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Brief report

Determinants of early identification of suicidal ideation in patients treated with antidepressants or anxiolytics in general practice: A multilevel analysis

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Abstract

Background: General practitioners (GPs) play a key role in identifying and managing patients with suicidal tendencies. Few studies, however, examine both GP and patient characteristics and GP practices associated with suicide assessment. This article aims to evaluate 1) GPs' success in early identification of suicidal ideation (SI) in patients starting antidepressant or anxiolytic treatment, and 2) patient- and GP-related factors associated with this success.
Methods: Survey of 144 GPs practising in southeastern France and of consecutive adults consulting them during June–October 2004 and prescribed antidepressant or anxiolytic treatment. Data were collected from GPs (consultation-questionnaires focusing on their prescription, diagnosis and detection of SI) and patients (self-administered questionnaires including the Hospital Anxiety and Depression scale and social and demographic characteristics). We used multilevel logistic regression to analyse factors associated with SI detection.
Results: GPs completed consultation-questionnaires for 713 patients, 405 of whom completed self-administered questionnaires. Eighty-nine patients (22%) reported SI; in 43 cases (48%) SI had not been detected by the GP. GPs detected SI more frequently when they had completed continuing medical education about depression, when patients had higher depressive symptom scores, and when consultations were relatively long.
Limitations: Study limited to patients receiving initial prescriptions for antidepressants or anxiolytics.
Conclusions: The percentage of undetected SI in this study population was high. Additional training of GPs increases the chances of detecting SI. Medical training and continuing medical education should include better instruction about SI risk factors and diagnosis, including non-major depressions, and stress that screening requires sufficient consultation time.

Keywords: Suicidal ideation; Psychotropic drugs; General practice; Multilevel model; Continuing medical education

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1. Introduction

General practitioners (GPs) have a key role in identifying and managing patients with suicidal tendency (Gaynes et al., 2004): significant proportions of people in psychological distress consult their GPs rather than mental health professionals (Paykel et al., 2005); half to two thirds of successful suicide completers visited their GP in the weeks or months before their death (Schulberg et al., 2004). Appropriate GP training programs on the diagnosis and treatment of major depressive disorders (MDD), as in Gotland, can reduce population rates of suicide and suicidal behaviour, although these findings are not always replicated (Rutz et al., 1992; Mann et al., 2005).

While there is some controversy about routine primary care screening for suicide risks in the general population (McNamee and Offord, 1994; Gaynes et al., 2004), several authors strongly recommend that physicians should be alert to suicidal ideation (SI: death wishes, consideration or planning of suicide) among patients with MDD or other suicide risk factors (Schulberg et al., 2004). SI, one of the strongest predictors of suicide, is a key factor in identifying suicide risk (Schneider et al., 2001; Gaynes et al., 2004).

Few studies, however, simultaneously examine both GP and patient characteristics and GP practices associated with suicide assessment (Schulberg et al., 2004; Matthews et al., 1994; Isometsa et al., 1995; Williams et al., 1999). Better understanding of the factors associated with GPs' suicide assessment practices may help in designing training programs. This article intends to evaluate 1) GPs' success in early identification of SI in patients for whom they are starting an antidepressant or anxiolytic treatment; and 2) patient- and GP-related characteristics associated with this success.

2. Methods

2.1. Population

The 550 members of a representative panel of GPs (Verger et al., 2005) practising in southeastern France were asked in May 2004 to participate in this study, which surveyed consecutive patients aged 18 years or older who consulted them in June–October 2004, whom they started on an antidepressant or anxiolytic, and who agreed in writing to participate. Patients were considered to "start" these drugs if they had had no such treatment during the preceding 6 months.

2.2. Instruments and procedure

When we contacted GPs, we collected information on their individual socio-demographic characteristics and their training and practices in MDD management. GPs were asked to complete a "consultation-questionnaire" for each patient meeting the inclusion criteria. It sought any psychotropic drug prescribed, diagnosis of MDD, anxiety disorder, or chronic pain, comorbid physical conditions, alcoholism, substance abuse, patient's history of suicide attempts (yes/no), suicidal plans or

Table 1
Characteristics of participating patients (N=405)

	Antidepressant prescription (N=259) %	Anxiolytic prescription (N=146)%
Age (years)		
18–24	5.0	6.2
25–39	27.8	30.1
40–59	40.9	42.5
60+	26.3	21.2
Sex		
Male	27.5	36.3
Female	72.5	63.7
Major Depressive Disorder (CIDISA–DSM IV)		
Yes	34.4	13.7
No	65.6	86.3
HAD Depression score*		
0 to 7	14.3	38.4
8 to 14	60.2	53.4
More than 14	25.5	8.2
HAD Anxiety score*		
0 to 7	7.3	7.5
8 to 14	51.4	56.2
More than 14	41.3	36.3
SF-36 Role emotional**		
M or greater	6.2	16.4
Between M and $M-\sigma$	10.0	17.8
Between $M-\sigma$ and $M-2\sigma$	27.0	23.3
Lower than $M-2\sigma$	56.8	42.5
SF-36 Social functioning**		
M or greater	4.2	11.6
Between M and $M-\sigma$	11.2	13.7
Between $M-\sigma$ and $M-2\sigma$	25.5	34.9
Lower than $M-2\sigma$	59.1	39.8
Self-reported suicidal ideation***		
No	70.3	91.8
Yes	29.7	8.2

* Threshold for a possible depression: HAD depression score of 8 or more. Anxiety: HAD anxiety score of 8 or more (Razavi et al., 1989).
** Comparisons are made with the average score (M) and its standard deviation (σ) estimated in a French general population survey, controlling for sex and age (Leplège et al., 2001).
*** Beck Depression Inventory.