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71 – Discussing Suicidal Thoughts in Primary Care

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Introduction

Since 2008, suicide rates have been rising. The rise is mainly explained by the economic crisis (6) . Suicidal behaviour is the end result of the complex interaction between vulnerability, stressors and the feeling of entrapment (5) . Due to the crisis, more people are feeling entrapped. They lost their job, have financial problems, and have become more hopeless of the future. Especially middle aged males have been vulnerable to experiences of loss.

Role of the GP in suicide prevention

Primary care plays an important role in the field of suicide prevention (1) . In many countries, the general practitioner (GP) is the first accessible contact for patients with mental health problems, making GPs important gatekeepers to identify suicidal ideation at an early stage. Early identification and adequate response of suicidal thoughts within general practice can prevent the patient from deterioration in the suicidal process, and prevent the transition from suicidal thoughts to suicidal action.

Difficulty in discussing suicidal behaviour

This is however more easily said than done. Almost half of the suicidal patients had been in contact with their GP in the 30-days period before the suicidal event (2) . However, only in one out of every 4 cases of these patients, did GPs identify suicidal ideation as an important concern during the last visit. In many other cases the suicidal event has come as a surprise. This may be related to the unwillingness of suicidal patients to reveal their suicidal thoughts and plans, or that perhaps at that moment the patient did not have suicidal ideation at all, but developed suicidal plans days and weeks after the last visit. It might also point towards the difficulty GPs face in responding to depressed patients when suicidal ideation is not overtly presented.

Asking about suicidal thoughts

Both patients and health professionals have difficulty to discuss suicidal behaviour. Patients can be ashamed, or had previous negative experiences in talking about their suicidal thoughts. Health professionals are often not trained to discuss suicidal thoughts, and might be worried that the patient becomes more suicidal. One way to facilitate the discussion of suicidal behaviour is to use a screener or psychological symptom inventory, such as the 4 dimensional symptoms scale (4DSQ), (7), or the symptom check List (SCL-90, (3) . The scales can be used as a good introduction to

discuss suicidal behaviour. One can simply state:

"Some patients who show similar scores on distress do not want to continue living. Do you sometimes have these thoughts?"

Risk assessment

Importantly, a GP should know how to assess the severity of the suicidal behavior. An easy but workable rule is that the more concrete the planning, the more likely future suicidal behaviour is. We provide an example of staging suicidal behaviour from the Dutch Guideline of Suicidal Behaviour that can be used as a rule of thumb (8) .

Table 1: staging of suicidal behaviour

Light	The patients only has short and infrequent thoughts that he does not want to continue living. He does not constantly ruminate about it, and does not expect to do an attempt. He has made no plans.
Ambivalent	The patients wants to both continue living and dying. Suicidal behaviour is rather impulsive, and waxes and wanes over time
Serious	The patients continuously has suicidal thoughts, and images about suicidal behaviour. The patient has considered different methods, and is afraid of his own impulsivity
Very serious	The patient can only think about suicide, and is very desperate. The patient does not sleep well, has no control over himself. He does not want to live anymore, and can any moment commit suicide

Continuity of care

It is important to know what to do after assessing the risk. If a patient gets referred to more specialized care, it is important the GP checks if the patient has arrived, and received appropriate care. Also, the GP should think about organizing care after a suicidal patient has finished treatment in specialized care and returns to the community. Especially the first month after treatment has been found to be a period of high risk for (repeat) suicidal behaviour (8) .

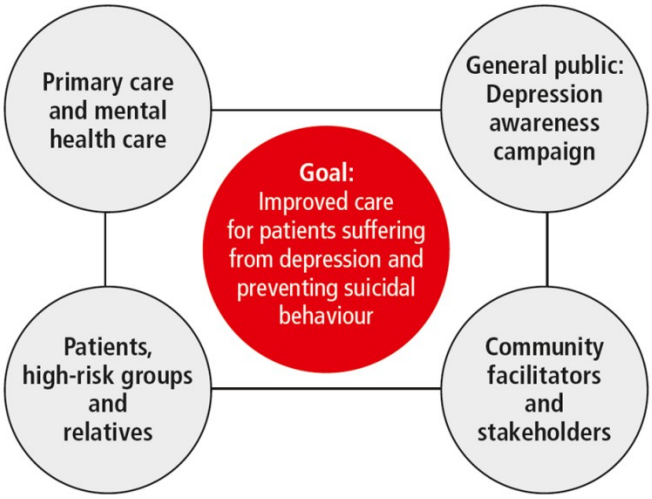
Training

There is evidence that the training of GPs or other mental health professionals to better recognize depression and assess suicide risk, may result in less suicidal behaviour (4) . As suicide is recognized to be a multifaceted problem, there has been interest in a specific 4 level-approach called the European Alliance Against Depression (EAAD, www.eaad.net). EAAD aims to improve care for depression and suicidal patients by 1) training professionals in primary care settings, 2) organizing local media campaigns to increase the awareness of depression and suicide, 3) targeting high risk people in the community, and 4) training local gatekeepers such as police men (Figure one).

Within EAAD, the training of GPs (and primary care mental health nurses or psychologists), consists of educational workshops on how to recognize and treat depression and explore suicidal tendency in a primary care setting. In Germany, EAAD resulted in a sustainable decline in suicidal behaviour of 32.4% in the three years after the start of the intervention (4) .

By targeting specific high risk groups in a community, such as unemployed middle aged men, EAAD aims to refer more high risk persons to the general practice. EAAD has been implemented in various countries such as Portugal, Hungary, Ireland and Australia. New countries are welcomed to join the initiative via http://www.eaad.net/mainmenu/members/become-a-member/.

Figure 1: the four level approach of the European Alliance Against Depression



In September 2016, a comparable intervention is being implemented in the Netherlands. The Dutch program, called SUPRANET community specifically focuses on the improvement of depression recognition and prevention of suicidal behaviour within primary care, as primary care has been given a central position in mental health care in the Netherlands since 2014.

Take Home Message

- Primary care plays an important role in suicide prevention
- Screeners for psychological symptoms to help discussing suicidal behaviour
- Continuity of care is an important aspect of suicide prevention
- Training in discussing suicidal thoughts can improve care

Original Abstract

http://www.woncaeurope.org/content/1289-suicide-risk-evaluation-primary-care-%E2%80%93-revision

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