
  - Are suicidal thoughts chronic?
    - Yes: start routine psychiatric work-up
    - Assess – if major psychiatric problem
      - Known patient, mild to moderate severity: continue to treat
      - Consult or hospitalise
    - No acute suicidal ideation
      - Is the client in crisis?
        - Start intervention
          - Patient is responsive: continue intervention & risk assessment & follow up
          - Patient in non-responsive
            - Risk assessment
            - High Suicidality
            - Consult/hosp or PC
            - Management of mental disorder: Consult if necessary
            - Low Suicidality
              - Ref consult
              - Consider hospitalization
              - Continue Intervention
            - Low Suicidality: OPA treatment
              - High Suicidality: further assessment:
                - Consult/hosp or PC
                - Consider hospitalization
                - Continue Intervention
          - Persistent suicidal ideation: seek consult
      - No crisis – assessment and outpatient management in clinic
        - Presence of psychiatric disorder – detailed risk assessment
          - Consult/hosp or PC
          - Consider hospitalization
          - Management of mental disorder: Consult if necessary
          - Ref consult
          - Continue Intervention
        - Presence of potential psychosocial stress:
          - Consult/hosp or PC
          - Consider hospitalization
          - Management of mental disorder: Consult if necessary
          - Ref consult
          - Continue Intervention
    - No acute suicidal ideation
      - Is the client in crisis?
        - Start intervention
          - Patient is responsive: continue intervention & risk assessment & follow up
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        - Continue Intervention
      - Presence of potential psychosocial stress: 
        - Consult/hosp or PC 
        - Consider hospitalization 
        - Management of mental disorder: Consult if necessary 
        - Ref consult 
        - Continue Intervention
Flow chart – part 1

Client in suicidal behaviour or ideation

- Presence of agitation, hallucination or delusion
  - hospitalise

- No psychotic feature
  - Start assessment
    - Are suicidal thoughts chronic
      - No: psycho feature
        - Start psychiatric work-up
          - Yes: consult or hospitalise

Assess – if major psychiatric problem

Known patient, mild to moderate severity: continue to treat

Consult or hospitalise
**Flow chart part 2**

- **No acute suicidal ideation**
  - Is the client in crisis? Start intervention
    - Patient is responsive, continue intervention & risk assessment & follow up
    - Patient in non-responsive
    - Presence of psychiatric disorder – detailed risk assessment
      - Presence of potential psychosocial stress:
        - No crisis – assessment and outpatient management in clinic
        - High Suicidality: further assessment:
          - Low Suicidality: OPA treatment
            - Low Suicidality
              - Consult if necessary
            - High Suicidality
              - Consult/hosp or PC
          - High Suicidality
            - Management of mental disorder
              - Consult if necessary
            - Consider hospitalization
              - Ref consult
            - Continue Intervention
            - Hospitalize
A number of patients see their doctors before attempting suicide (Pfaff & Osvaldo, 2004; Luoma, et al., 2002; Vassilas & Morgan, 1994). 75% within the year, 33% during previous year, 50% with Adolescents.
Detection of suicide by General Practitioners

Patients with Suicidal Ideation, N=405

- Detected: 22
- Not detected: 55
Some of the gaps are: a lack of community programs, poor awareness drive, poor health care promotion, isolation of mental health from physical health, and lack of effective networking within social agencies and health care system. We need to identify risk factors related to suicide in order to treat such individuals.
• From a prevention point of view this is the most important phase. Here the benefit of treatment can sustain with good service. Poor service and short comings in this phase will undo the benefit of opportunity which the patient had. Some of these factors are: absence of any mechanism to provide consistent and ongoing care. In general, these patients remain disconnected from the services where they were treated.
• a relapse prevention program is not developed. Further when such patients again face a crisis, care and treatment is not easily available and they do not have any support. Facilities for short stay treatment are also lacking. Stigma plays an important role in accessing the care for those who have been treated. An anti stigma intervention program may go a long way in prevention of second attempt.
What are the problems in management of suicide behavior in family practice?

- Lack of training and skill development
- Poor resources and support
- Low identification
- Lack of intervention
Intervention and management
More than 30 to 40% patients do not receive any mental health service in developed countries

1. Lack of community programs
2. Awareness drive
3. Networking
4. Health promotion
5. Identification of newer risk groups
6. Consistent link between services and community
7. Poor services
8. Consistency and continuity of care
9. Relapse prevention
10. Crisis support
11. Short stay
12. Education
13. Rehabilitation
14. Anti-stigma intervention
15. Clinical data base

Treatment gaps

Patients do not access care due to stigma and unawareness
Suicide rate can be significantly reduced in primary care practice
Intervention

• Counseling / referrals
• Follow up from decision making
• Tx in the clinic counseling, prescribing ADD, follow up,
• Making referral
• Taking referrals back
Management

- Short term management
- Long term management

Management involves proper assessment, decision making, providing basic minimum intervention and making a referral for further treatment
• 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, Only 20% saw a mental health professional in the preceding month.
• Women
• and older patients are more likely to have sought care in
• the month before suicide than men and younger patients.
• Second, generalists (internists, pediatricians, family physicians) write most antidepressant prescriptions (62%) in the
• 11 United States. When these 2 facts are considered together,
• it becomes clear that primary care clinicians provide most antidepressant treatment and are the group most likely to see patients at risk of suicide in the month before their death.
• These findings have generated multiple suicide prevention efforts in primary care.12-15 Some research shows that educating primary care clinicians can help protect against suicide, primarily by improving the recognition of depression and leading to the increased prescribing of antidepressants.12-15 These effects are stronger when collaborative care models of depression treatment are used.16,17


<table>
<thead>
<tr>
<th>Relationship to suicide</th>
<th>Warning signs</th>
<th>Risk factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evidence basis</td>
<td>Proximal</td>
<td>Distal</td>
</tr>
<tr>
<td>Applicable group</td>
<td>Clinically derived</td>
<td>Empirical research</td>
</tr>
<tr>
<td>Clinical implications</td>
<td>Individuals</td>
<td>Populations</td>
</tr>
<tr>
<td>Time basis</td>
<td>Transient</td>
<td>Often static</td>
</tr>
<tr>
<td>Examples</td>
<td>Threats to harm self</td>
<td>White</td>
</tr>
<tr>
<td></td>
<td>Planning for suicide</td>
<td>Male</td>
</tr>
<tr>
<td></td>
<td>Talking or writing about suicide</td>
<td>History of a suicide attempt</td>
</tr>
<tr>
<td></td>
<td>Hopelessness</td>
<td>Family history of suicide</td>
</tr>
<tr>
<td></td>
<td>Rage, anger, seeking revenge</td>
<td>Psychiatric diagnosis</td>
</tr>
<tr>
<td></td>
<td>Impulsive or reckless actions</td>
<td>Smoker</td>
</tr>
<tr>
<td></td>
<td>Feeling trapped</td>
<td>Firearms access</td>
</tr>
<tr>
<td></td>
<td>Increasing alcohol or drug use</td>
<td>Physicians</td>
</tr>
<tr>
<td></td>
<td>Withdrawing from others</td>
<td>Prisoners</td>
</tr>
<tr>
<td></td>
<td>Anxiety or agitation</td>
<td>History of sexual abuse</td>
</tr>
<tr>
<td></td>
<td>Increased or decreased sleep</td>
<td>History of psychiatric admission</td>
</tr>
<tr>
<td></td>
<td>Dramatic mood changes</td>
<td>Increasing age</td>
</tr>
<tr>
<td></td>
<td>No purpose or reason for living</td>
<td>Divorced</td>
</tr>
</tbody>
</table>

Adapted from *Suicide and Life Threat Behav.* with permission.
Data from *J Clin Psychiatry.*
• Extent and description of the patient
• Stabilization and safety
• Patients history
• Mental state examination
• MANAGING CONTINUITY PATIENTS WHO HAVE ATTEMPTED SUICIDE
• When evaluating a suicidal patient, first and foremost, keep the patient safe. Stabilize the presenting medical condition and treat any comorbid conditions. Ask for collateral information from police, emergency medical staff, and any witnesses to the suicidal events. When the patient is able to participate in an interview, the physician should ask the question, why now? Î and listen intently for any clues to the patient's current situation. Perform a thorough and detailed physical examination. Obtain a psychi

• 1743

Catherine Goertemiller Carrigan, M.D., M.B.A., and Denis J. Lynch, Ph.D. managing Suicide Attempts: Primary Care Guidelines Primary Care Companion J Clin Psychiatry 2003;5(4)
• atric consultation and/or contact the patients existing physician(s) and make sure a follow-up plan is in place. If the primary care physician sees the suicidal patient on a continuity basis, the therapeutic patient-physician relationship as well as attention to suicidal risk factors and general health status will be important. Finally, coordination with and support for specialized psychiatric care by the primary care physician is recommended.
Managing suicide risk is inseparable from risk assessment.

Management techniques differ depending on the assessed level of risk. Key elements in order of ascending risk are:

1. If risk is low, maintain **usual contact** arrangements.

2. A **counselling approach** is useful in promoting engagement and encouraging the patient to take shared responsibility for their future care and safety.

3. If you are concerned or anxious seek advice from colleagues or people in other nearby services. Difficult clinical judgments are unavoidable, and they can be greatly aided by discussion.

4. If your judgment is that additional help is not needed, use the person's current or **past coping methods** as the basis for advice on managing present difficulties.
5 Use the person's **existing support system** by planning with them how to engage family and friends, or with their permission, by contacting family or friends yourself.

6 Arrange **earlier contact** by telephone or an appointment if you think this would be helpful and would reduce your concerns.

7 If you feel more concerned **alert other involved professionals** and encourage the patient to make **other appropriate contacts** if necessary.
• 8 If you are still more concerned refer the person for more urgent or more specialist care as indicated.
• This could mean seeking an earlier appointment with a mental health professional who is already in contact, or making a referral to another service.
• Available services vary between localities.
• 9 If you are very concerned arrange emergency help in the form of an urgent mental health assessment or a 999 call
C-

Managing suicide risk is inseparable from risk assessment.

1. Maintaining usual contact
2. Counseling approach
3. Seek advice from colleagues
4. Past coping methods
   • Further follow up
   • Social support
   • If a patient is emotionally disturbed, with vague suicidal thoughts, the opportunity of
   • Ventilating thoughts and feelings to a physician who shows concern may be sufficient.
Management in the clinic

- 5. existing support system
- 6. earlier contact
- 7. alert other involved professionals
- 8. refer
- 9. emergency help
- 10. social support

- an opportunity for further follow-up should be left open, particularly if the patient has inadequate social support.
• Whatever the problem, the feelings of the suicidal person are Usually a triad of helplessness, hopelessness and despair.
• 1. *Ambivalence*. The majority of suicidal patients are ambivalent till the very end. There is
• A see-saw battle between the wish to live and the wish to die. If the ambivalence is used by the
• Physician to increase the wish to live, the suicide risk may be reduced.
2. Impulsivity. Suicide is an impulsive phenomenon and impulse by its very nature is transient. If support is provided at the moment of impulse, the crisis may be defused.

3. Rigidity. Suicidal people are constricted in their thinking, mood and action and their reasoning is dichotomized in terms of either/or.

By exploring several possible alternatives to death with the suicidal patient, the physician gently makes the patient realize that there are other options, even if they are not ideal.
Management

- Other people close to the patient can be included in negotiating the contract.
- The negotiation of the contract can promote discussion of various relevant issues.
- In the majority of instances patients
- respect the promises they give to a physician. Contracting is appropriate only when patients
- have control over their actions.
In the absence of severe psychiatric disorder or suicidal intent, the physician can initiate and arrange pharmacological treatment, generally with antidepressants, and psychological (cognitive behavior) therapy. The majority of people benefit from continuing contacts; these should be structured to meet individual needs.
Management

- Except for the treatment of underlying diseases, few persons require support for longer than two or three months and the focus of the support should be providing hope, encouraging
- independence, and helping the patient to learn different ways of coping with life stressors.
Important aspects

Suicide Contract
Duration of treatment
Previous attempt
Family history
Physical ill-health;
No social support.

Medication
Psychiatric consult
When to hospitalize a patient
violent methods
Arrange transfer
• Do not leave the patient alone;
• Arrange for hospitalization;
In one study 60% of physicians were unaware of previous suicidal behaviour in individuals who ultimately complete suicide.

Suicide behaviour often remains undetected in family practice.
Detection of suicide by General practitioners

suicidal ideation

<table>
<thead>
<tr>
<th>Present (out of 405 subjects)</th>
<th>Not detected by GPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>22%</td>
<td>48%</td>
</tr>
</tbody>
</table>

Deficiency of training is well established

A number of suicides has shown that more than 90% of PCP want to learn more for management of suicide behavior.

Education and training has significant merit

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. Better detection and treatment for sui and depression
5. Role of training of trainers for community mental health workers

Education of family physicians for suicide prevention can also increase their motivation and reduce stigma for mental disorders
Family physicians have clearly pointed out need for acquiring of knowledge, competency and increased Mental health resources which can increase identification, interventions and referrals.
Evidence of success in treatment of suicide in family practice

3. Treatment of depression
Early identification and intervention

- Robust literature suggests that a number of methods employed in general practice can reduce suicide attempt, increase identification, and providing brief intervention to their patients who have suicidal ideas.

- Patients who have not developed frank symptoms of an illness also have strong suicidal ideas and in fact do attempt suicide. (at-risk candidates for mental disorders/ prodromal phase/ early phase of illness)

- Suicidal behaviour is often a starting point for the earliest treatment.
Treatment of depression

• Another evidence that family physicians can successfully treat suicide is available from study of depressed patients in their practice

• Depression and suicide are closely related and about 17 to 20% patients are likely to attempt suicide during their life time
• When symptoms of depression are more severe, physicians are able to detect suicide with more accuracy and they can also refer the patients well in time for treatment by specialist.

• About 40 to 50% of all patients seen in clinics of general practice are found to have depression.

• Use of antidepressant drugs by family physicians also reduces incidence of suicide.
Treatment of depression effectively brings down suicide rates in primary care


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

Combination with psycho-social interventions and public education improve the identification and treatment of depression and reduces the rate of completed and attempted suicide in the areas served by trained doctors.


Depression: identification and treatment in family practice

- 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

Training & education

- Studies have been conducted to find out if general practitioners can identify patients with suicidal thoughts after they receive proper education.
- The results confirmed that indeed by providing proper education general practitioners can identify patients with suicidal thoughts and successfully treat them.
Chapter 5. Developing suicide prevention strategies in family practice
4. Prevention
   1) Screening tools
   2) Prevention of first attempt
   3) Prevention of future attempt
   4) Long term management and compliance
   5) Family interaction and postvention
   6) Dealing with legality in suicide prevention
   7) Developing suicide prevention strategies
Evidence of successful prevention
Educational Intervention increases identification

- Study: 0%
- Control: 90%

Suicide rate decrease

Increase by 0.9
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).
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

- Present (out of 405 subjects): 22%
- Not detected by GPs: 48%
Depression: identification and treatment in family practice

- 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

GP diagnosed depression:

- Mild: 31%
- Moderate: 50%
- Severe: 19%

Depression among suicidal patients:

- Reviewed prescription of Antidepressants: 43%

Other psychotropics:

- Other psychotropics: 29%

Non Pharmacological threatments:

- Non Pharmacological threatments: 36%

Referrals:

- Referrals: 25%
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.

Suicide rate decrease by 34% after education and training.
The chart shows the percentage decrease in suicide rates compared to a control group. The suicide rate decrease in the study group is 34%, while the control group shows an increase by 90%.
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
Suicide rate in early phase of illness: Psychosis

- Prodromal:
  - Attempted: 8
  - Completed: 5

- Early psychosis:
  - Attempted: 18
  - Completed: 11
Reduction in suicide rate after education: Early intervention program. 2 years follow up

![Graph showing reduction in suicide rate before and after education. Before education: 59.9, After education: 49.9, Reduced by years rate: 5.](image-url)
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**

<table>
<thead>
<tr>
<th></th>
<th>Community with EI</th>
<th>Community without EI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicidal rates</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Previous attempt</td>
<td>16%</td>
<td>5%</td>
</tr>
<tr>
<td>Decrease over</td>
<td></td>
<td></td>
</tr>
<tr>
<td>first clinical</td>
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<tr>
<td>contact</td>
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<tr>
<td>Similar</td>
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<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>
4. Efficacy of empowerment

5. Brief psychotherapeutic programs

6. Involvement in national programs

- Community initiatives
Educational awareness

1. 60% of physicians were unaware of previous suicidal behaviour 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.
Public health and Prevention  
risk management and early intervention

Involving family physicians in national suicide prevention programs have been encouraging
Evidence and experience for change in practice

10. Close-networking with non-psychiatric physicians
11. Peer-review of resistant cases
12. Follow up treatment in primary care (mandatory)
13. Clinical data-base
14. Treatments (all are equally effective)
15. Side-effect checklist
16. Inpatient facility for challenging behaviour
17. Zero tolerance for noncompliance
18. Appropriate use of MHA
19. Periodic review for implementation of policy
Suicide index reduction in Slovenia: the impact of primary care provision: Reduced Suicide index in Slovenia 1998–2008

Beškovnik L, Jurčič NK, Svab V.
Training program: WPA program in Chile

- measured changes in knowledge, attitudes and practice.
- 37 primary care physicians
- 2589 patients participated.
- it had some limited impact on actual clinical practice,
- post-training agreement between physician diagnosis and patient self-report remained low.
- increased use of antidepressant agents.
- but their competence to play a crucial role remains limited
Evidence and experience for change in practice

1. Community development and awareness drive linked to services
2. Networking with agencies
3. Program-based intervention
4. Early intervention across diagnosis
5. Qualitative and quantitative risk assessment (clinical situations)
6. ‘Standard of care’
7. Supervised continuity of care
8. Specialised service for extremely high risk patients
9. Suicide registry

Mandatory educational drive for professionals
Screening

- 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?”

1) Prevention of first attempt

Effective questions

“In past month have you been feeling depressed”

“In past one month have you felt loss of pleasure?”
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.
1. These tools have been developed by WHO, tested in a number of countries and have a high validity, sensitivity and specificity.

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

3. These tools are easy to administer and can provide important information about identification of suicidal client.
Screening for Suicide and depression

Simple and easy methods

Standard questionnaires take long and have limited utility.

Brief questionnaires developed and found effective
Qualities for questioners

Specificity
Sensitivity
Easy to Administer
Can be used in a busy practice
Identification Scales for Suicide

- Most common - Beck Suicide Ideation Scale
- Some other scales for identification of depression also detect suicidality
Beck Suicide Inventory

Of all questions, 2 are the most effective:

- “This past week, have you had any thoughts that life is not worth living?”
- “What about thinking you’d better be dead?”

A New Brief Scale to Assess Suicidality: Scale for Impact of Suicidality-Management, Assessment and Planning of Care - Brief Screener (SIS-MAP-Brief Screener)

Amresh Srivastava MD MRCPsych, FRCP, Megan Johnston PhD, Miky Kausal MD, Robbie Campbell MD FRCPc, Charles Nelson PhD, Regional Mental Health Care St. Thomas & London, London Ontario, Canada

Part A: Construction of the Scale: Objective and Background

A Hypothetical Sketch

1. Concept of Risk: We believe Risk is a Multi-dimensional Construct consisting of 8 Domains.
   - 1. Mechanism of interaction between Risk and Protective factors, its constituents and constructs are not known.
   - 3. Furthermore, a shorter version of tools are required for emergency room and primary care.
   - 4. Primary objective of this study is to create a brief & valid instrument for decision making in a short period of time.

We further believe that 'Absolute' Risk appears when an individual's resilience is compromised by various risk factors, making an individual more vulnerable.

5. Risk of Suicide is a clinical entity which is multidimensional in origin.
6. We examine the merits of a 24-item scale: SIS-MAP Brief Screener developed from the original 108-item scale.

The measurement is called RISK INDEX, which was defined after deducting score of protective factors from total score, used for assessment and prediction of risk. State and Trait Risk interesting in a complex manner.

A 5 Top Five Most Prominent Responses

1. Do you ever feel like there is no reason to go on living?
2. Have you often thought about hurting yourself or doing harm to yourself but haven't tried much?
3. Do you often feel sad or blue?
4. Do you often feel your life is empty or meaningless?
5. Do you often feel like you would feel better if you were dead?

A 3 DIS-MAP Items Most Prominent Responses

16. Is your family and friends of your problem and/ or satisfying moments?

Conclusions

1. SIS-MAP-Brief Screener appears to be a clinically useful tool for assessment of suicide behaviour for deciding planning for care.
2. Most frequent responses, significant risk factors and score on Risk Index together can give better idea about risk for suicide, when assessment in required to be completed in a short time period.
3. A Score of Risk Index of 9 and more suggests a need for hospitalization. A score of 7 and 8 indicates need of caution in clinical judgement.
4. Future research in this area may find more precise pathways for decision making in management of suicide.

Contact: dr.amresh@gmail.com

Part B: Examining Clinical Merits of the Scale: Risk Index

A.4. Common Risk FACTORS identified from the scale:

| Severity of suicide risk was positively correlated with Risk Factors like: |
|--------------------------|--------------------------|
| 1. Low level of resilience (CD-RISC Scale) | n=44, r=0.265, p=0.082 |
| 2. Duration of illness | n=3.071, p=0.042 |
| 3. History of Depressive Symptoms | n=0.62, p=0.001 |
| 4. Severity of Psychotic Symptoms | n=0.413, p=0.041 |
| 5. Problem with Friends or neighbor or relatives | n=7.931, p=0.008 |

A.1. Discrimant function analysis to predict inpatient/outpatient status from SIS-MAP-108 scores

A.2. Validity

A.3. SIS-MAP, mean value of subdomains

A.2.1. Domain Analysis

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Conclusion

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A New Brief Scale to Assess Suicidality: Scale for Impact of Suicidality-Management, Assessment and Planning of Care Brief Screener (SIS-MAP-Brief Screener)

Amresh Srivastava MD MRCPsych, FRCPC, & Charles Nelson, Ph.D
On a day-to-day basis, use of the two PRIME-MD screening questions followed by either the rest of the clinician-administered PRIME-MD or

Two quick questions from Primary Care Evaluation of Mental Disorders can provide us with a highly sensitive (94%) but not very specific (35%) screening test for depression

1. “Have you been bothered by little interest or pleasure in doing things?”
2. “Have you been feeling down, depressed, or hopeless in the last month?”
PRIME-MD

If a patient responds positively to the two questions, only four follow-up questions are needed to confirm a diagnosis of depression. These will be on the topic of:

- sleep disturbance,
- appetite change,
- low self-esteem, and
- anhedonia
Scales for detection of depression

General health questionnaire – GHQ 12

INTERNATIONAL CLASSIFICATION OF DISEASES-PRIMARY Care – ICD 10- PC

Hamilton Depression Scale Items - HDRS

MADRS (Montgomery-Asberg Depression Rating Scale)
GHQ-12

• 12 items
• 1960
• all 12 questions useful, however a physician can ask only the most sensitive ones
GHQ-12

“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?”
ICD-10 PC: Questionnaire for

Depressive Disorder

During the last month have you had any of the following complaints most of the time for at least two weeks. If you, please check or mark the relevant box.

1. Have you been feeling sad, blue or depressed? □
2. Have you lost interest or pleasure in things that you enjoyed previously? □
3. Have you been feeling your energy decreased and/or you are tired all the time? □

If YES to any of the above, continue below

1. Have you been experiencing any problems falling asleep or waking up much earlier than before? □
2. Have you lost your appetite or have you been eating much more than usual? □
3. Any difficulties concentrating; for example, listening to others, working, watching TV, listening to the radio? □
4. Have you noticed any slowing down in your thinking or moving around? □
5. Has your interest in sex decreased? □
6. Have you felt negative about yourself or lost confidence? □
7. Have you thought of death, wished that you were dead or tried to end your life? □
8. Do you often feel guilty? □

1. During the last month have you been limited in one or more of the following areas most of the time:
   - Self care: bathing, dressing, eating? □
   - Family relations: spouse, children, relatives? □
   - Going to work or school? □
   - Doing housework or household tasks? □
   - Social activities, seeing friends, hobbies? □
   - Remembering things? □

II. Because of these problems doing the last month:

   How many days were you unable to fully carry out your usual daily activities?

   How many days did you spend in bed in order to rest?

   □ □
ICD-10 PC: Questionnaire for

Depressive Disorder

During the last month have you had any of the following complaints most of the time for at least two weeks. If yes, please check or mark the relevant box.

I. Have you been feeling sad, blue or depressed? □

II. Have you lost interest or pleasure in things that you enjoyed previously? □

III. Have you been feeling your energy decreased and/or you are tired all the time? □

If YES to any of the above, continue below

1. Have you been experiencing any problems falling asleep or waking up much earlier than before? □
I. Have you been feeling sad, blue or depressed?

II. Have you lost interest or pleasure in things that you enjoyed previously?

III. Have you been feeling your energy decreased and/or you are tired all the time?

If YES to any of the above, continue below

1. Have you been experiencing any problems falling asleep or waking up much earlier than before?
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8. Do you often feel guilty?

I. During the last month have you been limited in one or more of the following areas most of the time:
ICD 10

If YES to any of the above, continue below

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2. Have you lost your appetite or have you been eating much more than usual?
3. Any difficulties concentrating; for example, listening to others, working, watching TV, listening to the radio?
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6. Have you felt negative about yourself or lost confidence?
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8. Do you often feel guilty?

I. During the last month have you been limited in one or more of the following areas most of the time:

- Self care: bathing, dressing, eating?
- Family relations: spouse, children, relatives?
- Going to work or school?
Other important clinical symptoms

Depression also presents with a number of somatic symptoms (e.g., headache, body ache, backache, pain in abdomen, etc), anxiety, sleep disturbances.

It is common in known psychiatric patients.

It co-exists with a large number of medical disorders.

High incidence of depression exists with chronic medical conditions and terminal illnesses.
High Risk Groups

- Recent suicide attempt
- History of past suicide attempt
- Alcohol and drug addiction
- A family history of mental disorder
- A family history of suicide
- Presence of psychiatric disorders
- Presence of depression
- Current severe stress
Suicide Assessment
Five stem evaluation test

RESOURCES
- Download this card and additional resources at http://www.sprc.org

ACKNOWLEDGMENTS
- Originally conceived by Douglas Jacobs, MD, and developed as a collaboration between Screening for Mental Health, Inc. and the Suicide Prevention Resource Center.
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National Suicide Prevention Lifeline
1-800-273-TALK (8255)

SAFETY

1 IDENTIFY RISK FACTORS
   Note those that can be modified to reduce risk

2 IDENTIFY PROTECTIVE FACTORS
   Note those that can be enhanced

3 CONDUCT SUICIDE INQUIRY
   Suicidal thoughts, plans, behavior, and intent

4 DETERMINE RISK LEVEL/INTERVENTION
   Determine risk. Choose appropriate intervention to address and reduce risk

5 DOCUMENT
   Assessment of risk, rationale, intervention, and follow-up

SAMHSA
Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
www.samar.gov
Suicide assessments should be conducted at first contact, with any subsequent suicidal behavior, increased ideation, or pertinent clinical change; for inpatients, prior to increasing privileges and at discharge.

1. RISK FACTORS
   - **Suicidal behavior**: history of prior suicide attempts, aborted suicide attempts, or self-injurious behavior
   - **Current/past psychiatric disorders**: especially mood disorders, psychotic disorders, alcohol/substance abuse, ADHD, TBI, PTSD, Cluster B personality disorders, conduct disorders (antisocial behavior, aggression, impulsivity)
   - **Co-morbidity and recent onset of illness increase risk**
   - **Key symptoms**: anhedonia, impulsivity, hopelessness, anxiety/panic, global insomnia, command hallucinations
   - **Family history**: of suicide attempts or current psychiatric disorder requiring hospitalization
   - **Precipitants/Stressors/Interpersonal**: triggering events leading to humiliation, shame, or despair (e.g., loss of relationship, financial or health status—real or anticipated). Ongoing medical illness (e.g., CNS disorders, pain). Intoxication. Family turmoil/chaos. History of physical or sexual abuse. Social isolation
   - **Change in treatment**: discharge from psychiatric hospital, provider or treatment change
   - **Access to firearms**

2. PROTECTIVE FACTORS
   - **Internal**: ability to cope with stress, religious beliefs, frustration tolerance
   - **External**: responsibility to children or beloved pets, positive therapeutic relationships, social support

3. SUICIDE INQUIRY
   - **Specific questioning about thoughts, plans, behaviors, intent**
     - **Ideation**: frequency, intensity, duration—in last 48 hours, past month, and worst ever
     - **Plan**: timing, location, lethality, availability, preparatory acts
     - **Behaviors**: past attempts, aborted attempts, rehearsals (tying noose, loading gun) vs. non-suicidal self-injurious actions
     - **Intent**: extent to which the patient (1) expects to carry out the plan or (2) believes the plan/act to be lethal vs. self-injurious. Explore ambivalence: reasons to die vs. reasons to live
     - *For Youth*: ask parents/guardian about evidence of suicidal thoughts, plans, or behaviors, and changes in mood, behaviors, or disposition
     - *Homicide Inquiries*: when indicated, esp. in character disordered or paranoid males dealing with loss or humiliation. Inquire in four areas listed above

4. RISK LEVEL/INTERVENTION
   - **Assessment of risk level is based on clinical judgment, after completing steps 1–3**
   - **Reassess as patient or environmental circumstances change**

<table>
<thead>
<tr>
<th>RISK LEVEL</th>
<th>RISK/PROTECTIVE FACTOR</th>
<th>SUICIDALITY</th>
<th>POSSIBLE INTERVENTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>High</strong></td>
<td>Psychiatric diagnoses with severe symptoms or acute precipitating event; protective factors not relevant</td>
<td>Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal</td>
<td>Admission generally indicated unless a significant change reduces risk. Suicide precautions</td>
</tr>
<tr>
<td><strong>Moderate</strong></td>
<td>Multiple risk factors, few protective factors</td>
<td>Suicidal ideation with plan, but no intent or behavior</td>
<td>Admission may be necessary depending on risk factors. Develop crisis plan. Give emergency/crisis numbers</td>
</tr>
<tr>
<td><strong>Low</strong></td>
<td>Modifiable risk factors, strong protective factors</td>
<td>Thoughts of death, no plan, intent, or behavior</td>
<td>Outpatient referral, symptom reduction. Give emergency/crisis numbers</td>
</tr>
</tbody>
</table>

5. DOCUMENT: Risk level and rationale; treatment plan to address/reduce current risk (e.g., medication, setting, psychotherapy, E.C.T., contact with significant others, consultation, firearms instructions, if relevant; follow-up plan. For youths, treatment plan should include roles for parent/guardian.

US department of health and human services
Prevention of first attempt
Prevention of first attempt
Prevention of repeated attempt
Long term management
Short term management
Family interaction
Postvention
Dealing with legality
Suicide prevention strategies
Conclusion

- Patients with suicidal thoughts and behaviour 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 behaviour is essential, while being sensitive to agitated states and aggressively treating them may resolve a psychiatric emergency.
Developing suicide prevention strategy for suicide prevention in PCP
5. Chapter 5. Developing suicide prevention strategies in family practice
5. Chapter 6. Workshop and case-based learning for identification

6. Chapter 7. Workshop and case-based learning for intervention techniques

7. Chapter 8. Q & A