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Can we save more lives?

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Psychotic depression represents a considerable suicide risk. Our review of early warnings in the aftermath of suicide shows that symptoms of psychotic depression are frequently described, but have been interpreted as something else. It is crucial that this potentially life-threatening condition be detected and treated.

Illustration: Cecilie Maurud Barstad

Since the early warning system was established pursuant to the Specialist Health Services Act in 2010, the Norwegian Board of Health supervision has received and dealt with 4 505 early warnings. Of these, 2 113 came from the mental health services and interdisciplinary specialised addiction treatment service, and more than one-half of them were closed after initial investigations. Most early warnings involved suicide or attempted suicide. It appears that there is insufficient diagnostic competence in psychotic depression.

In all healthcare, it is essential that the patient's condition and need for treatment be clarified as quickly as possible. Untreated severe depression has a poor prognosis (1). With appropriate, individually adapted treatment, however, the prognosis will normally improve significantly. In our review of early warnings we have found a series of examples showing that those who have identified and assessed the patients apparently had insufficient knowledge about psychotic depression. In some cases we found that virtually all the core symptoms of psychotic depression had been described, but no diagnosis had been made. The cases we have reviewed are evenly distributed among different health authorities all over Norway. In most of the cases, the patient had been treated by many professionals, including psychiatrists and psychology specialists. Often, the patient had undergone several weeks of treatment, both as an outpatient and in a psychiatric unit.

Examination and risk assessment

Severe depression with psychotic symptoms is underdiagnosed and undertreated (2). Brooding, anxiety and irritation can be prominent, in addition to the common symptoms of guilt, shame or somatic disease. In many cases, the patient finds it difficult to speak about their feelings with others, and they will not spontaneously divulge their symptoms. Even though these ideas are identified, their psychotic nature often goes undetected (3). A Norwegian study has demonstrated how impulsiveness in these patients represents a considerable challenge in the identification of suicide risk (4), since the patients may act on a psychotic impulse with a lethal outcome.

Often, a marked decline in functioning and change in behaviour have occurred over a short time before the onset of symptoms in an otherwise high-functioning person. In many of the early warnings we find a short case history, often no more than a few weeks, with no obvious precipitating incident. The patient may have visited their GP due to anxiety and sleep disturbances and have been prescribed a tranquiliser or hypnotics that have had no particular effect. In particular, we have noticed that severe anxiety and agitation have been assessed and treated as a primary anxiety disorder and not as part of a depressive syndrome, even after referral to the specialist health service. This applies especially to male patients (5) with simultaneous depressive and psychotic symptoms and a marked functional decline. An American study of suicides that occurred in hospital wards and immediately after discharge showed that 60 out of 76 patients who later took their own lives suffered from severe anxiety or agitation (6). In some early warnings we have seen information from family members reporting that the patient was walking around at home screaming that they could not bear it any longer.

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Psychotic depression is such a serious and significant risk factor that it alone should be given major emphasis. In the early warnings we observe that these patients may have given a negative answer to questions about suicide ideation and plans. This concurs with the findings made by Busch and colleagues (6), where 78 % of the patients who took their own lives had denied any suicidal thoughts in their last communication on this topic before the suicide occurred. Furthermore, these patients often lack many of the other risk factors for suicide, such as previous suicide attempts, substance abuse problems or relationship issues.

From the medical records we observe that many of the patients have been considered to be at 'low risk of suicide'.

Treatment level

We have seen that many patients with severe depressive and psychotic symptoms are treated as outpatients or in a regional psychiatric inpatient unit. We would argue that a regional psychiatric clinic (DPS) or an open inpatient ward will not normally provide an appropriate framework for adequately examining, treating or protecting the patient in the most severe phase, primarily because of the suicide risk. In retrospect, we regularly see that patients who ended by taking their own lives were treated at a service level that in all likelihood was too low.

This may be so because some of the patients appeared to be calm and cooperative. Severe anxiety and agitation may also conceal the more serious underlying psychotic symptoms. The psychosocial conditions surrounding the patients will often be good, and this will further prevent them from being perceived as seriously ill. It is important for the healthcare personnel that assess the treatment level to be aware that in cases of depression, psychotic symptoms are often hidden (7).

Severe depression with psychotic symptoms is underdiagnosed and undertreated

The degree of capacity to provide consent may fluctuate in these patients. They are therefore often hospitalised voluntarily, in conditions that provide insufficient protection against suicide. Some also decline the offer of hospitalisation. It is right to focus on the patient's autonomy and reduced use of coercion, in line with the guidelines from the authorities, but we would nevertheless warn against the risk of underestimating the severity of the patient's condition in cases of psychotic depression. In many of the early warnings of psychotic depression that ended in suicide, no assessment had been made as to whether those patients met the risk criterion in the Mental Healthcare Act.

Parallel assessment and treatment

In the cases that we have examined, no criteria-based diagnostics or scoring tools had normally been used. Some of the patients had undergone treatment for several weeks without any diagnosis. Many of the patients suffered from anxiety and sleep disorders, for which treatment must be provided at the acute stage. Listening to the patient's history and helping instil hope already in the initial meetings are part of an appropriate course of treatment. A key goal is to reduce the time during which the patient has serious and distressing symptoms (7). Treatment of the underlying disorder and any comorbid conditions should be initiated without delay when the condition has been identified and sufficiently assessed.

Listen to the relatives

Relatives are an extremely important source of information. Patients rarely take the initiative to contact the healthcare services themselves; most often they will arrive accompanied by a concerned relative. Information from relatives indicating serious symptoms and functional decline should be given considerable weight. Our impression is that healthcare personnel have not sufficiently listened to or attached importance to information from concerned relatives when assessing apparently incomprehensible changes in the patient.

Occasionally, relatives have not been given sufficient support and information in a critical phase for the family. In some cases we have seen that relatives have been unreasonably burdened and given considerable responsibility for the care and monitoring of patients with serious and distressing symptoms that are treated at home. We therefore wish to emphasise that the relatives' need for information and support must be continuously

assessed.

Furthermore, it is necessary to assess the burden that the family members themselves feel that they are shouldering and to have realistic expectations of the contribution they might make. Where psychotic depression is suspected or confirmed, treatment at home is generally not recommended because of the suicide risk. For this reason, it is important to enable the family to make good decisions on their own behalf. Both the patient and their relatives must be provided with suitable information about the condition in question and the risk that it presents, including information on suicide risk and the type of treatment that is recommended at the different stages of the clinical pathway (8).

Review of serious incidents

It is crucial that healthcare personnel have the competence to identify, diagnose and treat this condition. Quick implementation of good, evidence-based treatment can save lives (8). Each health enterprise is responsible for ensuring that its healthcare personnel possess the required competence in suicide prevention, treatment of psychotic depression and identification of a break with reality. Psychotic depression occurs infrequently, and it is thus difficult for clinicians to acquire extensive practice. Medical simulation training, sharing of clinical experience and review of case histories are examples of methods that could help ensure the required interdisciplinary competence. Moreover, the health enterprises must establish adequate frameworks that can identify patients with symptoms of psychotic depression at the earliest possible stage and provide them with proper treatment.

Information from relatives indicating serious symptoms and functional decline should be given considerable weight

The health enterprises are responsible for systematically undertaking a retrospective review of all suicides or serious attempts at suicide, with a view to learning and improvement. This practice is endorsed by Section 8e of the Regulations concerning management and quality improvement in the healthcare services (9), but also characterises good professional management. The Norwegian Board of Health Supervision has prepared a template for self-evaluation that we have requested health enterprises to undertake once we have assessed the early warning (10). The objective is to encourage managers and healthcare personnel to jointly reflect on their own practices to identify what went wrong: were the symptoms identified, how were they assessed, and what impact did these assessments have on the treatment? Are the staff members sufficiently trained and competent? Are there any procedures for specialist assessment?

Conclusion

In a patient safety perspective, the entire course of treatment should be mapped out and each step analysed to identify the potential for both failure and improvement. Experience indicates that when serious incidents occur, there have often been several points of failure. Other risk-exposed sectors, such as aviation and the petroleum industry, assume a system perspective when lessons are to be learned from serious incidents.

To avoid unrealistic expectations that all suicides can be prevented, it is also important to acknowledge that patients who are treated by the mental health service might take their own lives without this invariably being due to failure on the part of the healthcare services.

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