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Suicide attempt in first-episode psychosis: A 7.4 year follow-up study

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ABSTRACT

Background: Individuals with first-episode psychosis demonstrate high rates of suicide attempt (SA).
Aims: 1) To examine the prevalence of, and risk factors for, SA in a first-episode psychosis (FEP) cohort over a 7.4 year follow-up period. 2) To investigate differences between single versus multiple suicide attempters.
Methods: This study reports baseline and follow-up data from a naturalistic, prospective follow-up of 413 FEP patients treated at a specialist early psychosis centre. Assessments were conducted at treatment entry, initial symptom remission or stabilization, and long term follow-up. Binary logistic regression models were used to assess unadjusted and adjusted associations between early illness and sociodemographic characteristics and two outcome measures: any SA during follow-up; and multiple SAs.
Results: Follow-up data were available for 282 participants. Sixty-one (21.6%) made a suicide attempt over the follow-up period, including 12 successful suicides. The following baseline risk factors increased the risk of any SA: history of self-harm (OR = 4.27; $p < 0.001$), suicidal tendencies (OR = 2.30; $p = 0.022$), being depressed for >50% of the initial psychotic episode (OR = 2.49; $p = 0.045$), and hopelessness (OR = 2.03; $p = 0.030$). History of problem alcohol use increased the risk of multiple SAs (OR = 4.43; 95% CI (1.05–18.7); $p = 0.043$).
Discussion: The prevalence of suicide attempt in this study exceeds reports from short-term FEP studies but is comparable to longer term follow-up studies, indicating that risk remains elevated for at least 7 years following commencement of treatment. The key predictor of future suicide attempt was previous self-harm, indicating that interventions for self-harm are required.

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1. Introduction

Individuals with psychotic disorders demonstrate high rates of suicide attempt (SA); up to 40% will attempt suicide during their lifetime (Harkavy-Friedman, 2006). Risk is highest during the early phase of illness (Palmer et al., 2005). Among people with first-episode psychosis (FEP) rates of suicide are estimated at between 1 and 3% over a 4 to 5-year follow-up period (Clarke et al., 2006; Bertelsen et al., 2007). Rates of deliberate self-harm (DSH) and SA are higher; between 10% and 14% of people with FEP report either DSH or a SA prior to presentation for treatment (Robinson et al., 2009; Harvey et al., 2008; Clarke et al., 2006). Rates remain high following the commencement of treatment. One-year prevalence rates of SA range from 2.9% to 11% (Robinson et al., 2009; Addington et al., 2004; Nordentoft et al., 2002). Longer term follow-up studies have reported a 2-year prevalence rate of 11.3% (Verdoux et al., 2001) and a 4-year prevalence rate of 18.2% (Clarke et al., 2006).

Substance use disorder (SUD), the presence of depressive symptoms, younger age, female gender and greater illness insight have been associated with SA; however the strongest

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predictor of future SA is a previous attempt (Robinson et al., 2009; Bertelsen et al., 2007; Clarke et al., 2006; Crumlish et al., 2005; Verdoux et al., 2001; Power et al., 2003, Roy, 1982). People who make multiple suicide attempts are more likely to demonstrate a more severe psychopathology, alcohol and drug use, greater suicidality and greater social and familial adversity than those who make only one attempt (Forman et al., 2004; Vajda and Steinbeck, 2000), however to our knowledge this has not been examined in FEP.

To date the majority of studies have only looked at outcomes over shorter follow-up period, only one study has reported suicide attempt rates over a period of 5 years or longer (Bertelsen et al., 2008), and none have reported on predictors of SA. The aims of this study were to examine the prevalence of, and risk factors for, suicide attempt among a FEP cohort over a 7.4 year follow-up period, and to investigate differences between single versus multiple suicide attempters.

2. Methods

2.1. Participants

Data were collected as part of a prospective follow-up of a cohort of FEP patients (see Henry et al., 2007) treated at the Early Psychosis Prevention and Intervention Centre (EPPIC). The EPPIC program (McGorry and Edwards, 1998; McGorry et al., 1996) is a comprehensive, specialized mental health service for FEP patients originating from a geographically-defined catchment area in metropolitan Melbourne, Australia with a population of approximately 800,000.

The sample for this study comprised 413 patients accepted into EPPIC between April 1993 and July 1997. Participants met the following inclusion criteria at baseline: 1) age between 15 and 30 years; 2) a DSM-III-R (American Psychiatric Association, 1987) and from 1995, a DSM-IV (American Psychiatric Association, 1994) diagnosis of a psychotic disorder (schizophrenia, schizophreniform disorder, schizoaffective disorder, delusional disorder, bipolar psychotic disorder, major depressive disorder with psychotic features, brief reactive psychosis/brief psychosis and psychosis not otherwise specified); 3) informed consent for research participation; 4) living in the geographical catchment of the EPPIC service; 5) adequate English language comprehension; 6) experiencing the first treated episode of psychosis with less than 6 months of prior neuroleptic medication. Individuals with primary organic mental syndrome, intellectual disability, drug and/or alcohol induced psychosis, or epilepsy were excluded. Assessments were conducted at multiple time-points including: within the first few days following entry into treatment (index presentation; T1); at the time of symptom remission or stabilization (median 8.9 weeks after index presentation; T2); and approximately 7.4 years after index presentation (T3).

2.2. Procedure

At T3, re-location of participants was guided by a standardized tracing algorithm (Henry et al., 2007) which included linkage to the National Death Index (NDI) and checking against records held by state Coroner's offices. Of the 413 subjects, 270 were interviewed and had non-missing SA information. A further 12 subjects were included who were deceased at follow-up and whose cause of death was determined to be suicide as recorded in the NDI (ICD-9, E950-E959; ICD-10, X60-X84) or, if NDI data were not available, a finding of suicide was recorded on the Coroner's report. These 282 subjects comprise the study sample. The mean length of follow-up for the total study sample was 7.4 years (SD = 1.25; range 0.61–10.7 years), with a marginally longer follow-up interval for the 270 interviewed subjects (mean = 7.5 years; SD = 0.91; range 5.7–10.7 years). Loss to follow up among the remainder of the sample ($n = 131$) was due to refusal to be interviewed ($n = 79$; 19.1%), previous refusal of all further follow-up ($n = 3$; 0.7%), death, not due to suicide ($n = 14$; 2.3%); failure to locate the participant for interview ($n = 27$; 6.5%) or missing SA data despite being interviewed ($n = 8$; 1.9%).

All assessments were conducted by interviewers with graduate psychology education, who received specific training in the administration of all instruments, and ongoing supervision to maintain reliability and consistency. Very good to excellent inter-rater reliability was found for baseline and for the primary outcome instruments at T3, including DSM diagnosis of schizophrenia (kappa = 0.92) and the onset and duration of symptoms (mean kappa = 0.79). Inter-rater reliability for the LCS at T3 was assessed by calculating the percentage of discrepancies between raters, with only 2% of ratings found to be discrepant (see Henry et al., 2007). Raters at T3 were blind to diagnostic information and clinical ratings from previous assessments unless such information was inadvertently revealed during the tracing process. The study was approved by relevant institutional human research ethics committees.

2.3. Measures

At T1, the Royal Park Multidiagnostic Instrument for Psychosis (RPMIP; McGorry et al., 1990a,b) was used to measure illness duration components, diagnosis, and other clinical and sociodemographic variables. Onset of psychosis was defined as the emergence of the first sustained positive psychotic symptom (i.e. the presence of delusions, hallucinations, clear-cut disorder of thinking/speech, or disorganised, bizarre or markedly inappropriate behaviour) at threshold level, dated as precisely as possible to the nearest day, week or month. Age at onset was the patient's age at the date of onset of psychosis. Duration of untreated psychosis (DUP) was defined as the number of days between the onset of psychosis and the initiation of treatment, with the latter defined as the first recorded date of admission or acceptance into the service. The onset of prodrome was defined as the earliest deviation from the patient's premorbid personality, behaviour or level of functioning prior to the onset of psychotic symptoms. The duration of prodrome was the period of time in days between the onset of the prodrome and the onset of psychotic symptoms.

DSM-III-R diagnoses obtained from the RPMIP were subsequently converted to DSM-IV (American Psychiatric Association, 1994) and categorized into five groups: Schizophrenia and Schizophreniform disorders; Schizoaffective disorder, Bipolar disorder; Depressive psychosis; and other psychotic disorders (Delusional disorder, Psychotic disorder NOS, Brief reactive psychosis). Information derived from the

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