Screening for Depression and Suicide

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Background

- My background
- A word about language
Today’s Topics

- Why screen for depression/suicide
- What is depression?
- Depression and Suicide: Prevalence, comorbidity, epidemiology
- Who should be screened?
Today’s Topics

- How to screen
- Treatment options
- Resources
- Conclusion and questions
Why Screen for Depression and Suicide?
Why Screen for Depression

- Two thirds of people who are clinically depressed do not seek treatment
- Clinical depression can complicate other medical issues
- May help resolve physical complaints with no known cause
- Depression can lead to more depression and to suicide
- Tracking depression severity and treatment response
- Depression screening has been recommended by the U.S. Preventive Services Task Force
What is Depression?
What is Depression: Clinical Definition

For a duration of two weeks or more, five or more of the following with at least one symptom being depressed mood or loss of interest/pleasure. Symptoms must cause significant distress or impairment.

1) Depressed mood
2) Decreased interest or pleasure in almost all activities
3) Weight loss or gain, decrease or increase in appetite
What is Depression: Clinical Definition

4) Insomnia or hypersomnia
5) Psychomotor agitation or retardation (observable by others)
6) Fatigue or loss of energy most days
7) Worthless or guilty feelings
8) Decreased ability to think (e.g. concentration problems)
9) Thoughts of death or suicide
What is Depression: Rule Outs

- Mixed bipolar episode
- Substance abuse
- Medical problems (e.g., hypothyroidism)
- Bereavement
Prevalence, Comorbidity, and Epidemiology
Prevalence of Depression

1-2% of children (occurs as early as preschool) and 3-8% of adolescents (Costello et al., 1996)

About 9.5 percent of the U.S. population age 18 and older in a given year has a mood disorder (Kessler et al., 2005).

Depression in primary care ranges from 4.8% to 8.6% (Olfson et al., 2000).
More than 30,000 people die by suicide each year in the U.S (Roy, 2000).

Up to 88% of patients who complete suicide had contact with their physician in the previous year. Up to 66% had contact within the month previous to their suicide (Luoma et al., 2002).

These same individuals see a mental health professional less than half as frequently in the year and month prior to their suicide (Luoma et al., 2002).
Comorbidity: Depression

Children

- Anxiety disorders (more common in girls)
- Conduct and substance abuse (more common in boys)
- ADHD
Comorbidity: Depression

**Adults**
- Anxiety disorders
- Medical illness (e.g., heart disease, diabetes, cancer)
- Substance abuse
- Negative life events
Comorbidity: Depression

Older Adults
-Dementia
-Medical illnesses
-Cognitive impairments: memory or executive functioning problems, sometimes called “pseudodementia”
Approximately 90% of people who commit suicide had a DSM-IV disorder. Of that 90%:
1. More than 50% of suicides are associated with a Major Depressive episode.
2. Twenty-five percent are associated with a substance abuse disorder.
3. Ten percent with a psychotic disorder such as Schizophrenia.

(Conwell, 1995; Roy, 2000; Lagomasino & Stern, 1998; Jamison, 2000)
Epidemiology of Depression and Suicide

Mental Health of America (2007)
Ranking America's Mental Health: An Analysis of Depression Across the States
Epidemiology of Depression and Suicide

- Distribution
- Risk and protective factors
- Course
Distribution of Depression and Suicide

- Both depression and suicide attempts are more common among females.
- Successful completion of suicide is higher in males.
- White males 85 and older have the highest rates of suicide.
Distribution of Suicide

High risk groups:
- Adolescents
- White males
- Elderly
- Native Americans and Alaska Natives
Risk Factors for Depression

- Negative life events
- History of depression
- Family history of depression
- Physical illness
Risk Factors for Suicide

- Mental illnesses
- History of suicide attempt/family history of suicide
- Comorbid substance abuse disorder
- History of deliberate self-harm (e.g., cutting)
- Impaired mental status
- Physical illness
- Triggering events
Protective Factors for Suicide

- Children in home
- Life satisfaction
- Positive coping skills
- Positive problem-solving skills
- Positive social support
- Positive therapeutic relationship
- Pregnancy
- Reality testing ability
- Religious faith
- Sense of responsibility to family
Course of Depression

- Childhood depression often persists, recurs and continues into adulthood, especially if it goes untreated.
- Higher risk of recurrence for earlier onset and comorbid cases
Course of Depression

- Depression is likely to worsen many medical problems.
- Suicide is a possible outcome.
Who Should be Screened?
Who Should Receive Depression Screening?

- *U.S. Preventive Services Task Force recommends routine depression screening for adults.*
- *Patients showing sign or symptoms of depression*
- *Patients with significant risk factors or from populations at risk*
Who Should Receive Suicide Screening?

- Routine suicide screening is not recommended by the U.S. Preventive Services Task Force for adults or children
- Screen depressed patients, patients with substance use/abuse issues
- When patient expresses suicidal ideation or family or friends express concerns about patient
- Consider screening individuals at risk (physically ill, triggering events, etc.).
How to Screen
How to Conduct Depression Screening: Children

- Use multiple sources aside from a clinical interview (parent, child, teachers, pediatric depression tool, medical records etc.)
- Rule outs (bipolar etc.)
- Use age appropriate language when asking diagnostic questions.
- Watch for diagnostic barriers due to stigma (e.g., children don’t get depressed) or parents feeling guilty/blamed.
Depression Screening Tools for Children

- Tools exist for ages 7 and up
- Some examples: Children’s Depression Inventory, Center for Epidemiological Studies Depression Scale for Children
- A complete review of screens can be found in the American Family Physician:

  Screening for Depression Across the Lifespan: A Review of Measures for Use in Primary Care Settings (Sharp & Lipsky, 2002)
How to Conduct Depression Screening: Adults/Older Adults

- Clinical interview including important rule outs
- Rule out dementia in older adults
- Stigma barrier
- Choose a screening method that best fits your practice.
Depression Screening Tools for Adults and Older Adults

-The Center for Epidemiological Studies Depression Scale

-Beck Depression Inventory

-PHQ-9
PHQ-9 Two Question Depression Screen

During the past month, have you been bothered by:

1) Little interest or pleasure in doing things?
2) Feeling down, depressed, or hopeless?
Suicide Screening: Risk Assessment

- Suicide screens exist, but few are both reliable and valid. Suicide screening lacks a clinical research base.
- No suicide screen has been studied in primary care.
Suicide Screening: Risk Assessment

- Warning signs
- Risk and protective factors
- Suicide inquiry
- Risk level assessment
- Documentation
American Association of Suicidology Warning Signs

- Dramatic mood changes
- Someone threatening to hurt or kill him/herself, or talking of wanting to hurt or kill him/herself
- Looking for ways to kill him/herself by seeking access to firearms, available pills, or other means
- Talking or writing about death, dying or suicide, when these actions are out of the ordinary for the person
Warning Signs

- Hopelessness
- Rage, uncontrolled anger, seeking revenge
- Acting reckless or engaging in risky activities, seemingly without thinking
- Feeling trapped - like there's no way out
- Withdrawing from friends, family and society
- Anxiety, agitation, unable to sleep or sleeping all the time
- Increased alcohol or drug use
Risk and Protective Factors

- Risk factors?
- Member of high-risk population?
- Do protective factors exist as well?
Suicide Inquiry

- Suicidal thoughts
- Planning
- Behaviors
- Intent
- Access to means
Sample Questions

- Other people with similar problems sometimes loose hope; have you?
- Do you ever consider running away from your problems?
- With this much stress, have you thought of hurting yourself?

(Stoval and Domino, 2003)
Risk Level and Related Interventions

- High
- Moderate
- Low
RESOURCES

- Download this card and additional resources at www.sprc.org or at www.stopasuicide.org
- SAFE-T drew upon the American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors www.psych.org/psych_pract/treatg/pg/SuicidalBehavior_05-15-06.pdf

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National Suicide Prevention Lifeline
1.800.273.TALK (8255)

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www.sprc.org www.mentalhealthscreening.org

SAFE-T

Suicide Assessment Five-step Evaluation and Triage

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

National Suicide Prevention Lifeline
1.800.273.TALK (8255)
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
   ✓ Current/past psychiatric diagnoses: especially mood disorders, psychotic disorders, alcohol/substance abuse, Cluster B personality disorders. Co-morbidity and recent onset of illness increase risk
   ✓ Key symptoms: anhedonia, impulsivity, hopelessness, anxiety/panic, global insomnia, command hallucinations
   ✓ Suicidal behavior: history of prior suicide attempts, aborted suicide attempts or self-injurious behavior
   ✓ Family history: of suicide, attempts or Axis I psychiatric diagnoses requiring hospitalization
   ✓ Precipitants/stressors: triggering events leading to humiliation, shame or despair (i.e., loss of relationship, financial or health status—real or anticipated). Ongoing medical illness (esp. CNS disorders, pain). History of abuse or neglect. Intoxication
   ✓ Access to firearms

2. PROTECTIVE FACTORS  Protective factors, even if present, may not counteract significant acute risk
   ✓ Internal: ability to cope with stress, religious beliefs, frustration tolerance, absence of psychosis
   ✓ External: responsibility to children or beloved pets, positive therapeutic relationships, social supports

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 and (2) believes the plan/act to be lethal vs. self-injurious; Explore ambivalence: reasons to die vs. reasons to live
   * Homicide Inquiry: when indicated, esp. postpartum, and in character disordered or paranoid males dealing with loss or humiliation. Inquire in all 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>High</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>Moderate</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>Low</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>

(This chart is intended to represent a range of risk levels and interventions, not actual determinations.)

5. DOCUMENT: Risk level and rationale; treatment plan to address/reduce current risk (i.e., medication, setting, E.C.T., contact with significant others, consultation); firearm instructions, if relevant; follow up plan
Document suicide risk assessment, plan, actions that occurred (e.g., met with family) and any consultation (e.g., with psychiatrist) thoroughly.
Documentation and Follow-up Care

- Monitor patient and assess for increased suicidality.
- Address concerns regarding side effects.
- If patient has been referred to a mental health provider, seek ongoing collaboration with that provider.
Treatment Options
Treatment Options for Depression

- In many cases psychotherapy and medication combined will be the most effective treatment for major depression.
- Cognitive Behavioral and Interpersonal psychotherapy are most effective for depression.
- Physician-therapist collaboration when possible
Other Treatment Options for Depression

- Exercise
- Behavioral activation
- Help patient rally social support
- Patient education on depression and depression treatment
Treatment Options: Suicidality

- **Always conduct a thorough risk assessment and respond appropriately to risk level.**
- Aggressive treatment of any underlying mental health or substance abuse disorder
- Assist patient and family in reducing risk factors (especially access to means) and increasing protective factors (e.g., social support).
Treatment Options: Suicidality

- Safety contracts
- Safety or crisis planning
Resources
Suicide Prevention Websites

- **The Suicide Prevention Resource Center**
  [www.sprc.org](http://www.sprc.org)

- **National Suicide Prevention Lifeline**
  [www.suicidepreventionlifeline.org](http://www.suicidepreventionlifeline.org)
Reports and Journal Articles

- Mental Health of America (2007) Ranking America's Mental Health: An Analysis of Depression Across the States

- American Family Physician:
  Screening for Depression Across the Lifespan: A Review of Measures for Use in Primary Care Settings (Sharp & Lipsky, 2002)
Books

- The Feeling Good Handbook
  - David Burns, M.D.

- Learned Optimism
  - Martin Seligman, Ph.D.

- Aging Well
  - George Vaillant, M.D.
Depression Screening Tools

*PHQ-9*

www.depression-primarycare.org
Suicide Screening Guidelines

- SAFE-T Pocket Card found at www.sprc.org
- American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors
National Suicide Prevention Lifeline

1-800-273-TALK

- Crisis intervention
- Local mental health referrals
Questions?