

CHAPTER 62

Treatment of attempted suicide and suicidal patients in primary care

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Abstract

Although suicidal behaviour is a rare event in society in general, it is very common among psychiatric patients who contact their general practioner (GP) before the suicide event. The most common current psychiatric diagnosis among suicide victims and attempters is major depressive episode (56-87 per cent). The current prevalence of major depressive episodes in GP practice is around 10 per cent but at least half of these cases are not recognized and treated adequately by GPs. Successful acute and long-term treatment of depression significantly reduce the risk of suicidal behaviour. Given that more than half of all suicide victims contact their GPs within four weeks before their death, GPs play an important role in suicide prevention. Several large-scale community studies demonstrate that education of GPs on the diagnosis and appropriate pharmacotherapy of depression, particularly in combination with psychological interventions and public education, improve the identification and treatment of depression and reduces the frequency of suicidal behaviour in the areas served by trained GPs.

Introduction

Suicide, an 'unnecessary death', the expression coined by Wasserman (Wasserman 2001), is among the most tragic events in human life, causing serious distress among relatives and friends as well as imposing a great economic burden on society as a whole. Although suicide attempts, and particularly completed suicides are relatively rare events in the community, in many countries they exceed the number of traffic accidents. About 10-18 per cent of adults across diverse regions of the world, including western and central Europe, North America and the Far East, report lifetime suicidal ideation and 3-5 per cent have made at least one suicide attempt at some point in their life (Kessler et al. 1999; Weissman et al. 1999; Szádóczky et al. 2000; Bertolote et al. 2005). Suicidal ideation, suicide attempt and completed suicide are three different, but greatly overlapping features. Previous suicide attempt and current major depression are the two best predictors of future suicide, and the vast majority of suicide attempters/completers come from a population of people with current suicidal ideation, particularly in the presence of untreated major depression (Kessler *et al.* 1999; Rihmer *et al.* 2002; Goldney *et al.* 2003). More than one-third of suicide victims have at least one previous suicide attempt, and the first suicide attempt (even if the method used is non-violent or non-lethal) significantly increases the risk of completed suicide during the next 10–15 years (Isometsa and Lönnqvist 1998; Hawton and van Heeringen 2000; Wasserman 2001; Suokas *et al.* 2001; Rihmer *et al.* 2002; Suominen *et al.* 2004). This is partly due to the fact that repeating suicide attempters frequently switch their method from non-violent to violent or from non-lethal to lethal methods (Rihmer *et al.* 1995; Isometsa and Lönnqvist 1998).

Suicide attempts are common among psychiatric patients who contact different levels of health care, particularly a few weeks or months before the suicide or suicide attempt (Isometsa et al. 1994a, 1995; Michel et al. 1997; Pirkis and Burgess 1998; Andersen et al. 2000; Rihmer et al. 2002; Fekete et al. 2004; Qin and Nordentoft 2005). In spite of the fact that suicidal behaviour is a relatively rare event in the primary care practice, but considering that depression is very common among completed suicides, depression and suicidality should be taken very seriously by general practitioners. In a given region, where the suicide rate is 20/100,000, a GP with a list of 2000 patients would be likely to have one completed suicide in every 2-3 years, but the yearly number of people with suicide attempts, current suicidal ideation and with current major depression would be 4-8, 40-50, and 160-200 respectively (Lecrubier 1998; Gunnel et al. 2004; Berardi et al. 2005; Rihmer and Angst 2005a, b).

Suicide risk and protective factors, detectable in primary care

Suicidal behaviour is neither a normal response to the levels of stress experienced by most people, or a standard consequence of major mental disorders. Suicide is a very complex, multicausal human behaviour with several biological as well as psychosocial, existential and cultural components. It is also associated with a number of psychiatric–medical (e.g, major mental) disorders, psychosocial (e.g, adverse) life situations, and demographic (e.g, gender, age)







Table 62.1 Lifetime and current suicide risk factors

Lifetime risk factors	Current acute risk factors
History of:	Current
Depressive/bipolar disorder	Major (severe) depression:
Substance use disorders	◆ agitation/anxiety/insomnia
Schizophrenia	◆ hopelessness
Anxiety disorders	 comorbid anxiety/substance use and severe medical disorders
Prior suicide attempt	◆ hospital discharge
Family history of suicide	◆ suicide thoughts
Childhood negative life events	◆ psychosocial stressors
Isolation/living alone	(loss-events, financial disaster)
Unemployment	
Male gender, old age	◆ spring/early summer

suicide risk factors of varying prognostic utility (Rihmer et al. 2002). Although the statistical relationship between the different psychosocial and demographic risk factors and suicidal behaviour is well documented, they have limited value in predicting suicide in individual cases. However, since suicide and attempted suicide is very rare in the absence of current major psychiatric disorders. psychiatric-medical suicide risk factors, particularly current major depression with a prior suicide attempt are the most powerful and clinically useful predictors of suicidal behaviour, especially in the presence of psychosocial and demographic risk factors (Beautrais et al. 1996; Shah and De; 1998; Wasserman et al. 1998; Hawton and van Heeringen 2000; Wasserman 2001; Rihmer et al. 2002; Balázs et al. 2003; Goldney et al. 2003; Tylee and Rihmer 2004; Rihmer 2005). The classification of suicide risk factors in terms of their duration are shown in Table 62.1. Lifetime (permanent) suicide risk factors result in high-risk groups, while current (acute) suicide risk factors create high-risk situations (Wasserman 2001; Rihmer et al. 2002; Tylee and Rihmer 2004), and when a high-risk period occurs in a high-risk person, the chance of suicide increases markedly.

Notwithstanding the fact that more than two-thirds of suicide victims and attempters have current major depression (Beautrais et al. 1996; Wasserman 2001; Hawton and van Heeringen 2000; Rihmer et al. 2002; Balázs et al. 2003) and up to 66 per cent of them contact their GPs within four weeks before the suicidal act (Rihmer et al. 1990; Pirkis and Burgess 1998; Andersen et al. 2000; Luoma et al. 2002; Balázs et al. 2003; Fekete et al. 2004) the rate of pharmacotherapy with antidepressants and/or mood stabilizers in depressed suicidal patients is less than 20 per cent and thus disturbingly low (Rihmer et al. 1990; Marzuk et al. 1996,; Oquendo et al. 1999; Henriksson et al. 2001; Balázs et al. 2003). The same applies to short term psychological treatments effective in therapy of depression. This is a direct reflection of the well-documented fact that only a minority of depressed patients are recognized by their GPs in primary care and fewer still are adequately treated (Tylee et al. 1993; Lecrubier 1998; Davidson and Meltzer-Brody 1999; Berardi et al. 2005).

In contrast to the numerous suicide risk factors, only a few factors are known to have protective effects. Good family support as well as social significance, good life mastery skills, a sense of coherence and meaningfulness in life, pregnancy, the post-partum period,

having children, holding strong religious beliefs, together with appropriate medical care are traditionally cited as protective factors. It is important to note, that in spite of the fact that the post-partum period is regarded statistically as a protective factor, it may in individual patients, particularly in the cases of 'post-partum blue' and postnatal depression, increase the suicide risk (Appleby et al. 1999; Hawton and van Heeringen 2000; Malone et al. 2000; Wasserman 2001; Rihmer et al. 2002; Rihmer 2005). In the everyday clinical practice, however, the presence of one or more suicide risk factors is more important than the lack of protective ones. Given the very high proportion of current major mental disorders among people with suicidal behaviour, in the early 1980s Khuri and Akiskal (1983) considered that much of the putative psychosocial and demographic suicide risk factors were not modifiable in the frame of individual health care. Consequently they proposed that suicide prevention should focus on the treatable contributory psychiatric disorders involved in such behaviour. On an aggregate level, however, organization and societal changes, e.g. the improvement of a primary health care system, empowerment strategies in the workplace and community, or the alleviation of unpredictability and stressful transitions in a society seem to reduce increased suicide figures (Rutz 2006).

Depressive and related disorders in primary care

Unipolar and bipolar major depressive episodes, the most common current diagnoses of suicide victims and attempters are among the most frequent psychiatric illnesses in the community and in a variety of clinical settings. In addition to their frequent and serious complications (suicidal behaviour, secondary substance use disorders etc.) they are strongly associated with limitations in well-being and daily functioning that are equal to or greater than those of several chronic medical disorders (Davidson and Meltzed-Brody 1999; Rihmer and Angst 2005a, b). About two-thirds of patients with unipolar depression and bipolar disorder have comorbid anxiety disorder(s), and/or substance use disorders, and around one-third of them have one or more serious medical illness, and as it has been reported that these comorbid conditions increase the risk of suicidal behaviour (Davidson and Meltzer-Brody 1999; Tondo et al. 1999; Wasserman 2001; Hawton and van Heeringen 2000; Rihmer et al. 2002; Rihmer 2005; Rihmer and Angst 2005a; Wasserman 2006). Anxiety disorders also lead to risk of suicidal behaviour, but they are often associated with an elevated risk of subsequent major depression and suicidality particularly among untreated patients (Rihmer et al. 2002; Goodwin and Olfson 2001).

Less than half of all depressed patients in the community seek medical help. The majority of the ones who do consult their GPs however, are not adequately diagnosed and treated; which is to a large extent due to many GPs still widespread difficulties in recognizing and monitoring depression, despite the last decades great diagnostic and therapeutic achievements in the field (Lecribier 1998; Lerrubier and Hergueta 1998; Davidson and Meltzer-Brody 1999; Tylee 1999; Lecrubier 2001; Berardi *et al.* 2005; Wasserman 2006). Several European and North American studies have confirmed this by demonstrating that the current prevalence of DSM-III/DSM-IV or ICD-10 major depression in the primary care practice is around 8–10 per cent (range 4–18 per cent), but the majority of depressed patients are not recognized by their GPs and the rate of adequate



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antidepressive pharmacotherapy among identified depressives was less than 20 per cent (Spitzer et al. 1994; Lecrubier 1998; Davidson and Meltzer-Brody 1999; Christensen et al. 2001; Wittchen et al. 2001; Ansseau et al. 2004; Szádóczky et al. 2004; Al Windi 2005; Berardi et al. 2005). The WHO Collaborative Study, Psychological Problems in General Health Care, conducted in 1991 on more than 25,000 primary care patients in 14 countries from 4 continents found that on the whole, approximately 50 per cent of the patients with an ICD-10 diagnosis of major depressive episode were recognized as suffering from some kind of mental disorder by their GPs, but only 15 per cent of major depressives were recognized as having depression, and fewer than half of them were prescribed antidepressants for their depression (Lecrubier 1998, 2001; Lecrubier and Hergueta 1998). Studies from some European countries and from the USA, performed 5-10 years later, reported much higher rates of recognition and treatment of depression in primary care practice: 62-85 per cent of the depressed cases were recognized by the GPs and 33-50 per cent of them were treated with antidepressants (Wittchen et al. 2001; Lecrubier 2001; Simon and von Korff 1995; Berardi et al. 2005). These findings indicate that the situation does appear to be improving as a consequence of steadily increasing awareness of depression and development of better treatment strategies in primary care.

Most patients with depression consult their GPs mainly for somatic reasons, either because of their somatic comorbidity or because of the predominant somatic symptom because they do not 'believe' or understand they solely have a depression (Tylee et al. 1993; Davidson and Meltzer-Brody 1999; Tylee 1999,; Lecrubier 2001; Tylee and Rihmer 2004). This is particularly important, since major depression is frequently associated with chronic physical disorders (cardiovascular diseases, hypertension, stroke, cancer, epilepsy, Parkinson's disease, HIV infection/AIDS, etc.) which further increase the suicide risk (see Chapters 35 and 67 in this book). The 1-year prevalence of severe major depression in individuals with two or more chronic physical disorders is fourfold higher (12 per cent) than in persons without such conditions (3 per cent) (Kessler et al. 1997), but paradoxically, primarily depressed patients with significant somatic comorbidity remain unrecognized in primary care (Tylee et al. 1993; Davidson and Meltzer-Brody 1999; Stoppe et al. 1999; Tylee 1999; Lecrubier 2001).

Another cause for somatization, however, especially in males, is the common alexithymic incapacity of men to recognize and realize their own depressive symtoms in a self-reflective way, to feel and show weakness and to ask for help, resulting in the tendency of many depressed males to seek primary health care for downplayed somatic symtoms (Möller-Leimkühler 2002). Several factors, relating to both patients and doctors, are likely to influence the recognition of major depression in primary care. Patient factors associated with non-recognition include: comorbid psychiatric (anxiety, substance abuse and personality) disorders, comorbid (mostly chronic) medical disorders, low degree of disability, less severe depressions, predominantly somatic symptom presentation (pains, paresthesias, anorexia, weight loss, etc.), male gender, younger or older age, and married status. On the other hand, high-level disability, lack of comorbid psychiatric and medical disorders, more severe depression, higher number of depressive symptoms, presenting depression predominantly with psychological symptoms (depressed mood, poor concentration, fatigue, psychomotor retardation), middle age-range, female gender and separated or divorced marital

status increases the chance of correct identification (Tylee *et al.* 1993; Rutz *et al.* 1995, 1997; Lecrubier 1998; 2001; Stoppe *et al.* 1999; Tylee 1999; Wittchen *et al.* 2001; Szádóczky *et al.* 2004).

Although many depressed patients report somatic symptoms and there is a permanent pressure in primary care not to miss organic disorders leading to suffering and death, it should be taken into account that untreated or inadequately treated depression can be highly dangerous, leading to dramatic suffering in the individual and their family and that this disorder is in fact among the most successfully treatable illnesses in medicine. Despite improvements in the last decade, the recognition of depression in primary care is still far from the ideal (Lecrubier 2001; Wittchen et al. 2001; Berardi et al. 2005). Physician factors related to poor recognition of depression are: lack of experience, insufficient or suboptimal knowledge about the symptoms, prejudices about mental illness, lack of postgraduate psychiatric training, insufficient interview skills, lack of cooperation with psychiatrists, and low level of empathy (Rutz et al. 1997; Tylee 1999; Lecrubier 2001; Thompson 2001; Wittchen et al. 2001). There is also evidence suggesting that specific organizational interventions and postgraduate training programmes improve the recognition and treatment of depression in primary care (Butler et al. 1997; Rutz et al. 1997; Appleby et al. 2000; Thompson 2001; van Oss et al. 2002; Gilbody et al. 2003; Hegerl et al. 2003; Mann et al. 2005; Szántó et al. 2007). Short screeninginstruments (e.g. Shortened Beck Depression Inventory, Zung Self-Rating Depression Scale, the WHO 5 Well-Being Scale, the depression module of the Primary Care Evaluation of Mental Disorders [PRIME-MD], the Mini International Neuropsychiatric Interview [MINI], the Geriatric Depression Scale and the General Health Questionnaire), some of them designed specifically for primary care (Davidson and Meltzer-Brody 1999; Lecrubier 2001; Parashos et al. 2002; Szádóczky et al. 2004) are also helpful, but they do not replace a well-performed clinical interview.

While the majority of the literature on suicide in primary care focuses on unipolar major depression, less attention is paid to bipolar disorder, the point prevalence of which is between 1–2 per cent in the GP practice (Spitzer *et al.* 1994; Szádóczky *et al.* 1997; Ansseau *et al.* 2004; Das *et al.* 2005). Since the depressive episode of bipolar disorder carries an even higher risk of suicide than unipolar major depression, and because the vast majority of hypomanic and manic patients also become depressed (Rihmer 2005; Rihmer and Angst 2005b; Wasserman 2006), patients with history of hypomania and mania, particularly in the presence of current depression, should be considered as persons at very high risk of suicide.

The suicidal patient in primary care

Suicidal behaviour in major mood disorder patients occur mostly during major depressive episodes (79–89 per cent), less frequently in the frame of dysphoric (mixed) mania (11–20 per cent), but practically never during euphoric mania and euthymia (0–1 per cent) (Isometsa *et al.* 1994b; Tondo *et al.* 1999). This suggests that suicidal behaviour in mood disorder patients is a state-dependent phenomenon, indicating the crucial role of recognition and treatment of depression in suicide prevention (Khuri and Akiskal 1983; Rihmer *et al.* 2002; Mann *et al.* 2005; Wasserman 2006). Since up to 66 per cent of suicide victims contact their GPs 4 weeks before their death (Isometsa *et al.* 1995; Pirkis and Burgess 1998; Andersen *et al.* 2000; Luoma *et al.* 2002), it is very likely that at these visits







the vast majority of the patients are definitely depressed, and most of them have one or more comorbid psychiatric and/or medical disorder. Alcohol also plays an important role in suicidal behaviour (Rutz et al. 1995, 1997; Wasserman et al. 1998; Tondo et al. 1999; Wasserman 2001, 2006). Men who are depressed tend to act out and resort to alcohol and it may be that they mask their depression in this way (Angst et al. 2002; Rutz et al. 1995, 1997; Wasserman 2006). The results of the Swedish Gotland Study showed that the clinical picture of suicidal, depressed men is often masked by aggressive, impulsive, and abusive behaviour (so-called male depressive syndrome), and that these men are better known to legal and social welfare agencies than to their GPs (Rutz et al. 1995, 1997).

Both specific acute psychiatric features (psychomotor agitation, insomnia, hopelessness, guilt etc) and adverse psychosocial factors (permanent adverse life situations, acute negative life events) play a significant role in triggering the actual suicidal behaviour (Hawton and van Heeringen 2000; Malone *et al.* 2000; Wasserman 2001; Rihmer *et al.* 2002; Mann 2004; Mann *et al.* 2005; Rihmer 2005). The complex interaction between these personality, psychiatric and psychosocial factors in suicidal behaviour is best explained by the stress—diathesis model for suicidal behaviour (Mann 2004), where the stressors include acute psychiatric disorder and negative life events ('state'), and the diathesis includes aggressive, impulsive and pessimistic personality features ('trait'). Both pessimism and aggressivity/impulsivity may be amenable to cognitive/behavioural therapy and pharmacotherapy, like SSRI antidepressants and lithium (Mann 2004).

As stated above, GP contact is very common before suicide: 47–73 per cent of suicide victims visit their GPs 3 months before their death, and 34-66 per cent and 20-40 per cent also do so in the last 4 weeks and in the last week, respectively (Ismometsa et al. 1995; Pirkis and Burgess 1998; Andersen et al. 2000; Luoma et al. 2002). Recent GP contact is particularly frequent among elderly suicide victims, as up to 90 per cent are reported to have seen their GPs in the preceding 3 months and up to 50 per cent in the last week (Shah and De 1998; Luoma et al. 2002). The rate of suicide victims without any recent medical contact is higher in males and in younger persons. Compared to non-suicidal primary care patients, suicide victims visit their GPs three times more frequently (Rutz et al. 1995, 1997; Isometsa et al. 1994a; Pirkis and Burgess 1998; Andersen et al. 2000; Luoma et al. 2002). In addition, the number of GP visits increases significantly before the suicidal act both among completed suicides (Appleby et al. 1996; Andersen et al. 2000) and suicide attempters (Michel et al. 1997; Fekete et al. 2004). However, among those with medical contact, the frequency of persons who communicate explicitly their intention to commit suicide is only around 20 per cent, and it is particularly rare in primary care (11 per cent) and in other (non-psychiatric) specialist settings (6 per cent). At the last GP contact, female suicide victims communicate their suicide intent almost twice as frequently as males (17 vs 10 per cent), and suicide victims with past history of suicide attempt report suicidal ideation more frequently than those without such history (Isometsa et al. 1994a, 1995). One study found that 18 per cent of the suicide victims visited GPs on the last day of their life, but the topic of suicide was discussed in only 21 per cent of these cases (Isometsa et al. 1995). Similarly low figures of communication of suicidal intent have also been reported for suicide attempters (Fekete et al. 2004). On the other hand, however, it has

also been reported that only 3 per cent of the GPs asked about suicidal ideation at least in old-age depressed patients (Stoppe *et al.* 1999; Wasserman 2001).

Discussing the possibility of suicidal behaviour with the patient and family members as a common but preventable complication of acute severe mental disorders is particularly important, given that there is a general consensus that asking questions about suicidal ideation and past suicide attempts does not trigger suicide (Hawton and van Heeringen 2000; Gould et al. 2005). This is particularly true if such a discussion is accompanied by an explanation that suicidal behaviour in psychiatric patients is a 'state-dependent' phenomenon, that depressive disorders can be successfully treated, and that suicidal ideation/wishing to die will vanish after (or even before) the recovery from depression. This is beneficial, as many patients think they are alone or unique in their suicidal ideas. Leaflets, posters, and fliers left in the waiting room indicating the main symptoms and dangers of depression as well as information on good prognosis of treatment may prompt people to ask for help. Short screening instruments, like the Beck Scale for Suicide Ideation (an interview-rated 19-item scale) and the Beck Hopelessness Scale (a 20-item self-reported questionnaire) are useful in clinical practice for detecting actual suicide risk (Hawton and van Heeringen 2000; Wasserman 2001) (see also Chapter 36 in this book). Yet no one screening instrument can replace the optimal doctor-patient relationship, including asking the right questions at the right time, accompanied by a highly professional and empathic atmosphere. Asking simple questions ('what do you think about the future?', 'do you feel that life is not worth living?', etc.) can easily facilitate further, more deep and honest discussion on the topic of suicide.

The risk of suicide is extremely high a few days and weeks after the discharge from inpatient psychiatric departments, particularly in the case of unplanned discharge and in patients with short hospital stay and with a high number of previous hospitalizations (Appleby *et al.* 1999; Hawton and van Heeringen 2000; Wasserman 2001; Qin and Nordentoft 2005). Therefore, GPs should be alert when a patient discharged from the psychiatric clinic seeks help.

The most characteristic clinical, psychosocial, and demographic features of the acutely suicidal patient in primary care are listed in Table 62.2.

Prevention of suicide in primary care

Prevention of suicide in primary care is possible. Self-destructive behaviour usually does not occur in the very early stages of the depression and this allows enough time to make a precise diagnosis and to start appropriate treatment. Several studies from Europe, the United States and Australia showed that depression-training for GPs improved recognition of depression including detection of current suicidal ideation, and increased treatment of depression, while a few others from the United Kingdom, the United States and Brazil found no positive effects (Mann et al. 2005; Nutting et al. 2005; Szántó et al. 2007). Since no one study reported the opposite (i.e. decreasing recognition and worsening treatment after the GP education), specific training and organizational interventions remain the only possibilities to make further progress on this field. However, improved primary care education in isolation does not have any significant long-term effect, and only complex educational and organizational interventions that incorporate continuous clinician education, an enhanced role of nurses and social







Table 62.2 Most characteristic features of acutely suicidal patients in primary care

Clinical features	Psychosocial features	Demographic features
Severe depression	Acute psychosocial stressors	Male gender
(agitation, anxiety, insomnia,	(loss-events, acute major	Old age (both genders)
hopelessness, guilt)	financial problems)	Young males
Acute/chronic alcohol/drug	Isolation/living alone	Spring/early summer
problems	Gun/poison at home	
Severe comorbid medical		
disorder(s)		
Wish to die, suicide ideas,		
suicide plan, suicide gestures		
Recent discharge from		
inpatient psychiatric		
department (short hospital		
stay, high number of prior		
hospitalizations, unplanned		
discharge)		

workers, as well as high level of integration between primary and secondary (psychiatric) care (consultation-liaison) are beneficial. Education should be well-focused, relatively short and interactive, include written materials, lectures, seminars, video demonstrations, and small-group discussions (Butler *et al.* 1997; Rutz *et al.* 1997; Schulberg *et al.* 1998; Appleby *et al.* 2000; Thompson 2001; Gilbody *et al.* 2003; Mann *et al.* 2005; Szanto *et al.* 2007).

The first example for the significant role of GPs in suicide prevention comes from the Swedish Gotland Study. Rutz et al. demonstrated that after a short intensive postgraduate training for GPs on the island of Gotland on the diagnosis and treatment of depression, the suicide rate and the rate of hospital admissions for depression declined significantly and antidepressant prescription increased markedly a few years after the training (Rutz et al. 1995, 1997). The rate of depressive suicides among all suicides decreased significantly after the training, indicating that the decline in suicide mortality after the education resulted directly from a robust decrease in depressive suicides, and suggesting that this result might not be caused by random fluctuation (Rihmer et al. 1995). However, the decline in depressive suicides after the training was almost entirely the result of a decrease in female depressive suicides, whereas male suicidality was almost unchanged. Few suicidal males were known to the local medical services, although many of these people were known to the police and social welfare services. These favourable effects faded in a few years and repeated education again led to another decrease in suicides, again mainly in females (Rutz et al. 1995, 1997).

Improved management of depression requires not only better recognition and treatment skills from the doctors, but also good compliance from the patients, since non-adherence to antidepressant therapy is one of the most common major causes of treatment failure. About one-third of patients stop taking antidepressants during the first 4 weeks of therapy, and around half of them take them until the end of the third month (Lin *et al.* 1995). The better side-effect profile and less toxic nature of SSRIs and other new

antidepressants, and therecently increasing practice of GPs preferring these drugs over tricyclic antidepressants, is also beneficial for improving the quality of care and reducing the risk of death in the case of overdose (Lin *et al.* 1995; Butler *et al.* 1997; Donoghue 1998; van Os *et al.* 2002). Using simple psycho-educational messages (i.e. why, how, and how long to take antidepressants and what to do in the case of side effects, to optimize the clinical response) both in oral and written form increases the adherence to antidepressant therapy (Lin *et al.* 1995). Psychological treatments of depression should also be available in the GP's office or in adjunction to it (Wasserman 2006).

Treatment of depression in primary care should follow international and national guidelines established (Schulberg et al. 1998; van Os et al. 2002; Wasserman 2006). In contrast to recent concerns on the 'suicide-provoking potential' of antidepressants, it is evident that antidepressants and mood stabilizers, like lithium, carbamazepine, valproate, and others treat depression effectively and decrease suicidality markedly among unipolar and bipolar depressives (Yerevanian et al. 2004; Akiskal et al. 2005; Simon et al. 2006). However, since antidepressant monotherapy, unprotected by mood stabilizers in bipolar depression, sometimes induces agitation, excitement (and rarely also auto- and hetero-aggressive behaviour) in the first few days or weeks of treatment, all depressive patients should be carefully checked for bipolarity and followed closely in the fist 1–3 weeks of the therapy (Akiskal et al. 2005). Anxiety, agitation or insomnia should always be controlled with concomitant use of high-potency benzodiazepines, which hasten the clinical response if combined with antidepressants (Furukawa et al. 2001). Regular after care with fixed appointments is highly recommended, particularly for those patients with previous suicide attempts. Psychological support should be available for suicidal depressed patients. This is important, since the actual clinical picture immediately after suicide attempt is often misleading, due to the cathartic effect of self-aggression, resulting in a short-lived but sometimes marked improvement of the depression (Jallade et al. 2005). This can also serve as one of the explanations why some health care workers misinterpret suicide attempts as manipulative acts.

Patients with acute suicidal danger usually need inpatient treatment even of an involuntary nature. In the case of severe agitation or anxiety prompt anxiolysis with benzodiazepines and close observation before and during transportation to the hospital is highly recommended. After an open discussion with the patient and relatives, involuntary admission is rarely needed. It should be explained that hospitalization is for and not against the patient's best interests. When acute hospitalization is not indicated, a close observation by family members and removing possible means of suicide (i.e, guns, drugs, pesticides, car key etc.) as well as consultation with a local outpatient psychiatrist is advised. GPs should work in close and permanent collaboration with the local mental health services. Outpatient psychiatric consultation is also helpful in the cases of differential-diagnostic problems, treatment resistance and comorbid substance use disorder regardless of whether the patient is suicidal or not. If long-term/prophylactic pharmacotherapy is needed (bipolar disorder, recurrent unipolar major depression) the GP may direct the patient to a psychiatrist for optimizing the therapy (Hawton and van Heeringen 2000; Wasserman 2001; Tylee and Rihmer 2004). The most frequent reasons of outpatient consultation and inpatient admission are shown in Table 62.3.







Table 62.3 When to refer primary care patients to mental health services?

Outpatient psychiatric care	Inpatient psychiatric admission
Recent suicide attempt	Acute suicidal danger
Treatment-resistant depression	Extreme severe (psychotic, catatonic
Differential diagnostic problem	negativistic) depression
Comorbid substanceuse disorders	Manic episode
Noncompliance with the treatment	Acute psychosis
Severe personality disorder	Severe comorbid medical disorder
Hypomanic episode	
Newly recognized bipolar disorder	

Conclusion

Suicide prevention in primary care is not an easy task, but it is possible, as general practitioners are key persons in suicide prevention. GPs are the first to meet depressed patients and should be trained in diagnostics and up to date use of antidepressants. Although until now specific depression-targeted psychotherapies exceed the frame of primary care, psycho-education and supportive psychotherapy is needed and it is essential to offer this kind of treatment in primary care settings. Regardless, GPs should have knowledge and collaboration with facilities offering psychological treatments. If every second suicide in primary care could be prevented this would mean that the suicide rate of a given area would drop by one-third.

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