

OCCULT HELP-SEEKING IN MEDICAL SETTINGS PRIOR TO SUICIDE

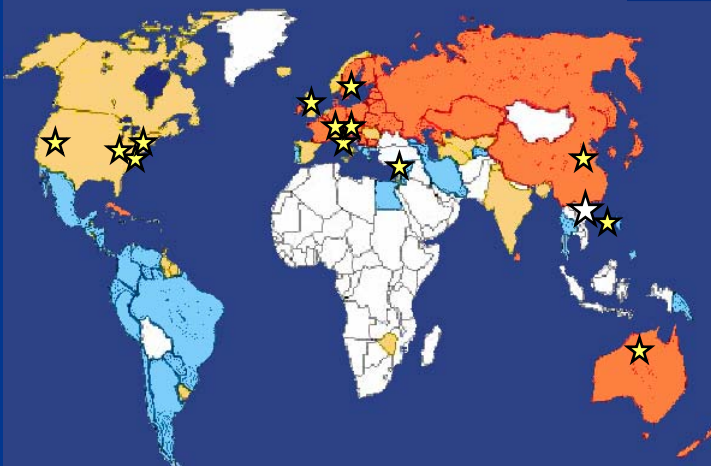
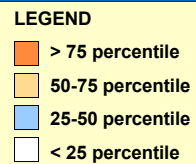


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What do we know?

WORLD Suicide Rates, 1989-98



Acknowledgements....

Mentors & Collaborators:

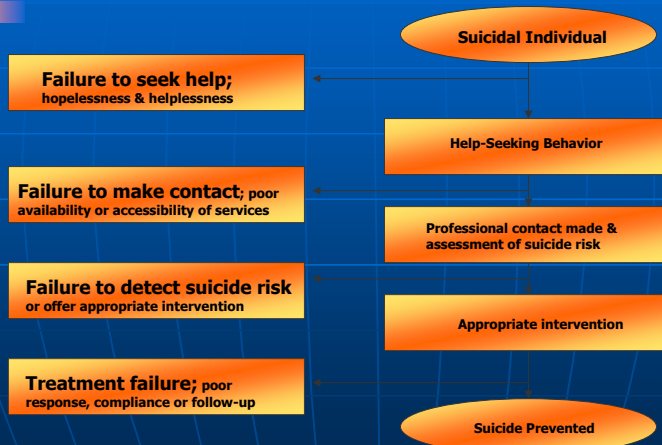
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from: "Pathways to Suicide Prevention"





from:
British National Clinical Review of Suicides

- **Subjects: 2 yr sample of all UK completers (n=10,040)**
- **Only 24% had contact with mental health services within year before death (n=2370)**
- **“Broad social/clinical needs,” incl. sub abuse**
 - 50% of these had MH contact wk before death
 - 20% had MH contact in 24 hrs preceding death
- **At final contact immediate risk of suicide estimated as: absent in 30%, low in 54%, moderate in 13%, and high in 2%.**

*Suicide within 12 months of contact with mental health services: national clinical survey
Louis Appleby, director, BMJ 1999;318:1235-1239 (8 May)*



Pathway Analysis of British National Review



Suicide within 12 months of contact with mental health services: national clinical survey Louis Appleby, director, BMJ 1999;318:1235-1239 (8 May)



Treatment for Depression & Completed Suicide* '89-'01

	1987	2001	% change
Annual No. Visits for MDD per 100,000 population ¹	5943.31	8593.66	+ 70%
Annual No. Suicide Fatalities per 100,00 population ²	12.71	10.74	- 15.5%
Annual No. Nonfatal Suicide Attempts per 100,000 population ³	120**	158	+ 75.9%

*Age-Adjusted Rate per 100,000 US Standard Million Population: (year 2000 age adjusting)

¹Stafford, R.S., MacDonald, E.A., & Finkelstein, S.N. National Patterns of Medication Treatment for Depression, 1987 to 2001. *Primary Care Companion J Clin Psychiatry* 2001;3(6): 232-235.

²WISQARS; CDC accessed at <http://webappa.cdc.gov/sasweb/ncipc/mortrate.html> 3.7.05

³Larkin et al., Trends in suicide attempts, 1992-2001, submitted.



Nonfatal Rates in Medical Settings:

USA: Help-Seeking Behavior Prior to Nearly Lethal Suicide Attempts

- 153 suicide attempters, 13 to 34 years old
- 513 non-attempting case controls
 - Significantly more male attempters than controls
- Only 37% sought help from any professional:
 - Psychiatrist 18%
 - Primary Care Physician 15%
- Only 41% of help seekers discussed suicide during consultation

(2001) Barnes LS, Ikeda RM, Kresnow M. Help-seeking prior to nearly lethal suicide attempts. *Suicide and Life-Threatening Behavior*, 32 (Suppl) 68-75



WHO Multicentre Study on Parasuicide:

Stockholm / Bern: Comparison of Prior Contact of Suicide Attempters with GPs:

Do factors related to the organization of the local health care system influence help-seeking behavior prior to suicidal behavior?

	Bern	Stockholm
Health Care System	Private	Public
Patient Choice	Yes	No
Ratio of GPs / pts	710 pts/GP	1374 pt/GP
1989 Attempt Rates	129/100,000 M 177/100,000 F	190/100,000 M 342/100,000 F

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WHO Multicentre Study on Parasuicide:

Stockholm / Bern: Comparison of Prior Contact of Suicide Attempters with GPs:

	Bern	Stockholm
No. Attempters	60 / 327 (18%)	202 / 458 (44%)
Seen GP >3 times in past 12 months	42%	4%
Seen GP in month before attempt	41%	39%
Had Suicidal Ideation at time of visit	26%	18%
Discussed suicidal ideation with GP	35%	82%
Used medications prescribed during visit for self-poisoning	28%	50%

“There was an increase in the number of GP visits 1 month before the suicide attempts, and this increase was greater in Stockholm than in Bern. Such an increase In our view must be interpreted as a sign of increasing psychological distress.”

Conclusions: Differences in physician-patient relationships influence the extent to which patients are likely to share their suicidal thoughts

(1997) Runeson MK, Valach I, Wasserman D. Contacts of suicide attempters with GPs prior to the event: A comparison between Stockholm and Bern. Acta Psychiatrica Scandinavica, 95:94-99



Attendance At The Accident & Emergency Department Before Suicide

- **Gairin, et al., 2003:**
 - 39% of suicide completers visited the local Emergency Department (ED) within a year of their death
 - Of these individuals, 69% sought help for non-suicide-related reasons.
- **Yim, et al., 2003:**
 - “Cases were four times more likely to have had contact with a doctor in the week preceding death than controls, even after adjusting for other significant risk factors for suicide. Besides, more cases had attended accident and emergency departments or psychiatric clinics before their scheduled appointments prior to death.”

Gairin, I., House, A., Owens, D. (2003) Attendance at the accident and emergency department in the year before suicide: retrospective study. *British Journal of Psychiatry*, 183, 28-33.

Yim, P., et al. (2003) Suicide after discharge from inpatient care. *Australian and New Zealand Medical Journal*



Methods

- **Setting:** A large, urban ED in Dallas, Texas--
(average = 10,000 visits/month)
- **Subjects:** ED waiting room patients—
 - Only patients presenting with non-mental health-related chief complaints were included in these analyses.
 - Self-reported suicide attempters presenting for post-attempt medical treatment were therefore excluded from study analyses
 - as well as patients seeking explicit treatment of suicidal ideation, psychosis, depression, anxiety, or other mental health-related conditions.
- **Procedure:** Recruitment during randomized shifts over 45 days





Assessment:

- **Quick PsychoDiagnostics Panel:**
- **A computerized mental health assessment used to screen for Axis I:**
 - **mood (major depressive [MDD] or bipolar),**
 - **anxiety (generalized anxiety, panic and PTSD)**
 - **& substance-related difficulties (alcohol and/or substance abuse, binge drinking, at-risk drinking).**

Shedler, J. (2000a) The Shedler QPD Panel (Quick PsychoDiagnostics panel): A psychiatric "lab test" for primary care. In Handbook of Psychological Assessment in Primary Care Settings (ed M. Maruish), pp. 277-296. NY: Erlbaum.

Shedler, J., Beck, A., Bensen, S. (2000b) Practical mental health assessment in primary care. Validity and utility of the Quick PsychoDiagnostics Panel. Journal of Family Practice, 49, 614-21.



Dallas County: Background Information

Second largest county in Texas behind Harris with 2,211,000 average population in 1998-2000 of which approximately 47% were minorities.

- **2003 unemployment rate**, at 7.9% remained higher than for the state, which was 6.8%.
- **Percentage of uninsured persons** in Dallas County increased through 2002 — from about 23% in 2000, to 27.8% in 2002, compared to a 2002 national average of 15.2%. **1 out of 4 people in Dallas and surrounding counties is uninsured; compared to 1 out of 6 nationwide.** (CDC Behavioral Risk Factor Survey)
- **Substance abuse related deaths increased** each year from 1999 through 2002 (from 1,281 in 1999 to more than 1,500 in 2002).
- Nationwide, violent and property crimes dipped in 2002 to lowest levels in 30 years; yet Dallas, San Antonio and Houston saw little or no change in total crimes per capita.
 - **Dallas ranked first in total crimes per capita, among cities with population over one million**, for six years in a row through 2003.



Rationale & Objective of this Analysis

- Given the potential consequences of a missed opportunity to identify and treat the seriously suicidal, it is important to identify markers of occult suicidality within medical visits, if they exist.
- ***This analysis sought to:***
 - Establish the prevalence and severity of current suicidal ideation and co morbid psychopathology in a cohort of ED patients seeking treatment for non-psychiatric problems.
 - Describe the clinical course and visit outcome associated with these ED presentations.



Quick PsychoDiagnostics Panel (QDP)

- Commercially available, computer module that has been used in the primary care network of Kaiser Permanente Health System
- Primary care patients can self-administer the test in an average of 6.2 minutes, suggesting the potential utility of such an approach to screen for commonly missed mental health problems in a busy emergency department setting
- **A series of screening questions if answered positively are branched into a full assessment of psychopathology related to the associated syndrome**

Shedler, J. (2000a) The Shedler QPD Panel (Quick PsychoDiagnostics panel): A psychiatric "lab test" for primary care. In Handbook of Psychological Assessment in Primary Care Settings (ed M. Maruish), pp. 277-296. NY: Erlbaum.

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QDP Convergent Validity:

- **QPD Depression**
 - SCID major depression--sensitivity and specificity were .81 and .96 respectively; Beck Depression Inventory $r=.80$; Hamilton Depression Inventory-SR $r=.87$; Zung Self-Rating Depression Scale $r=.78$; Center for Epidemiological Studies-Depression Scales $r=.79$
- **The QPD anxiety score**
 - SCID anxiety--sensitivities range from .69-.79, and specificities range from .90-.97; Spielberger State-Trait Anxiety Inventory $r=.67$; anxiety subscale of Derogatis Symptom Checklist-90 $r=.76$; Derogatis, 1975)
- **QPD Alcohol/Substance module**
 - were established by correlating screening panel results against medical records and are reported as .98 and .92, respectively.

Shedler, J. (2000a) The Shedler QPD Panel (Quick PsychoDiagnostics panel): A psychiatric "lab test" for primary care. In Handbook of Psychological Assessment in Primary Care Settings (ed M. Maruish), pp. 277-296. NY:Erlbaum.
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Suicidality as measured in the QPD

A series of questions reflecting levels of acuity:

- 1) "I think a lot about death (my own, other people's, or just death in general),"
- 1) "Sometimes I think I'd be better off dead,"
- 2) "I think about killing myself," and
- 3) "I am planning to kill myself."

For the purposes of analyses, divided into three categories:

- * **Passive ideators** endorsed both frequent thoughts of death and thoughts that they would "be better off dead."
- * **Active ideators** reported specific thoughts about self-harm,
- * **Ideators with intent/planners** responded affirmatively to the statement "I am planning to kill myself."

Analytic Approach:

- **Simple descriptive analyses** were used to characterize subgroups of suicidal ideators and to compare them to all others in the sample.
- **Univariate odds ratios for each level of suicidality** were calculated for major demographic, and visit-related variables.
- **2003 official death and hospital records for the six months after study enrollment** was completed were checked in order to identify any deaths or suicide attempts among study subjects.
- **Available demographic variables:** age group (18-29, 30-44, 45-59, 60 and over), ethnicity (Caucasian, African American, Hispanic, other), gender.
- **Available clinical variables:** time of day of screening (12a-6a, 6a-12p, 12p-6p, 6p-12a), category of complaint (cardiac, respiratory, acute injury, gastrointestinal/urinary, pain, infections, other), patient status (new/previously-treated), number of ED visits in the previous 24 mos and number of ED visits specifically for psychiatric treatment in the previous 24 mos.

Study Enrollment

16,047 total ED patients during study enrollment period

2122 pts approached

301 declined to participate

1778 qualified for enrollment

5 were excluded based on mental status,
38 ultimately admitted primarily psychiatric reasons for their visit

188 failed to complete the screen

1590 QPD panel completers available for analysis



Sample-to-Population Comparison

- Racial and gender composition of the final sample (n=1590) was not statistically different from the ED population during the study enrollment period ($\chi^2=0.5719$ (2) $p=0.75$; $\chi^2=1.1315$ (1) $p=0.29$, respectively).
- Statistically significant age difference between study sample and ED population ($\chi^2=73.81$ (1) $P<.0001$),
 - More 18-44 year olds and significantly less 60+ year olds
 - Refusers were more likely to be over 45 years of age ($\chi^2=96.0154$ (3) $<.0001$), less likely to be Caucasian, and more likely to be Hispanic ($\chi^2=15.12$ (2) 0.0005).



Prevalence of Suicidal Ideation

Passive Ideation: 185/1590; 11.61%

Active Ideation: 134/1590; 8.41%

Intent with a Plan: 31/1590; 1.95%

Suicidal patients by Severity of Ideation: Univariate Analyses: Odds Ratios (95% CI)

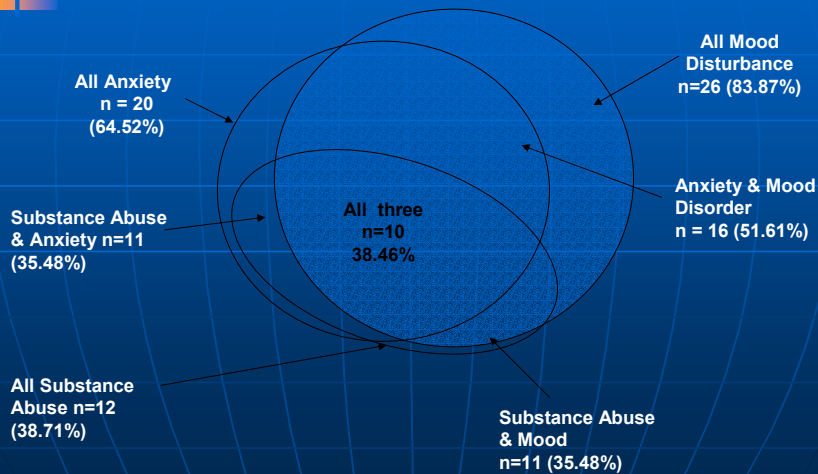
Demographic & Visit Variables:	Passive Ideators n=185/1590	Active Ideators n=134/1590	Plan with Intent n=31/1590
Age Group:			
18-29	1.18 (.85, 1.65) p= 0.32	0.87 (.58, 1.29) p= 0.48	1.58 (.76, 3.28) p= 0.22
31-44	0.93 (0.68,1.27) p=0.64	1.34 (0.94,1.91) p=0.11	1.06 (0.52,2.18) p=0.87
45-59	1.05 (0.74,1.48) p=0.80	0.94 (0.62,1.41) p=0.76	0.69 (0.28,1.69) p=0.41
> 59	0.49 (0.20,1.24) p=0.12	0.41 (0.13,1.32) p=0.12	0
Ethnicity:			
Caucasian	1.19 (0.85,1.65) p=0.31	0.94 (0.64,1.40) p=0.77	1.02 (0.46,2.23) p=0.97
African American	1.53 (1.12,2.08) p=0.007	1.42 (1.00,2.03) p=0.05	1.01 (0.49,2.10) p=0.97
Hispanic	0.50 (0.34,0.73) p=0.0002	0.71 (0.47,1.08) p=0.09	0.87 (0.40,1.91) p=0.74
Male gender	1.20 (.88, 1.64) p= 0.24	1.23 (.90, 1.65) p= 0.17	1.87 (.87,3.99) p= 0.10
New Patient to Study ED	0.72 (0.47, 1.10) p=0.13	1.05 (0.67, 1.64) p=0.83	1.27 (0.54, 2.99) p=0.58
Shift during which survey was taken:			
12a-6a	0.66 (0.43, 1.03) p= .07	0.91 (0.57, 1.46) p=0.70	0.47 (0.14, 1.56) p=0.21
6a-12p	1.02 (0.76, 1.65) p=0.57	0.67 (0.23, 1.94) p=0.49	0.67 (0.23, 1.94) p=0.46
12p-6p	0.88 (0.62, 1.25) p=0.48	0.69 (0.46, 1.08) p=0.09	0.86 (0.38, 1.94) p=0.72
6p-12a	11.31 (0.96,17.9) p=0.03	1.28 (0.89,1.84) p=0.18	3.01 (1.03,9.10) p=0.03
> 1 total ED visit in prev 24 mo	1.71 (1.24,2.35) p=0.007	1.41 (0.98,2.01) p=0.06	1.80 (0.86,3.79) p=0.11
Any psychiatric ED visit within previous 24 months	5.21 (3.58,10.77) p<.0001	8.88 (4.94,15.25) p<.0001	10.74 (4.58,25.21) p<.0001
Presenting Problem*:			
Cardiac	0.61 (0.22, 1.72) 0.35	0.42 (0.10, 1.74) p=0.22	0
Respiratory	1.02 (0.63, 1.65) p=0.94	1.17 (0.69, 2.00) p=0.56	0.85 (0.26, 2.82) p=0.79
Acute Injury	0.96 (0.45, 2.05) p=0.93	1.20 (0.54, 2.68) p=0.65	0.71 (0.10, 5.29) p=0.73
Gastrointestinal/Urinary	0.83 (0.56, 1.21) p=0.33	0.68 (0.43, 1.08) p=0.10	0.98 (0.42, 2.30) p=0.97
Pain	0.91 (0.55, 1.50) p=0.70	1.45 (0.88, 2.40) p=0.15	1.19 (0.41, 3.44) p=0.75
Infections	1.33 (0.87, 2.03) p=0.15	1.10 (0.65, 1.84) p=0.70	0.98 (0.34, 2.83) p=0.97
All Other	1.26 (0.87, 1.83) p=0.23	1.05 (0.65, 1.64) p=0.82	1.48 (0.65, 3.29) p=0.38

Suicidal patients by Severity of Ideation: Univariate Analyses: Odds Ratios (95% CI)

Psychopathology:

	Passive Ideators n=185/1590	Active Ideators n=134/1590	Plan with Intent n=31/1590
Major Depressive Disorder	9.88 (7.02,13.80) p<.0001	10.17 (6.85,15.09) p<.0001	9.81 (4.35,22.12) p<.0001
Bipolar Disorder	9.69 (6.83,13.89) p<.0001	9.97 (6.68,14.87) p<.0001	12.83 (6.09,26.18) p<.0001
Substance Abuse	4.87 (3.43,6.83) p<.0001	4.70 (3.19,6.91) p<.0001	4.26 (2.03,8.89) p<.0001
Anxiety	1.81 (0.99,3.30) p=0.05	2.18 (1.14,4.15) p=0.02	3.11 (1.05,9.19) p=0.03
Panic	8.65 (6.11,12.25) p<.0001	8.33 (5.58,12.25) p<.0001	9.50 (4.50,19.60) p<.0001
Traumatic Stress Symptoms	6.50 (4.43,9.54) p<.0001	7.84 (5.20,11.84) p<.0001	5.20 (2.40,11.28) p<.0001
History of Childhood Sexual Abuse	2.19 (1.55, 3.07) p<.0001	2.57 (1.7, 3.77) p<.0001	2.03 (0.95, 4.35) p=0.06

Co morbid Psychopathology in ED Suicide Ideators who acknowledge intent to attempt and a plan n=31/1590



From Index Visit Medical Records:

The 31 Suicidal Planners

- According to billing physician records, only 12/31 were identified while in the ED as having a co-existing mental health-related problem of any kind
- Only 2 had a positive review of systems for a non-substance-related mental health disorder.
- Hospital records of visits prior to the index visit for only 6/31 planners specifically mentioned past or present suicidality.



From Index Visit Medical Records:

The 31 Suicidal Planners

- 1 ultimately admitted to ED physicians that he was presenting for injuries sustained as a result of deliberate self-harm-- stabilized and transferred to psychiatric care.
- 2 identified as having current suicidal ideation and triaged to psychiatric care voluntarily.
- 3 had reported suicidality during other recent hospital contacts prior to the index visit, but suicidality was apparently not a focus of concern during the index visit, as no appraisal of self-harm tendencies were done.
- **25/31 actively suicidal patients went undetected during the index visit according to structured review of the medical records, nursing notes, and physician chart**



From Index Visit Medical Records:

The 31 Suicidal Planners

- **Patient #186:**
 - Required urgent care related to medication nonadherence.
 - Discovered to have knotted off IV tubing during subsequent rehydration.
 - Nursing notes indicate that the patient was “educated about the importance of the procedure” after which rehydration was resumed.
 - The patient was discharged apparently without further questioning about his actions.
- **Patient #24:**
 - Presented with vague complaints of dizziness while attending a funeral a few hours prior.
 - All laboratory results were within normal limits.
 - She was treated for dehydration and released, only to present again 33 days later following a suicide attempt.



From Index Visit Medical Records:

The 31 Suicidal Planners

- In the 180 days post study enrollment, none of the 31 patients expressing suicidal intent was listed as deceased in local obituaries.
- Four of the 31 returned to the ED within 90 days of discharge for suicide attempts, two having overdosed on prescriptions given during the index visit, one after jumping out of a window and one having attempted to hang himself. All survived.



Limitations

This is a single-site study in an urban ED, so generalizability of these findings awaits further investigation.

The anonymous screening procedure used in this study may have produced some “false positive” results, as we had no systematic way of externally validating psychopathology or suicidality reported by study participants.

Follow-up data on additional suicidal attempts was obtained only from the study hospital and local newspaper obituaries, and may not truly reflect the magnitude of post-study suicidal acts by study participants.



Relationship of Chief Complaints, Psychological Distress and Suicidal Ideation in Non-Psychiatric Settings

- **McKelvey, et al., 2001: (USA)**
 - Patients who experienced “substantial, but unstated,” suicidal symptoms tended to be female and somewhat younger
- **Joiner, et al., 2002: (Australia)**
 - 22% of 15-24 year olds presenting to GPs had “significant levels” of suicidal ideation
- **Foster, et al., 2002: (Ireland)**
 - The time between last contact and death was greater among suicides under 30 years and male suicides.
- **Hawton, et al., 1999: (UK)**
 - “Little support was found for an earlier finding of increasing frequency of general practitioner visits shortly before death.”

Hawton, K, Houston, K, Shepperd, R. 1999. Suicide in young people. *British Journal of Psychiatry* 175:271-276. Joiner TE, Pfaff JJ, Acres JG. 2002. Characteristics of suicidal adolescents and young adults presenting to primary care with non-suicidal (indeed non-psychological) complaints. *European Journal of Public Health* 12(3):177-9. McKelvey, Rs. Pfaff JJ, Acres JG. 2001. The relationship between chief complaints, psychological distress, and suicidal ideation. *Medical Journal of Australia* 175:550-2. Foster T, Gillespie K, McClelland R. Mental disorders and suicide in Northern Ireland. *British Journal of Psychiatry* 170:447-452



Clinical Implications

The ambulatory Emergency Department (ED) population appears to be a patient group with significant numbers of suicidal individuals.

Even seriously suicidal ED patients are often missed.

Simple questioning procedures used during routine ED care may potentially identify many of these suicidal individuals



Questions:

....Why don't patients openly admit they are suicidal during these visits?

.....Why don't medical professionals recognize these visits as a plea for help more often?

....Why don't patients openly admit they are suicidal during these visits?



Shame:

"The patient's marked sense of shame about their suicidal thoughts and their unwillingness to expose their hard-pressed situation.... The perception of help-seeking as an act of weakness...."

Somatization:

"Most patients did not connect their psychological problems – in this context, their suicidal tendencies – with their somatic ailments."

Fluctuating Suicidality:

"Only rarely does the development of suicidal thoughts and behaviors continuously and progressively increase."



Why don't medical professionals recognize these visits as a plea for help more often?

CK Wong, MD, FHKAM (Psychiatry, Hong Kong):

"People who kill themselves shortly after they have seen a doctor can be divided broadly into two groups....."

- Those with **no previous history** who kill themselves in their first suicide attempt.
 - The most important reason why they are not identified as at risk is that the attending doctor has not suspected their suicidal intent.
- Those whom the doctor knows have made **previous suicide attempts**.
 - The reason that they are not identified as at risk is that the doctor often underestimates the likelihood of suicide.

Wong CK (2003). Suicide prevention and intervention: A call to all doctors. Hong Kong Medical Journal, 9:397-398



Why don't medical professionals recognize these visits as a plea for help more often?

De Leo et al. (Psychopathology, Brisbane):

"The hectic nature of emergency wards, coupled with the often-recurrent presentation of subjects with suicide attempts, may render staff attitudes toward such patients quite insensitive....."

De Leo et al. (Psychiatry, Hong Kong):

"The doctors as a rule connected suicidal tendencies with depression and – in the absence of easily observable signs of depression – did not think of investigating the presence of suicidal thoughts."

Yet -- a significant proportion of suicide attempters are judged to be not clinically depressed at the time of the attempt.

Wong CK (2003). Suicide prevention and intervention: A call to all doctors. Hong Kong Medical Journal, 9:397-398



Conclusions

Every measure which lowers the help-seeking threshold for people experiencing a suicidal crisis is of preventive value.

A consistent and personal relationship with a medical helper should facilitate the communication of suicidal ideation, however:

.....Those medical personnel who represent the easiest point of access to care for a patient population likely require the most training in recognition of and response to suicidal ideation.



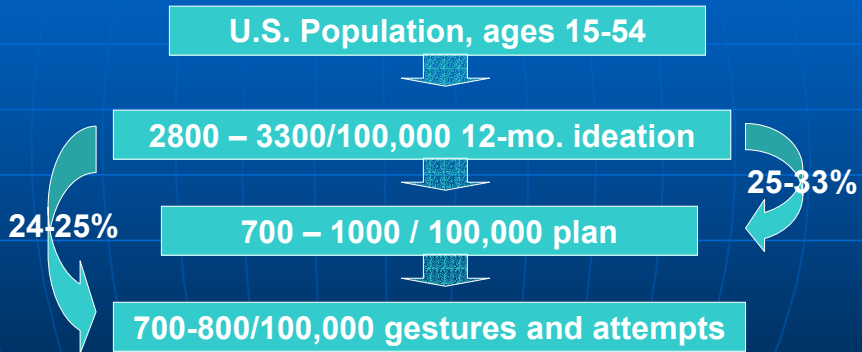
OCCULT HELP-SEEKING IN MEDICAL SETTINGS PRIOR TO SUICIDE

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University of Texas Southwestern Medical Center
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Population-Based Nonfatal Rates:

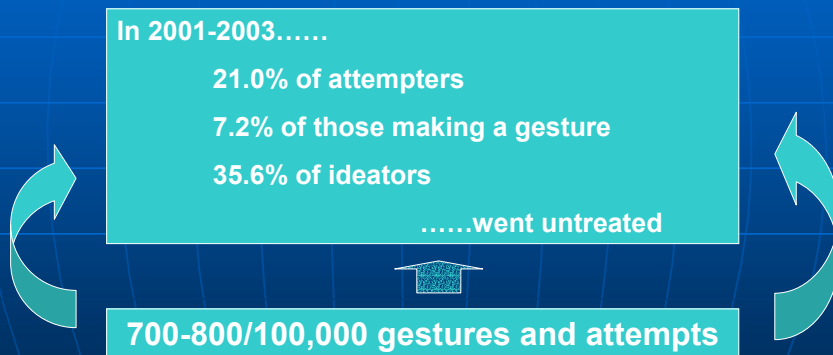
12-Month Suicidal Ideation, Plans, Gestures / Attempts



(2005) Kessler RC et al. Trends in suicide ideation, plans, gestures, and attempts in the United States, 1990-1992 to 2001-2003. JAMA, 293: 2487 – 2495.

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Nonfatal Rates in Medical Settings:

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Do factors related to the organization of the local health care system influence help-seeking behavior prior to suicidal behavior?

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Health Care System	Private	Public
Patient Choice	Yes	No
Ratio of GPs / pts	710 pts/GP	1374 pt/GP
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