3 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?
   - (If the answer is yes to question #5) Do you have the necessary items to complete that plan readily available?
6. Have you ever acted on any plans to end your life in the past (i.e., have you ever attempted suicide)?
   - (If the answer is yes to question #6) 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
- Psychosocial disruption (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

3 Suicide Assessment, Cont.

STEP 3. Respond to Suicide Risk

Imminent 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.qmo.amedd.army.mil; http://www.healthquality.va.gov/.

09/08/10

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

1 KEY ELEMENTS OF MDD CPG

Depression is common, under-diagnosed, and undertreated.

2 SCREENING: PHQ-2 and PHQ-9

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

3 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 visited their physician within one month of their death?

1 Key Elements of MDD Clinical Practice Guidelines

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-2), 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 (SSRI) along with the Seratonin Norepinephrine Reuptake Inhibitors (SNRI), bupropion, 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 intervention, 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.

2 Screening: Patient Health Questionnaire (PHQ)

- **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
- It can be administered in person, by telephone, or self-administered
- It aides in assessment of major depression and symptom severity
- It is 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. This may be due to the physician's limited time with the patient as well as the patient's focus on the somatic symptoms of his or her depression. Since almost two thirds of patients with depression receive treatment in primary care, the responsibility of assessing and treating these patients falls heavily upon primary care physicians. By using a quick, efficient, and valid screening mechanism, primary care physicians can increase the rates of detection within a primary care setting.

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 depression severity. Moreover, ease of use makes both the PHQ-2 and PHQ-9 useful and efficacious clinical tools for the primary care setting.

Overview of the PHQ-2

The PHQ-2 screener is a two-item self-report that inquires about the frequency of depressed mood and anhedonia over the last two weeks. The purpose of the PHQ-2 is 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. Screening with the PHQ-2 should be completed annually by all patients seen in primary care settings. Patients who screen positive on the PHQ-2 should be further evaluated with the PHQ-9, other diagnostic instruments, and a direct interview. The PHQ-2 has a reported sensitivity and specificity of between 82 to 97 and 78 to 91 percent, respectively, for major depression using a cut off score of ≥ 3.

Overview of the PHQ-9

The nine-item PHQ-9 is a validated self- or interviewer-administered instrument that assesses DSM-IV-TR criteria symptoms and effects on functioning. The PHQ-9 can be administered in less than two minutes and it is simple to score, easily understood, and available in multiple languages. It can be a powerful tool to assist clinicians with assessing depression and monitoring treatment response. Specifically, the PHQ-9 can help track a patient's overall depression severity as well as the specific symptoms that are improving (or not) with treatment. PHQ-9 scores have been validated against DSM-IV-IR using independent structured interviews. Validity has been assessed against an independent structured mental health professional interview. A PHQ-9 score ≥10 had a sensitivity of 0.88 and a specificity of 0.88 for major depression.

Interpreting the PHQ-2 and PHQ-9

Research has shown that certain scores on the PHQ-9 are strongly correlated with a subsequent major depression diagnosis. However, not everyone with an elevated PHQ-9 is certain to have major depression. The PHQ-9 is intended as a tool to assist clinicians with identifying and assessing 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 #9 should be further assessed for suicidal ideations and/or intent. 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 indicative 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-9 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.

PATIENT HEALTH QUESTIONNAIRE 2 (PHQ - 2)

Over the past two weeks, how often have you been bothered by either of the following problems?

A) Little interest or pleasure in doing things. (0-3)
B) Feeling down, depressed, or hopeless. (0-3)

Not at all	Several days	More than half the days	Nearly every day
0	1	2	3

Patients with a score of 3 or greater should be followed up with PHQ-9.

Score	% Prob. of MDD	% Prob. of Any Depressive Disorder
1	15.4%	36.9%
2	21.1%	48.3%
3	38.4%	75.0%
4	45.5%	81.2%
5	56.4%	84.6%
6	**78.6%**	**92.9%**

For more information on the PHQ-2 and PHQ-9, as well as the Clinical Practice Guidelines for Major Depressive Disorder, please visit: http://www.healthquality.va.gov/index.asp

PATIENT HEALTH QUESTIONNAIRE 9 (PHQ - 9)

Name:_____ Date:_____

Over the last two weeks, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at All	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
Add Columns:		+	+	
Total:				

10. If you checked off any problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not Difficult at All ☐ Somewhat Difficult ☐ Very Difficult ☐ Extremely Difficult ☐

PHQ-9 Score	DSM-IV-TR Criterion Symptoms	Depression Severity	Proposed Treatment Action
1-4	Few	None	None
5-9	< 5	Mild Depressive Symptoms	Watchful waiting; repeat PHQ-9 at follow-up
10–14	5-6	Mild Major Depression	Treatment plan; Consider counseling, follow-up, and/or pharmacotherapy
15–19	6-7	Moderate Major Depression	Immediate initiation of pharmacotherapy and/or psychotherapy
20-27	> 7	Severe Major Depression	Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy, expedited referral to a mental health specialist for psychotherapy and/or collaborative management