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Suicidal ideation among outpatients at general neurology clinics: prospective study

Alan J Carson, Steven Best, Charles Warlow, Michael Sharpe

Suicide is one of the ten most common causes of death for both men and women in Great Britain. Psychiatrist disorders are the main risk factor, but numerous studies have also identified physical illness as an important contributory factor. Although it is considered mandatory to enquire about suicidal ideation in psychiatric consultations, this is seldom part of a medical assessment. We aimed to examine suicidal ideation in a consecutive series of patients who had been newly referred to general neurology outpatient clinics. The study was approved by the local research ethics committee.

Participants, methods, and results

As part of another study, 300 of 312 consecutive new patients at the general neurology outpatient clinics at the Western General Hospital, Edinburgh, were interviewed using the primary care evaluation of mental disorders (PRIME-MD) structured psychiatric interview schedule. As part of the interview all patients were asked: “In the last two weeks, have you had thoughts that you would be better off dead or of hurting yourself in some way?”

Patients who answered yes were asked to describe the nature of these thoughts. To be classed as experiencing suicidal ideation the patient had to have thought about active plans for committing suicide—such as buying tablets—nearly every day for the previous two weeks. Whenever a patient reported such ideation the general practitioner was informed.

Diagnoses of anxiety and depressive disorders that were made using the structured interview were also recorded. After the clinical consultation, the neurologists recorded the neurological diagnosis and whether the patient required psychiatric or psychological assessment or treatment.

Before a patient attended the clinic the patient’s general practitioner was sent a brief questionnaire. The general practitioners were asked to indicate whether they believed that the patient required psychiatric or psychological assessment or treatment.

At the time of assessment the researchers were blind to the opinions of the neurologists and the general practitioners.

The clinical characteristics of the patients attending the clinics are shown in the table. One in 11 patients (26/300) seen at the general neurology clinics had given serious thought to committing suicide in the past two weeks. Almost all of these patients (25/26) had major depression. It might be assumed that suicidal ideation would be more likely to occur in patients with progressive, debilitating neurological conditions. However, this was not the case. Twelve of the 26 patients who had experienced suicidal ideation had medically unexplained symptoms, and most of the remainder had non-progressive conditions.

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Competing interests: None declared.


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Clinical characteristics of new patients attending neurology outpatient clinics. Values are numbers (percentages) unless indicated otherwise

<table>
<thead>
<tr>
<th></th>
<th>Patients with suicidal ideation* (n=258)</th>
<th>Patients without suicidal ideation (n=274)</th>
<th>Relative risk (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Men</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age &lt;40 years</td>
<td>15 (58)</td>
<td>128 (47)</td>
<td>1.50 (0.71 to 3.15)</td>
</tr>
<tr>
<td>Has non-progressive neurological disease‡</td>
<td>12 (46)</td>
<td>153 (56)</td>
<td>0.83 (0.54 to 1.27)</td>
</tr>
<tr>
<td>Has potentially progressive neurological disease§</td>
<td>2 (8)</td>
<td>43 (16)</td>
<td>0.49 (0.13 to 1.61)</td>
</tr>
<tr>
<td><strong>Women</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age &lt;40 years</td>
<td>14 (54)</td>
<td>160 (58)</td>
<td>0.84 (0.40 to 1.76)</td>
</tr>
<tr>
<td>Has medically unexplained symptoms</td>
<td>12 (46)</td>
<td>78 (28)</td>
<td>1.62 (1.03 to 2.56)</td>
</tr>
<tr>
<td>Has non-progressive neurological disease†</td>
<td>12 (46)</td>
<td>153 (56)</td>
<td>0.83 (0.54 to 1.27)</td>
</tr>
<tr>
<td>Has potentially progressive neurological disease§</td>
<td>2 (8)</td>
<td>43 (16)</td>
<td>0.49 (0.13 to 1.61)</td>
</tr>
</tbody>
</table>

Identified as needing psychiatric assessment§:
- By general practitioner: 8 (31) 43 (16) NA
- By neurologist: 12 (46) 40 (15) NA
- Not identified: 11 (42) 170 (62) NA

NA—not applicable.
*Prevalence is 9% (95% CI 6% to 12%).
†Includes conditions such as epilepsy, headache, migraine, and neuropathy.
‡Includes conditions such as multiple sclerosis, Parkinson’s disease, and brain tumours.
§Not specifically identified as being suicidal.

Comment

Our findings do not support the view that suicidal ideation occurring in neurology patients is largely a rational response to progressive physical illness. Instead, the findings underscore the importance of major depressive disorder in influencing the ways that medically ill patients think about their illnesses and themselves.

The prevalence of 9% (95% confidence interval 6% to 12%) for significant suicidal ideation described in this study is higher than the 2-3% described as occurring in primary care and community settings in the United States.1 We are unaware of any data that indicate what proportion of those who are medically ill and who report suicidal ideation actually go on to kill themselves. None the less, suicidal ideation of the type considered important in this study is clinically significant: it would be taken seriously during a psychiatric consultation.

It is encouraging that 58% of those patients with suicidal ideation were identified by either the general practitioner or the neurologist as needing psychiatric or psychological assessment or treatment. However, general practitioners and neurologists did not always identify the same patients. This highlights the importance of assessing the mental state of medically ill patients and the importance of communication of the findings between general practitioners and specialists.

Contributors: AC developed the primary hypothesis, discussed core ideas and study design, contributed to data collection and analysis, and participated in writing of the paper. SB assisted with data collection and analysis and contributed to writing the paper. CW and MS discussed core ideas and the design of the study and contributed to writing the paper. MS is guarantor for the paper.

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Competing interests: None declared.

2 Feinstein A. Multiple sclerosis, depression, and suicide: clinicians should pay more attention to psychotherapy. BMJ 1997;315:691-2.