

The last contact with a health professional before suicide – pilot data

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The Last Contact with a Health Professional

- ❖ Over 33% of elderly suicides have seen a GP in the week before death (Pearson et al, 1999)
- ❖ 58% elderly have consulted a GP in the month before death (Luoma et al, 2002)

Is the last contact with a health professional a 'missed opportunity' for suicide prevention?

This is unclear as little is known about what happens. Previous research has relied upon GP notes, police records or brief interviews. Studies suggest 42 -70% of contacts were for psychosocial reasons and 30 - 58% for physical reasons

(van Casteren et al, 1993; Isometsa et al, 1995; Vassilas & Morgan, 1994; Obafunwa & Busuttil, 1994)

Communication of Suicidal Intent to Health Professional

- ❖ Occurs in 22-45% of last clinical contacts but only 11% of GP contacts (Obafunwa & Busuttil, 1994; Isometsa et al, 1995)_
- ❖ Males are less likely to communicate suicidal intent than females (Isometsa et al, 1995)
- ❖ Older victims are less likely to communicate than younger victims (Conwell et al, 1998)_

Does improved GP recognition of depression and suicide risk lead to reduced suicide rates?

- ❖ GP Depression Education (Rutz et al, 1992 - Gotland) and Depression Screening & Primary Care Depression intervention (Oyama et al, 2004 - Japan) led to reduced suicide rates
- ❖ Primary Care patients screen positive for depression managed by depression guidelines – reduced suicidal ideation (PROSPECT study – Bruce et al 2004 – US)

Have antidepressants reduced suicide rates?

- Decline in suicide rates in older age groups in Australia during 1990s attributed to increased exposure to antidepressants (SSRIs) (Hall et al, BMJ, 2003)
- Ignored the longer term trends where rate reduction had been greater in the decades before 1990 (Draper, BMJ 2003)
-but a 3.5-fold increase in use of antidepressants in Sweden has also been accompanied by a fall in suicide rate (Isacsson, 2000)_

AIMS OF OUR STUDY

To examine:

- The last clinical contact suicide victims have had with health professionals in order to determine whether this contact offers an opportunity for suicide prevention.
- Individual context of suicide victim's last health care contact, the potential warning signs displayed, and the abilities of health professionals to identify and intervene prior to the event.

Our Study

- ❖ Based at Glebe Coroner's Court, Sydney
- ❖ All suicides aged 35 years and over in which the next-of-kin gives informed consent interviewed. Interviews with family informant and health professionals that have had contact in the last 3 months.

Procedure

- ❖ Semi structured (taped) interviews with:
 - Next-of-kin (or a person who knew the deceased best)
 - Health care professionals who had clinical contact with the deceased in the three months prior to death.
- ❖ Eligible participants identified through Coroner's records
- ❖ Letter send to next of kin with follow up phone call.
- ❖ Face-to-face interviews
- ❖ Consent is sought from the next-of-kin to contact the health professionals who had clinical contact in the three months preceding death.

Information collected from informants

Demography: Rochester Suicide Behaviour Profile (revised)

Psychopathology: SCID, IQCODE, NEOFFI, PM
Dementia diagnosis

Physical Health: CIRS, measures of health utilisation

Functional Status: IADL, Karnofsky Performance Status Scale, GAF

Life circumstances: Life Event Profile, Duke Social Support Index, social service utilisation

Interviews with health care professionals

Information collected:

Description of the last contact:

- rapport attained
- level of urgency
- compliance with appointments and treatments (particularly in last month before death);
- known active and past physical and mental illnesses and their management;
- active/past substance abuse;
- functional capacity;
- reported sleep problems;
- presence of pain and pain management strategies utilised;

Interviews with health care professionals (2)

- Past history of risk taking behaviour, accident proneness, suicide attempts, suicidal ideation, and non-suicidal deliberate self-harm
- Unusual behaviour by the deceased
- Behavioural changes of deceased

Suicides and Health Care Professional Contact in 3 months before death

52 Suicides in PA (45% participation)

No contacts = 11

Contact with 1 HCP = 20

Contact with 2 HCPs = 13

Contact with 3 HCPs = 7

Contact with 4 HCPs = 1

Overall = 71 HCPs

Health Care Professional Participation

- ❖ 40/71 participated (56%)
- ❖ 21 refused (30%)
- ❖ 6 could not be contacted (8%)
- ❖ 2 retired (3%)
- ❖ 2 access not granted by family (3%)

Health Care Professionals

- ❖ 40 Health professional Interviews,
(29 suicides < 60 years, 11 ≥ 60 years)
 - 15 GPs (64% ≥ 60; 28% < 60 years)
 - 9 Psychiatrists
 - 5 Mental Health Nurses
 - 4 Hospital doctors
 - 3 psychologists
 - 2 counselors
 - 2 specialist doctors

Health Care Professionals

- ❖ In addition, formal statements to the coroner were available for a further 17 HCP and informal statements from another 8 HCP
 - GPs = 11, Psychiatrist = 3, CNC = 2, Counsellor = 2, Specialist = 2, Other = 5

Suicide Victim Data

❖ 27 victims - 15 males, 12 females

❖ Age 60 yrs and over = 8

❖ Age 50-59 yrs = 10

❖ Age 35-49 yrs = 9

Mean age = 55.5 years

1 HCP interviewed – 17

2 HCP interviewed – 7

3 HCP interviewed - 3

Consensus Principle Psychiatric Diagnoses at Death (N = 27)

- ❖ Major Depression – 56%
 - 12 were diagnosed before death, 1 undiagnosed, 2 unknown
- ❖ Other Depression = 11%
- ❖ Schizophrenia/Psychosis = 11%
- ❖ Personality disorder = 7%
- ❖ No diagnosis = 15%

- ❖ 30% had history of substance abuse
- ❖ 52% were on antidepressants (nearly a third poor compliance)

Reasons for Last Contacts

- ❖ Mental health (65% all interviews; 55% 60+) (Only 48% of statements)
 - 3 after recent suicide attempts,
 - 5 were FU after psychiatric hospitalisation in previous month
- ❖ Physical Health (20% overall; 36% 60+)
- ❖ Social Reasons (15% overall; 9% 60+)

Last Contact Before Suicide

Interviews

- ❖ Within 24 hours of suicide = 8%
- ❖ Within 1 week of suicide = 48%
- ❖ Within 1 month of suicide = 93%
- ❖ Within 3 months of suicide = 100%

Statements

- ❖ Within 24 hours of suicide = 32%
- ❖ Within 1 week of suicide = 72%

Length of Last Contact – Interviews Only

Contact	Age 35-59 (n = 29)	Age 60+ (n = 9)	Overall (n= 38)
< 30 minutes	27.6%	66.7%	36.8%
30 mins+	72.4%	33.3%	63.2%

- ❖ Older patients have significantly shorter contacts $\chi^2 = 4.508$, $df = 1$, $p = 0.034$

Frequency of Contact with HCP

- ❖ 28% of HCPs had seen the suicide victim 2 or more times in the month before death (31% < 60; 18% elderly)
- ❖ 63% were given another appointment at their last contact, 2/3 the appointment was a week later

The Last Contact – What was it like?

- ❖ 88% - good rapport attained, 12% difficult interview (18% elderly)
- ❖ 90% - nothing unusual in the interview, 10% felt more hopeless than usual (each of these had a suicide risk assessment, none of these were elderly)
- ❖ 12% made statements of hopelessness, 1 talked of committing suicide – no reports of changing wills, hoarding tablets, giving away possessions, getting firearm – none were elderly

Depression and Anxiety at Interview

Symptoms	< 59 years	60+ years	Total
Depression	62%	27%	53%
Depression Improving	11%	100%	24%
Anxiety	45%	64%	50%

Suicide Risk Assessments Interview Data

- ❖ Overall 25% had a formal suicide risk assessment – none undertaken in elderly (34% in < 60 years)
- ❖ 5% were assessed to be suicidal
- ❖ 90% risk assessments occurred in persons with major depression
- ❖ Of contacts with depressed patients, 32% had a risk assessment

Type of Health Professional: Suicide Risk Assessment

- ❖ 100% counselors
- ❖ 67% psychiatrists
- ❖ 33% psychologists
- ❖ 7% GPs
- ❖ 0% Mental Health Nurses, Psych Hospital doctors, specialist doctors

The Elderly – Some Examples

- ❖ A 74 year old married man with alcoholism, dementia and hx of depression & OCD – appointment with psychiatrist about agitation & aggression that had worsened – felt to be related to cognition, prescribed antipsychotic
- ❖ A 61 year old female who saw GP about gynaecological problems – fearful of doctors, rather paranoid
- ❖ A 76 year old male carer of a disabled woman who wanted advice on her care from GP

Some more examples

- ❖ A 76 year old female with depression routinely reviewed by GP – feared she had cancer and dementia
- ❖ A 79 year old married man with terminal lung cancer who saw GP about a rash – wife was stressed and not coping, they talked about respite care

Issues raised from the health professional interviews

- ❖ Most are willing to participate in the study and see it as a way of debriefing
- ❖ A small number refuse due to concerns over litigation
- ❖ Where more than one health professional interviewed on a case, only 1/6 was their disagreement about suicide risk

Issues raised from the health professional interviews

- ❖ The identified 'high-risk' patients where there are multiple service providers – GP, Psychiatrist, mental health nurse
 - patients liable to fall through the gaps as unclear who is case manager
 - poor communication e.g. post discharge after suicide attempt
 - patient minimises risk to service provider
 - no behaviours identified to indicate extra risk
 - Families have expectations that all is taken care of by someone – hence suicidal utterances made to them not passed on

Issues raised from the health professional interviews

- ❖ The 'Anxious – Depressed' patient
 - Suicidality rarely discussed even though there is evidence that suicidal ideation has often been present in the past
 - Anxiety is the focus of the presentation, in one elderly case the anxiety was fueled by depressive delusions not identified by GP
 - On reflection, the health care providers did not identify anything unusual about the last visit

Issues raised from the health professional interviews – change in care

- ❖ About a third of the patients with mental health reasons for contact had decreased frequency of contact with service provider
- ❖ less care because they seemed to be improving
- ❖ some had long term contact with therapist – both ‘fatigued’
- ❖ some the patient had simply decided to end contact

Issues raised from the health professional interviews

- ❖ Patients experiencing social stressors
 - patients appear to have a one-track mind on the stressors e.g. job loss, housing, caregiving
 - highly stressed about the issues, thinking is clouded by them in the interviews – does this distract from adequate assessment of mental state?

Issues raised from the health professional interviews

- ❖ Patients presenting with physical problems
 - Routine reviews of chronic disorders such as HIV, MS where no change of mental state detected
 - New disorders e.g. subconjunctival haemorrhage
 - Few have comorbid depression

Conclusions

- ❖ Interviews of health care professionals about the last contact they had with a suicide victim have identified some areas that require further investigation in a larger controlled study that might be useful in developing strategies for proximal suicide prevention

Thank You!

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