How to identify risk in the General Practice setting
Psychosis,
Suicidal ideation

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Risk of Psychosis, early presentations to GPs

- Often a GP practice is the first point of call
- Unexplained functional decline;
  - Person may present with symptoms of depression and or anxiety
  - Decline in personal care, socialization, school or work performance, relationships
  - Fluctuating suicidality
- This may indicate the person has an increased chance of transitioning to psychosis

- This presentation is referred to as Ultra High Risk (UHR)
- Patients who seek health care usually from primary care agencies such as GPs are more often than not in better clinical condition and at less risk of suicide than those who do not seek help

- Mean time between the onset of symptoms and treatment is 1-2 years
- Duration of Untreated Psychosis (DUP), risk factor for poor outcomes
- Reducing DUP- reduce severity of illness
- Experiencing psychotic symptoms does not necessarily indicate the presence of a disorder.
- Psychotic symptoms- continuum of normal experiences, with a median incidence of 3% in the general population;
- 75-90% of psychotic experiences are transitory and disappear with time

Early Psychosis (EP)

- Includes period retrospectively called prodrome (the Ultra High Risk period), also considered to include the period of up to 5 years from entry into treatment for first episode psychosis

Risk facts to consider

- 10-25% of people with FEP report deliberate SH or suicide attempt prior to treatment
- Person with Dx of schizophrenia 4 x more likely to be convicted of violence offences
- Significant correlation between DUP and homicide
- 34% FEP have experience sexual or physical abuse, bullying, family violence, running away from home
- 30% FEP experience child sexual/physical abuse
- Suicide higher risk on adm and d/c from hospital
- 16-25% of people with Schizophrenia are reported victims of violence at some time in their life

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Treatment, Ultra High Risk (UHR)

The possibility of psychotic disorder should be considered for anyone who is experiencing unexplained functional decline.

- Mental state monitored regularly
- Manage symptoms such as depression, anxiety, substance use
- CBT to reduce psychotic symptomology to prevent or delay transition to psychosis; and improve social functioning- Referral to PHCP for CBT
- Omega-3 may delay or prevent transition to psychosis
- SGA not normally prescribed unless 1 wk+ of overt symptoms

Antipsychotic Medication,

refer to specialist services

- Antipsychotics shouldn't be prescribed unless at least 1 week of overt psychotic symptoms (accept if symptoms are directly associated with risk of self-harm or aggression)
- **'start low go slow'-** people with FEP respond to much lower doses(biological sensitivity, respond more rapidly)
- Low dose SGA indicated where there is a rapid worsening of psychotic symptoms or significant deterioration of function
- SGA- Amisulpride, Aripiprazole, Quetiapine, Risperidone, Ziprasidone, Clozapine (Olanzapine not recommended)

Medication con't

- UHR concerns because of SE and need to prioritise comorbid disorders (depression/anxiety)
- Low dose SGA with or without CBT helpful in ameliorating symptoms and preventing transition to psychosis
- Tx Naive person more susceptible to SE
- ADT associated with lower rates of transition to psychosis than antipsychotics
- Omega-3 polyunsaturated fatty acids reduce the rate of progression to psychosis
- Pharmacological Tx should con't for 2-5 years

Presentations with suicidal ideation and self harm

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- Suicide is the leading cause of death due to injury in Australia
- Most people who die by suicide do so because of overwhelming and unbearable psychological distress.
- If people are safely helped through this period of high risk they can usually recover their equilibrium and do well.
- A significant proportion of people who die by suicide have had contact with a health professional in the weeks prior to their suicide.
- For every person who dies by suicide, it is estimated that 20 more people attempt to take their life

KNOWN RISK FACTORS

Individual	Situational	Social and/or cultural
• Biological or genetic • History of suicidal behaviour • Major physical or chronic illnesses including chronic pain • Mental illness (including those unrecognised or untreated) • Alcohol or substance misuse • History of trauma, abuse or neglect • Low socio-economic status • Restricted educational achievement • Family history of suicide • Sense of isolation • Feelings of helplessness or hopelessness • Impulsiveness	• Job and financial losses • Long term unemployment • Stressful life events, including natural disasters such as drought • Breakdown of relationships • Bereavement or the loss of a loved one • Contact with the criminal justice system • Transition from school, hospital care, or correctional facilities • Maladjustment to residential aged care • Homelessness or the risk of homelessness • Social dislocation or discord • Easy access to lethal means	• Exposure to suicidal behaviours • Stigma associated with poor help seeking behaviour • Barriers to accessing healthcare, particularly mental health and substance misuse treatment • Social isolation and lack of social support • Victimisation, bullying and stigma • Discrimination • Cultural alienation or dislocation • Inappropriate media reporting

Source: Adapted from *WHO Public Health Action for the Prevention of Suicide 2012*[15]

Assessment of suicide risk

Assessment of risk determines the severity of self-harm, suicidal thoughts or behaviour including identifying

- Any specific plans for suicide,
- Access to means,
- Potential lethality of the chosen method,
- Persistence of ideation,
- What precautions against discovery were planned,
- Impulsivity and distorted thinking
- Details of any previous suicide attempts

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- Historical factors of past harm
- Current situational contexts / triggers which influence risk
- Assessment of clients likelihood to collaborate with risk management
- Previous positive resources/ protective factors and coping strategies

Protective factors