

MaineHealth

Learning Community

Assessing and Responding to Suicide Risk in Adults with Depression: A Guide for Primary Care

Neil Korsen, MD MS
Mary Jean Mork, LCSW

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Depression is the most common risk factor for suicide. Studies show that almost half of patients who commit suicide have seen or contacted their primary care physician in the month before their attempt.[1] It is important to assess suicide risk as you screen and diagnose patients with depression.

A 2005 paper in the *Annals of Family Medicine*, using data from the MacArthur Foundation funded RESPECT-Depression study, provides useful information about a primary care population with depression and their risk of suicide over 6 months after diagnosis with major depression, chronic depression or both.[2] This study of over 400 patients included more than 100 patients from MaineHealth practices.

Most patients (63%) had no risk of suicide. Twenty-six percent (26%) of patients were classified as low risk and reported only passive thoughts of suicide. Ten percent (10%) were classified as intermediate risk and had active thoughts of ending their lives, but no intent. One percent (1%) of patients was classified as high risk. They had active thoughts of suicide, means and present intent. This group was excluded from the study and referred for urgent mental health assessment.

The study also demonstrated that patients at no risk or low risk of suicide at diagnosis rarely increase their level of suicidal thinking over time. Only 1% of those patients at no or low risk were at intermediate risk at 3 months follow up. Only 2.6% were at intermediate risk at 6 months follow up. On the other hand, most patients at intermediate risk at baseline reduced to no or low risk – 76% at 3 months and 80% at 6 months. Only one patient out of the 405 included in the study attempted suicide during 6 months of follow up. That patient was classified as intermediate risk at baseline.

You can screen for suicide risk in your patients with depression using a relatively simple algorithm (Figure 1). The process begins with Question #9 of the PHQ-9, which asks “Over the last 2 weeks, how often have you been bothered by ... thoughts that you would be better off dead or of hurting yourself in some way?” If the answer is none, then there is no risk and the patient will be reassessed periodically, when he/she completes a PHQ-9.

Low Risk For those who say “yes” to Question #9, even answering ‘several days’, further assessment should take place. Determine whether the thoughts are passive (“I hope I don’t wake up” or “I wonder what it would be like if I were dead”) or active (“Today I thought about jumping off the bridge as I

walked here”). If the thoughts are passive and there are no additional risk factors, the patient is at low risk.

Intermediate Risk If the thoughts are active (i.e., there is a plan to take one’s life), but the patient does not have both the means and the intent to carry out the plan, they are classified as intermediate risk. That patient should be scheduled for a follow-up appointment, given the state-wide Crisis Number - included in the Crisis Pyramid (Figure 2), and encouraged to set up an appointment with a mental health specialist as soon as possible.

High Risk If there are active thoughts of suicide, and the patient has both the means and the intent to carry out that plan, the patient is at high risk. The patient should be referred for immediate assessment by a mental health specialist, local crisis program, or local emergency department.

Additional risk factors for suicide include: hopelessness, prior suicide attempts, social isolation/living alone, male and elderly, family history of completed suicides, significant comorbid anxiety or psychotic symptoms, active substance abuse, and access to firearms. Protective factors include: social/family support, pregnancy, parenthood, and religiosity. These factors should be considered when determining the overall level of suicide risk.

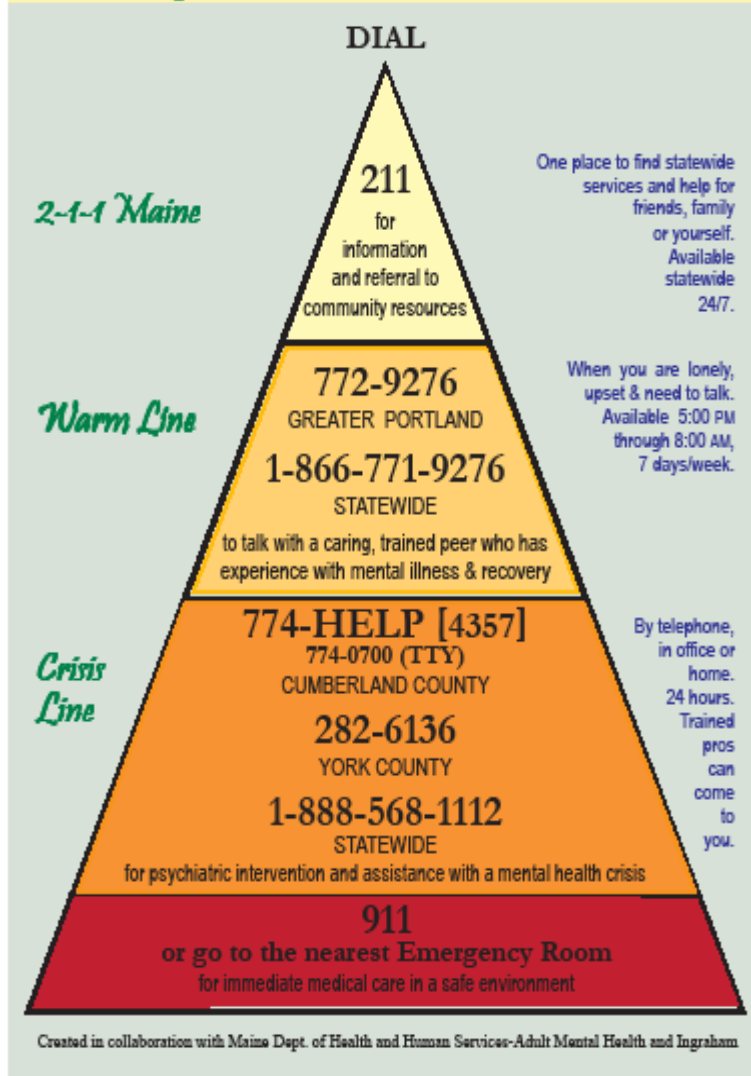
The data from the MacArthur study suggest that suicidality of intermediate or high risk won’t be seen often in a primary care practice. When it does, though, it is a life-threatening situation, no different from a patient having an acute MI. A simple algorithm can help a practice be prepared with a plan when an actively suicidal patient is identified. It is also useful to have a team response plan worked out for your practice, so that everyone knows what to do to keep the patient safe, and make the necessary link to crisis support services.

Figure 1

Suicide Risk Assessment	Risk Level	Action
No current thoughts of harming self and no other major risk factors	Low	Continue follow-up visits and counseling.
Current thoughts of harming or killing self, but lack either means or present intent. No previous attempts and/or other major risk factors.	Intermediate	Close follow-up, utilizing clinical visits. Refer to mental health specialist. Offer crisis information.
Current thoughts or attempts of harming or killing self, with means and intent to follow-through.	High	Refer for immediate assessment with mental health specialist, local crisis program, or local emergency department.

Figure 2

FINDING THE
Right MENTAL HEALTH RESOURCE
 BEGINS WITH DIALING THE
Right TELEPHONE NUMBER



1. Luoma, J.B.M., C.E.; Pearson, J.L. , *Contact with mental health and primary care providers before suicide: a review of the evidence*. American Journal of Psychiatry, 2002. **159**: p. 909-916.
2. Schulberg, H.C.L., P.W.; Bruce, M.L.; Raue, P.J.; Lefever, J.J.; Williams, J.W.; Dietrich, A.J.; Nutting, P.A., *Suicidal Ideation and Risk Levels Among Primary Care Patients with Uncomplicated Depression*. Annals of Family Medicine, 2005. **3**(6): p. 523-528.