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The Management of Adolescents at Risk of Suicide by Australian General Practitioners: Issues in Practice and Confidence

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This study involved an anonymous survey of 41 Victorian GPs regarding their diagnostic and treatment practices with adolescent patients with depression and/or suicide ideation. The results indicated that the majority of respondents correctly diagnosed the level of depression and the risk of suicide in a case scenario. Although they commonly asked some of the questions related to an assessment of suicide risk, they rarely conducted a comprehensive risk assessment and the level of referral to telephone and internet crisis services was poor. Most GPs indicated a lack of confidence in their ability to detect and manage depression and suicide in this population and strongly emphasized a need for more training.

Early identification and effective management of patients who are depressed and potentially suicidal is crucial. General Practitioners (GPs) have a pivotal role in this work. Concern has been expressed, however, regarding their ability to diagnose and manage these vulnerable patients (Joint Consultative Committee in Psychiatry, 1998; Victorian Suicide Prevention Task Force, 1997). As noted by Hickie (2000), although GPs are commonly exposed to depression and are well placed to effect early detection and treatment, this may not result unless they are equipped with “a high degree of suspicion and additional mental health training” (p.106). More specifically, Williams-Russo (1996) has contended that between 35-50 percent of patients with depression remain undiagnosed, misdiagnosed, untreated or less than optimally treated by GPs. This is particularly serious given claims that the chances of recovery from major depressive illness decreases in association with an increase in the time that a patient is ill or untreated (De-Wester, 1996). Also of great concern are reports suggesting that, of those who commit suicide, up to two-thirds had seen a physician in the month prior to their death (Katz, Streim, & Parmelee, 1994; Mathews, Milne, & Ashcroft, 1994). These findings highlight a need to explore issues impacting on current practice.

A number of suicide risk assessment models have been proposed (e.g. Hirschfeld & Russell, 1997; Ramsay, Tanney, Tierney, & Lang, 1994; Stoebl & Chiriboga, 1998). Relevant factors identified in these models include the existence of a current suicide plan and the extent of suicidal ideation; previous suicidal behaviour; a lack of buffering resources such as meaningful relationships, connectedness with work or school, a strong sense of self esteem; the presence of feelings of hopelessness; the presence of mental illness - most particularly depression, personality or conduct disorders and substance abuse; and the existence of situational or current life stressors such as death of a family member or friend, or relationship breakdown. Although it is acknowledged that the prediction of suicide on the basis of identified risk factors is complex and inexact (Public Health Association of Australia, 1995), the obligation for practitioners to routinely conduct comprehensive assessments has been widely emphasised (Hirschfeld & Russell, 1997; Hughes, 1995; Langwieler & Linden 1993; Victorian Suicide Prevention Task Force, 1997). According to Graham, Reser, Scuder, Zubrick et al., (2000), however, there is little research into the extent to which GPs undertake risk assessments.

It has been acknowledged by The Victorian Suicide Prevention Task Force (1997) that some GPs do not have the necessary training or confidence to fully assess depressive illness and risk of suicide, nor to respond with appropriate interventions. In some cases, intervention should include referral to specialist community mental health agencies, including those of a self-help and community support nature. The extent of referral to these services by GPs remains unclear.

Of particular concern are reports that many GPs lack confidence in assisting young people, viewing their management as complex (Phongsavan, Oldenburg, Gorden, & Ward, 1995). A survey of Australian GPs found that at least half
regarded the treatment of adolescent mental health problems as either 'very' or 'moderately' difficult and they indicated particular deficits in their ability to engage with young people (Joint Consultative Committee in Psychiatry, 1998).

Clearly GPs have both opportunity and responsibility to maximize the identification of depression and suicide risk in young people and to initiate appropriate referral or intervention. This study is an initial attempt to examine the practice of GPs regarding suicide risk assessment and referral to relevant services. It also seeks to ascertain their level of confidence and their views regarding the adequacy of their training in this area.

Method

Participants

This study involved an anonymous survey of 41 GPs who responded to a mail out to 181 (23% response rate) registered in the Eastern suburbs of Melbourne. The sample was comprised of 25 males (61%) and 16 females (39%) and the mean number of years in practice as a GP was 20.4 years (SD=11.67).

Instrument

Diagnosis and treatment. This section was comprised of a case scenario involving a 16 year old female that was adapted from one developed by Hirschfeld and Russell (1997) who also provided a diagnostic assessment of the case as being in the moderate to severe range for both depression and risk of suicide. Questions were posed to determine:

1) perceived level of depression; and 2) risk of suicide as measured on five-point Likert rating scales ranging from none, low, mild, moderate to severe; 3) level of confidence in managing the case according to a five-point Likert rating scale ranging from not at all, not very, moderately, very to extremely confident; 4) reasons for rating the level of confidence in managing the case; 5) the organisation or professional to whom they would refer the patient if applicable; and 6) treatment recommendations.

Suicide risk assessment and referral.

This section involved response on a four-point Likert rating scale ranging from never, sometimes, mostly to always. Questions concerned how thoroughly the GP investigates suicide risk in a patient and were derived from current models of suicide risk assessment (Ramsay et al., 1994; Hirschfeld & Russell, 1997; Stoelb & Chiriboga, 1998). Specifically, respondents were asked whether they directly question patients who may be at risk regarding any suicidal feelings, whether they have a current suicide plan, the extent of their support/resources, whether they have previously attempted suicide, and whether they have experienced the suicide of a close friend or family member. They were also asked whether they explore the individual's plans for the future, ascertain their feelings of self-worth, and undertake a screen for mental and physical illness. Further questions were included to determine whether GPs suggest to patients who may be at risk that they avail themselves of crisis support services such as Lifeline's 24 hour counselling service, Care-ring, G-Line, Lifeline Suicide Helpline, Kids Helpline, or Reachout (internet site).

Training

This section required GPs to rate on a five-point Likert scale (ranging from extremely well, very well, moderately well, not very well to not at all well) the extent to which they believed that their training had equipped them with the skills required to detect or diagnose someone who is suicidal, assess the severity of risk and provide appropriate treatment. They were also asked to rate their perceived need for more training in the area of suicide identification and treatment.

Results

Diagnosis and Treatment

On a five-point scale (1 = 'no depression' to 5 = 'severe depression') the mean rating score for the severity of depression in the case scenario was 4.27 (SD=0.63). Specifically, 15 (36.6%) perceived the level of depression as 'severe' and 22 (53.6%) estimated it to be 'moderate', whilst 4 (9.8%) rated it as 'mild'. Thus the majority of GPs correctly identified the level of depression as 'moderate to severe'.

On the risk of suicide rating scale (1 = 'no risk' to 5 = 'severe risk') the mean overall rating was 4.2 (SD=0.70). Risk was rated by 13 GPs as 'severe' (31.7%) and by 23 GPs as 'moderate' (56.1%), whilst 4 (9.8%) rated it as 'mild', and 1 (2.4%) rated the risk of a suicide attempt as 'low'. Thus the majority of GPs accurately described the level of suicide risk as 'moderate to severe'.

With regards to the professionals or agencies or to which they might refer this patient for alternate or adjunct intervention, all participants
The Management of Adolescents at Risk of Suicide

indicated they would refer to a Psychologist or Psychiatrist, 6 (14.6%) to a Counsellor and/or familiarity with the patient and their family. It appeared that confidence in their ability to provide good treatment increased proportionally with the extent and duration of previous relationships with the patient and/or members of their family. When asked specifically about the treatment they would provide for this patient, only 19.5% of respondents indicated that they would prescribe antidepressants, with many stating that they “thought it would be of little use”. In contrast, many (73.1%) stated that they would try and talk to this patient in general about her school, her friends, and in particular about her friend reported to have committed suicide. Many (75.6%) indicated that it would be appropriate for her to receive counselling and that they would make a referral on the basis of being unwilling or unable to provide the counselling themselves. A single GP indicated that she would invite her to contact her for support at any time and for her to call if she were to ever feel suicidal. None of the respondents indicated that they would inform her of crisis support services that can offer 24 hour counselling and assistance should she feel vulnerable, lonely or suicidal. Few GPs (14.6%) reported that they would undertake an assessment of her feelings of self worth or her suicidality.

Suicide Risk Assessment and Crisis Referral

When asked to indicate the frequency with which they generally ask depressed patients a list of specified suicide risk assessment questions (see Table 1) the overall mean rating score obtained by respondents indicated that they ‘mostly’ asked the risk assessment questions (M=3.0, SD=.56). With respect to specific questions, only 36.6% of the sample reported that they ‘always’ ask their patients suspected of suffering from depression if they are feeling suicidal (rating score M=3.1, SD=.80) and only 34.1% ‘always’ ask the patient whether they have previously attempted suicide (M=2.8, SD=1.01). Furthermore, only 19.5% of respondents ‘always’ ask if their patient has a current plan to commit suicide while 9.8% ‘never’ ask (M=2.6, SD=.92), 39% indicated that they ‘never’ assessed the patients feelings of self-worth (M=2.95, SD=.86), and 17% reported that they ‘never’ ask the patient if they have had a family member or friend commit suicide (M=2.4, SD=.92). In contrast, the majority (73.2% and 26.8% respectively) ‘always’ or ‘mostly’ ask

indicated they would make at least one referral. Specifically, 10 (24.4%) indicated that they would refer her to a Psychiatrist, 35 (85.4%) Social Worker, 3 (7.3%) to a hospital, 3 (7.3%) to a teacher and 2 (4.9%) to a Crisis Assessment Team.

Concerning how confident they felt in their ability to manage this patient’s condition on a five-point scale (1 = ‘not at all’ to 5 = ‘extremely’) the mean rating score was 2.4 (SD=0.67). Over half (n=23, 56.1%) of the GPs indicated that they did not feel very confident managing her condition, whilst 14 (34.1%) felt ‘moderately confident’ and only 4 (9.8%) felt ‘very confident’.

A number of factors emerged as having an impact on GPs’ confidence in their management of this case. The most influential negative factor was the age of the patient, with 73.9% of respondents who anticipated difficulty specifically attributing it to their lack of confidence in their ability to engage, assess and provide treatment for patients in the adolescent age range. Specific comments from respondents included “this age group is notoriously difficult to help”; she appears “ambivalent” thus suggesting that she would be “difficult to engage”; and “sixteen year oldgirls are often difficult to communicate with and my bally middle-aged male status may result in a failure to connect with her”.

The second key factor reported as impacting negatively on confidence to provide treatment concerned time pressures. Of the respondents who indicated low confidence, several (39.1%) stated that the case was complex and that the anticipated difficulties of engagement with this patient would necessitate extended consultations. Simply put by one respondent “She would be too time consuming for my practice” which is restricted to “15 minute appointments”.

The most common factor impacting positively on GPs’ confidence to provide treatment related to their knowledge of and willingness to access supportive services. The majority of GPs who stated they were ‘moderately’ or ‘very confident’ in their ability to provide treatment (88.8%) were aware of a variety of support services, and indicated a willingness to use them as a compliment to their treatment program. For example, one respondent stated “I acknowledge the fragility of these patients and their need for expert help” and so would “call upon extra support for assistance in providing treatment”. An additional positive factor suggested by 38.9% of confident respondents concerned their
vulnerable patients about their resources (rating score $M=3.73$, $SD=.45$).

When asked to indicate how frequently they provide vulnerable patients with information about specified telephone and internet crisis support services only 2 respondents (5.1%).

Table 1  Mean ratings and frequency of risk assessment questions asked by GPs of patients who present with depression or suicide ideation.

<table>
<thead>
<tr>
<th>Question</th>
<th>Never n (%)</th>
<th>Sometimes n (%)</th>
<th>Mostly n (%)</th>
<th>Always n (%)</th>
<th>Mean rating</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you feeling suicidal?</td>
<td>-</td>
<td>11 (26.8)</td>
<td>15 (36.6)</td>
<td>15 (36.6)</td>
<td>3.1</td>
<td>0.80</td>
</tr>
<tr>
<td>Do you have a current plan to commit suicide?</td>
<td>4 (9.8)</td>
<td>15 (36.6)</td>
<td>14 (34.1)</td>
<td>8 (19.5)</td>
<td>2.6</td>
<td>0.92</td>
</tr>
<tr>
<td>What current resources do you have?</td>
<td>-</td>
<td>-</td>
<td>11 (26.8)</td>
<td>30 (73.2)</td>
<td>3.7</td>
<td>0.45</td>
</tr>
<tr>
<td>Have you previously attempted suicide?</td>
<td>3 (7.3)</td>
<td>16 (39.0)</td>
<td>8 (19.6)</td>
<td>14 (34.1)</td>
<td>2.8</td>
<td>1.01</td>
</tr>
<tr>
<td>What are your future plans?</td>
<td>2 (4.9)</td>
<td>13 (31.7)</td>
<td>15 (36.6)</td>
<td>11 (26.8)</td>
<td>2.9</td>
<td>0.88</td>
</tr>
<tr>
<td>Has a family member or friend committed suicide?</td>
<td>7 (17.1)</td>
<td>16 (39.0)</td>
<td>13 (31.7)</td>
<td>5 (12.2)</td>
<td>2.4</td>
<td>0.92</td>
</tr>
<tr>
<td>Assess feelings of self-worth?</td>
<td>16 (39)</td>
<td>-</td>
<td>-</td>
<td>14 (34.2)</td>
<td>3.0</td>
<td>0.86</td>
</tr>
<tr>
<td>Do mental &amp; physical health check.</td>
<td>-</td>
<td>8 (19.5)</td>
<td>9 (22.0)</td>
<td>24 (58.5)</td>
<td>3.4</td>
<td>0.80</td>
</tr>
</tbody>
</table>

Table 2. Rate of referral by GP's of depressed patients to crisis support services.

<table>
<thead>
<tr>
<th>Service</th>
<th>Never n (%)</th>
<th>Sometimes n (%)</th>
<th>Mostly n (%)</th>
<th>Always n (%)</th>
<th>Mean R ratings</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lifeline n=39</td>
<td>13 (31.7)</td>
<td>22 (53.7)</td>
<td>5 (12.2)</td>
<td>1 (2.4)</td>
<td>2.00</td>
<td>0.86</td>
</tr>
<tr>
<td>Care-ring n=39</td>
<td>25 (64.1)</td>
<td>10 (25.7)</td>
<td>2 (5.1)</td>
<td>2 (5.1)</td>
<td>1.50</td>
<td>0.82</td>
</tr>
<tr>
<td>G-Line n=39</td>
<td>30 (76.9)</td>
<td>9 (23.1)</td>
<td></td>
<td></td>
<td>1.23</td>
<td>0.43</td>
</tr>
<tr>
<td>LifelineSuicide Helpline n=39</td>
<td>34 (87.1)</td>
<td>4 (10.3)</td>
<td>1 (2.6)</td>
<td></td>
<td>1.15</td>
<td>0.43</td>
</tr>
<tr>
<td>Kids' Helpline n=40</td>
<td>31 (77.5)</td>
<td>7 (17.5)</td>
<td>2 (5.0)</td>
<td></td>
<td>1.27</td>
<td>0.55</td>
</tr>
<tr>
<td>Reachout (internet) n=40</td>
<td>35 (92.1)</td>
<td>3 (7.9)</td>
<td></td>
<td></td>
<td>1.08</td>
<td>0.27</td>
</tr>
</tbody>
</table>
‘always’ suggested Care-ring and only 1 (2.4%) ‘always’ suggested Lifeline (refer Table 2). The service most frequently referred to was Lifeline, although 13 (31.7%) of the GPs never suggest this service to their patients and 22 (53.7%) only sometimes do so. Overall, the mean frequency rating score for advocacy or referral to these services was very low (M=1.4, SD=0.35).

Training
With respect to how well they believed that their training had equipped them to detect or diagnose someone who is suicidal, the overall mean rating score approximated ‘moderately’ (M=2.98, SD=0.76). Whilst 11 (26.8%) of the sample felt ‘very’ well trained and 18 (43.9%) felt ‘moderately’ well trained, 12 (29.3%) reported the opinion that they were ‘not at all’ well trained and none believed that they had been ‘extremely well’ trained in this domain.

Similarly, the extent to which GPs believed that their training had equipped them to assess risk in an individual thinking about suicide was also only moderately well (mean rating score 2.8, SD=0.71). A total of 15 GPs (36.6%) did not feel very well trained in this area, 19 (46.3%) felt ‘moderately well’ trained and only 7 (17.1%) felt ‘very well trained’. Again none indicated a belief that they had been extremely well trained in this area.

GPs were even less confident in the extent to which they believed that their training had equipped them with the skills needed to treat someone who is suicidal (M=2.5, SD=0.75). Only one respondent felt ‘extremely’ well trained and 3 (7.3%) indicated they were ‘very well trained’, whilst 12 (29.3%) believed they were only ‘moderately’ well trained and 25 (61%) did not feel ‘very well trained’.

Concerning their need for more training in the area of suicide identification and treatment the mean rating indicated a very high level of need (M=3.6, SD=0.7). Although 12 GPs (29.3%) believed their need was only ‘moderate’, 26 (63.4%) perceived it to be very high and one individual indicated that it was ‘extremely high’.

Despite this need, 36 (87.8%) of the respondents indicated that there were barriers to them participating in further training in this area. Although some respondents indicated more than one barrier, the three key obstacles related to lack of knowledge of relevant PD (6 individuals), financial cost (7 individuals) and a lack of available time (29 individuals).

Discussion
The majority of the GPs correctly identified the severity of depression and the level of suicide risk depicted in the case scenario as within the moderate to severe range. However, in four cases, the level of depression and suicide risk was rated as mild and in one further case, the risk of a suicide attempt was rated as low. Although these results do not support suggestions that GPs may be ill-equipped to diagnose (and manage) depressed and suicidal patients (eg. Victorian Suicide Prevention Task Force, 1997; Hickie, 2000), any underestimation of illness is of concern as it is likely to impact on the provision of ‘optimal’ treatment. An underestimated or incorrect diagnosis of depression has, for example, been associated with an increased number and intensity of symptoms and inappropriate treatment regimes (American Psychiatric Association, 1996; Unutzer et al., 1997). In addition, a misdiagnosis of depression has been suggested as a factor that renders the subsequent investigation of suicidal tendencies unlikely (Rost et al., 1998). This is particularly worrying due to the strong link between depression and suicide (Beautrais et al., 1996; Hall et al., 1999; Moscicki et al., 1998; Rey & Wever, 1995; Shaffer, Garland, Gould, Fisher & Trautman, 1998).

Although some respondents indicated that they routinely ask some of the specified suicide risk assessment questions of patients who present with depression or suicide ideation, most do not always do so. Nor do they consistently explore the full range of risk factors. Although the relative impact of any particular risk factor for suicide remains inconclusive (Public Health Association of Australia, 1995), those empirically related to increased risk, can be used to estimate potential (Hirschfeld & Russell, 1997; Ramsay et al., 1994; Stoolb & Chiriboga, 1998).

It also needs to be noted that the findings in this study may be an overestimate of the extent to which GPs consistently undertake a comprehensive risk assessment. Very few respondents spontaneously indicated that they would explore these areas when they had been asked in the earlier case scenario to specify the issues they would discuss with the patient. Additionally, it is possible that the voluntary nature of the study resulted in response from individuals who have an interest and thus perhaps a wider knowledge of this subject than others.
It is interesting that most GPs did not suggest the prescription of antidepressants for the treatment of the presented case and instead emphasised referral to a psychiatrist, psychologist or counsellor. This may reflect an understanding of the benefit of psycho-social interventions. It may also relate to the finding that the majority of respondents were not very confident in being able to provide assessment and treatment for this kind of patient. The most common inhibiting factor concerned the difficulties involved in communicating with adolescents. Deficits in this area have been previously identified (Phongsavan et al., 1995). A second factor involved time limitations. Although none of the respondents specifically mentioned financial constraints, it has been suggested (Commonwealth Department of Health & Family Services, 1993; Nazareth & King, 1992) that the poor remuneration associated with longer consultations and the lack of reimbursement for counselling and telephone consultations may serve as a disincentive.

A further factor impacting on confidence relates to the availability of support services. Certainly those respondents who indicated high levels of confidence were aware of and willing to collaborate with other professionals and agencies. The importance of shared responsibility has been highlighted (eg. Litman, 1989; Joint Consultative Committee in Psychiatry, 1998).

The rate of referral indicated by GPs to specific crisis telephone and internet support services was low, and was non-existent with regards to the case scenario. Although the efficacy of these referrals remains unclear (Joint Consultative Committee in Psychiatry, 1998) these services may provide an avenue of support, particularly at times when access to other sources is limited. Further research is needed to identify the factors behind the low referral rate.

Overall the GPs in this study felt that their training had only moderately well prepared them to assess suicide risk and most felt poorly trained in the treatment of identified individuals. This corresponded with a very high level of indicated need for further training in this area and confirms the reports of others (eg. Joint Consultative Committee in Psychiatry, 1998; Montano, 1994).

Certainly the findings of this preliminary study are limited by the small sample size, the voluntary nature of participation and the difficulties associated with self-reported information. It is also acknowledged that conclusions about actual practice can not be directly inferred from vignettes. However, the need for the provision of support to GPs in terms of training and professional development opportunities is indicated. Particular emphasis needs to be placed on risk assessment, management of adolescents and access to support services.

References


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