Depression and the Suicidal Patient

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KEYWORDS

• Depression • Suicide • Suicide risk • Emergency room

KEY POINTS

- The emergency department must maintain the safety of the patient and provide a thorough evaluation of the depressed or suicidal patient.
- Multiple screening tools may be used for depression, and all sources of information are important in providing a complete picture of patient symptoms and safety.
- Suicidal patients must be assessed for high risk and potentially protective factors to create the best disposition possible for the patient.
- Safety contracts have not been shown to be as effective as previously thought.
- Antidepressants may be initiated with the consultation and follow-up of a psychiatrist.

BACKGROUND AND EPIDEMIOLOGY

Depression is extremely common. The lifetime prevalence of depression is 20% to 25% in women and 7% to 12% in men.[1] In 2007, appoximately12 million visits to emergency departments (EDs) were related to mental health or substance abuse.[2] Typically associated with depressive symptoms or substance abuse, suicidal ideation and suicide attempts are also common in the ED, with approximately 650,000 patients evaluated in EDs for suicide attempts.[3] In a general hospital, depression accounts for approximately 50% of psychiatric consultations and 12% of all hospital admissions.[4] In recognition of this serious health impact, the Joint Commission established a National Patient Safety Goal (NPSG) to address this issue in 2010. This NPSG requires "behavioral health care organizations, psychiatric hospitals, and general hospitals treating individuals for emotional or behavioral disorders, to identify patients at risk for suicide."[5] Despite these numbers and the increased awareness established by the Joint Commission, depression is often underdiagnosed or missed completely in a busy ED. Often patients with

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depression can present with vague somatic complaints such as fatigue, anxiety, weakness, headache, and chronic pain, leading to multiple ED visits.[6] Depression is a mental illness with considerable disability, morbidity, and mortality. It has been well documented that depression is a common comorbidity in other debilitating diseases such as heart disease, stroke, diabetes, cancer, dementia, and many others.[1,4,7,8] The elderly are particularly at risk, and depression can be misdiagnosed as early dementia.[3] An early study by Meldon and colleagues[9] found that recognition of depression by emergency physicians in geriatric patients was low, with a sensitivity of only 27.5%.

Risk factors for major depression include female gender, African American or Hispanic, younger age or older age in a nursing facility, and marital status being never married, widowed, or divorced.[10] In a survey performed in 15 countries by the World Health Organization, women were nearly twice as likely have depression,[11] and in the United States women had a prevalence of 8% to 10%, whereas the prevalence in men was only 3% to 5%.[12] African Americans and Hispanic Americans have a 4.0% and 4.3% prevalence of depression, respectively, compared with 3.1% in non-Hispanic whites.[13]

DEFINITION OF DEPRESSION

Patients with depression display disturbances in their mood, psychomotor activity, and thought processes, and vegetative disturbances (sleep, appetite, and sexual function). Strictly speaking, major depressive disorder (MDD) is described in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) by 1 or more major depressive episodes.[14] According to DSM-5, major depressive disorder is established when 5 or more of the symptoms are listed (See 'DSM-5 Diagnostic Criteria for Major Depressive Disorder' in The diagnostic and statistical manual of mental disorders. American Psychiatric Association. 5th edition. Available at: http://www.dsm5.org/), and have been present during the same 2-week period and represent a change from previous functioning.[14] At least 1 of the symptoms must be either depressed mood most of the day, nearly every day (ie, feels sad, empty, or hopeless) or markedly diminished interest or pleasure in all, or almost all activities most of the day, nearly every day. Other symptoms include significant weight loss when not intentional, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue or loss of energy, feelings of worthlessness or excessive or inappropriate guilt, diminished ability to think or concentrate or indecisiveness, or recurrent thoughts of death, suicidal ideation, or a suicide attempt or specific plan. Of note, lack of interest and depressed mood are the most important factors. Also noteworthy is that these symptoms should cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. The episode is not attributable to physiologic effects of a substance or to another medical condition. The symptoms are not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorders, delusional disorder, or other specified or unspecified schizophrenia spectrum. In addition, the patient should not have previously exhibited a manic episode or a hypomanic episode to distinguish it from bipolar disorder (BD).[4,14]

There are various subtypes of MDD, the more common of which include major depression with melancholy, major depression with psychotic features, and seasonal affective disorder. Major depression with melancholy is particularly notable because of its association with increased suicide rates.[15]

DIFFERENTIAL DIAGNOSIS

Other mental disorders have signs and symptoms similar to those of depression. In addition, depression often coexists with other mental illnesses, and it is important to

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