

Conversation with a ...

Vocational training scheme organiser

Today I was discussing mental health training for general practitioner (GP) registrars with the local general practice vocational training scheme organiser. One of the big worries for registrars is assessing suicidality of patients, as they will often have limited experience by the time that they start their out of hours work.

Later I read two papers in the *Annals of Family Medicine* that help to throw some light on this.^{1,2}

We know that every GP can expect to have one patient kill themselves every five years, on average. Each suicide is a tragedy, and has enduring effects on the family and the healthcare workers involved. Unlike those working in secondary care it is likely that primary care staff will continue working with the families of victims for many years, each encounter being a reminder of the event to both sides.

Nutting *et al* looked at 21 different US primary care practices, and assessed the effect of one of two different interventions on their ability to detect suicidal ideation.¹ The two interventions were brief training (four conference calls for doctors and nurses, with nurses having an extra 8 hour training on depression management), or 'guided development of quality improvement teams', which consisted of brief training (4½ hours), followed by 16 hours to develop a quality improvement plan, which was then implemented.

The effect of the interventions was to nearly double the detection of depression with suicidal ideation, from 20.5% in usual care practices, to 40.7% in intervention practices. Interestingly there was no effect on starting an antidepressant, referral, or suicidal ideation at 6 months.

Sculberg *et al* studied suicidal ideation in patients in 60 practices, with 'uncomplicated depressive disorder', screening first with part of the Patient Health Questionnaire (PHQ)-9, then using a symptom checklist and an algorithm to firm up on the level of risk.²

They found that about 90% of the patients judged to need treatment of their depression were at no or low risk of self-harm, with 10% having an intermediate risk. In the low-risk group, only 1.1% at 3 months and 2.6% at 6 months had suicidal ideation requiring the physician's immediate attention.

From these two papers I learnt that it is definitely worth training health workers in depression and suicide assessment. Once they have learnt to do a competent job, then almost all patients with uncomplicated dysthymia, major depression, or both who are judged to be at low or no risk, will still be at low or no risk of suicide in 6 months.

REFERENCES

- 1 Nutting PA, Dickinson LM, Rubenstein LV *et al*. Improving detection of suicidal ideation among depressed patients in primary care. *Annals of Family Medicine* 2005;3:529-36.
- 2 Schulberg HC, Lee PW, Bruce ML *et al*. Suicidal ideation and risk levels among primary care patients with uncomplicated depression. *Annals of Family Medicine* 2005;3:523-8.

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