Suicide Assessment

STEP 1. Assess Suicidal Ideation

1. Are you discouraged about your medical condition (or social situation, etc.)?
2. Are there times when you think about your situation and feel like crying?
3. During those times, what sorts of thoughts go through your head?
4. Have you ever felt that it would not be worth living if the situation did not change (i.e., have you thought about ending your life)? If so, how often do you have such thoughts?
5. Have you devised a specific plan to end your life? If so, what is your plan?
6. (If the answer is yes to question #5) Do you have the necessary items to complete that plan readily available?
7. Have you ever acted on any plans to end your life in the past (i.e., have you ever attempted suicide)?
8. (If the answer is yes to question #7) When did this occur? How many times has it occurred in the past? By what means? What was the outcome?

STEP 2. Assess Risk Factors

- Family history of suicidal behavior
- Substance use/dependence
- Presence of psychiatric illness
- Serious medical illness
- Means for suicide completion readily available
- Psychological/Guidance (recent separation, divorce, job loss, retirement, bereavement, living alone)
- History of previous suicide attempts
- Impulsivity or history of poor adaptation to life stress
- Male
- Elderly (age 65 and above)
- Caucasian

STEP 3. Respond to Suicide Risk

Immediate Risk

Suspect if ANY of the following are present:
- Patient endorses suicidal intent
- Organized plan is presented
- Lethal means are available
- Signs of psychosis are present
- Extreme pessimism is expressed

Immediate action is required: hospitalize or commit. DO NOT leave patient alone.

Short-Term Risk

Suspect if several risk factors but no suicidal behaviors are present:
- With patient’s permission, involve family or close friend
- Initiate steps to remove potentially lethal means
- Develop safety plan with patient and family, including suicide hotline and ER contact number
- Maintain contact with patient and frequently reevaluate risk
- Treat psychiatric conditions, including substance abuse
- Consider hospitalization as appropriate

Long-Term Risk

The goal is to eliminate or improve modifiable suicide risk factors.
- Treat psychiatric conditions, including substance abuse
- Maintain contact with patient and frequently reevaluate risk
- Consider all management suggestions on this card

For more information, please visit: https://www.ptsd.va.gov/about PTSD.aspx

Suicide Assessment, Cont.

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VA/DoD Essentials for Depression Screening and Assessment in Primary Care

KEY ELEMENTS OF MDD CPG

Depression is common, under-diagnosed, and undertreated.

SCREENING: PHQ-2 and PHQ-9

Routine screening for depressive disorders is an important mechanism for reducing morbidity and mortality.

SUICIDE ASSESSMENT

Did you know...

Suicide is the leading cause of violent death in the United States.
As many as two-thirds of patients who commit suicide visit their physician within one month of their death.

1. Depression is common, under-diagnosed, and undertreated.
2. Depression is frequently a recurrent/chronic disorder, with a 50% recurrence rate after the first episode, 70% after the second, and 90% after the third.
3. Most depressed patients will receive most or all of their care through primary care physicians.
4. Depressed patients frequently present with somatic complaints to their primary care doctor rather than complaining of a depressed mood.
5. Annual screening for Major Depressive Disorder (MDD) is recommended in the primary care setting as an important mechanism for reducing morbidity and mortality. Screening should be done using a standardized tool such as the Patient Health Questionnaire (PHQ-9), a two-item screen.
6. A standardized assessment tool such as the PHQ-9 should be used as an aid for diagnosis, to measure symptom severity, and to assess treatment response.
7. Mild depression can be effectively treated with either medication or psychotherapy. Moderate to severe depression may require an approach that combines medication and psychotherapy.
8. Selective Serotonin Reuptake Inhibitors (SSRIs) along with the Serotonin Neuropeptide Reuptake Inhibitors (SNRIs), imipramine, or mirtazapine are considered a first-line treatment option for adults with MDD.
9. No particular antidepressant agent is superior to another in efficacy or response time. Choice can be guided by matching patients’ symptoms to side effect profile, presence of medical and psychiatric comorbidity, and prior response.
10. Patients treated with antidepressants should be closely observed for possible worsening of depression or suicidality, especially at the beginning of therapy or when the dose is increased or decreased.
11. Evidence-based, short-term psychotherapies, such as Cognitive Behavioral Therapy (CBT), Interpersonal Therapy (IPT), and Problem-Solving Therapy (PST), are recommended treatment options for major depression. Other psychotherapies are treatment options for specific populations or are based on patient preference.
12. Patients in early treatment require frequent visits to assess response to interventions, suicidal ideation, side effects, and psychosocial support systems.
13. Continuation therapy (nine to 12 months after acute symptoms resolve) decreases the incidence of relapse of major depression.
14. Long-term maintenance or lifetime drug therapy should be considered for selected patients based on their history of relapse and other clinical factors.
The PHQ tools are reliable, valid, and efficacious clinical tools for primary care settings.

The PHQ-2 is effective for identifying patients with depression and can also be used to measure treatment outcomes.

The PHQ-9 is effective for assessing the presence and severity of depression.

Advantages of the Patient Health Questionnaire

- It is shorter than other depression rating scales
- Can be administered in person, by telephone, or self-administered
- Adequate in assessment of major depression and symptom severity
- Well validated and documented in a variety of populations, including the geriatric population.

Detecting Depression Within a Primary Care Setting

Although many patients with depression receive care exclusively within a primary care setting, up to half of depression cases in these settings go unrecognized. The PHQ-2 may be a simple, valid, and brief screening tool.

Screening and Assessment Measures for Depression

A number of self-administered questionnaires are available to assist primary care physicians in the assessment, diagnosis, and ongoing management of depression in adults. Both the Patient Health Questionnaire-2 (PHQ-2) and the Patient Health Questionnaire-9 (PHQ-9) are reliable and valid measures of detecting depression and identifying the level of severity.

Overview of the PHQ-2

The PHQ-2 is a two-item self-report instrument for assessing the presence and severity of depression in adults. It is designed to screen for depression in a “first step” approach. The PHQ-2 includes the first two items of the PHQ-9, which screens for and diagnoses depression based on the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) criteria.

Interpreting the PHQ-2 and PHQ-9

Research has shown that certain scores on the PHQ-2 are strongly correlated with a subsequent major depressive diagnosis. However, not everyone with an elevated PHQ-2 is certain to have major depression. The PHQ-9 is intended as a tool to assist clinicians in identifying and measuring depression but is not a substitute for diagnosis by a trained clinician.

A positive response to the screen does not necessarily indicate that a patient has depression. However, a positive response does indicate that a patient may have symptoms of possible depression and that further investigation of symptoms by a mental health professional may be warranted. Those screening positive for moderate, moderate severe, or severe depression should be further evaluated and assessed for the presence of depression. Moreover, patients that have a positive response to question 4 should be further assessed for suicidal ideations and/or suicide plans. This strategy increases a provider’s ability to detect depression and to initiate appropriate referral and treatment. Proper triage should occur within 24 hours of the screen indicating of possible depression.

Monitoring Depression with the PHQ

The PHQ-9 can be used to monitor the severity of depressive symptoms and to assess response to treatment. PHQ-9 scores of 5 points or higher reliably indicate mild depressive symptoms. Scores of 15 points or higher reliably indicate moderate to severe impairment from depression.

Recommendations for Using the Patient Health Questionnaire

- The PHQ-2 should be completed annually on all patients seen in primary care settings.
- Patients who screen positive on the PHQ-2 should have both a documented assessment using a quantitative questionnaire to further assess whether the patient has sufficient symptoms to warrant a diagnosis of clinical major depression and a full clinical interview that includes evaluation for suicide risk.
- Patients with certain medical illnesses (e.g., Hepatitis C starting interferon treatment or post-myocardial infarction), may be at higher risk for developing depression and should be given a diagnostic assessment tool such as the PHQ-2 when depression is suspected.
- Caution should be used in screening patients older than 75 years because screening instruments may not perform as well as in patients 65 to 75 years old.

Screening: Patient Health Questionnaire (PHQ)