

# Surgeon General NOTAM

## RISK MANAGEMENT LESSONS

16 December 1999

The following Notice to Airman (NOTAM) is released by the Clinical Quality Management Division, Air Force Medical Operations Agency, (AFMOA/SGOC) to disseminate critical information and lessons learned from medical incident investigations, sentinel events, malpractice claims and adverse actions.

**ATTENTION:**  
**THE FOLLOWING IS AN OFFICIAL SG NOTAM**  
**PLEASE PRINT, READ, AND DISSEMINATE TO ALL MTF**  
**PERSONNEL.**

### **99-012: SUICIDE PREVENTION**

#### **Back to basics: Diagnosing and Treating Depression**

The following information is presented to heighten awareness regarding the need to carefully evaluate patients presenting to Mental Health with complaints of depression. A review of critical steps including attention to diagnosis, identification of complicating variables increasing suicide risk, and discussion/consideration of appropriate treatment modalities are emphasized. This NOTAM does not intend to exhaustively review all elements of the diagnosis and treatment of depression, but draw attention to key areas that must be considered.

The Air Force Active Duty Community has continued to see a decline in number of suicides over the past five years and most dramatically over the past year. There have been 19 suicides in CY 99 for a total rate of 5.6/100,000 in comparison to 33 suicides at this time in CY98 for a total rate of 9.6/100,000. The overall rate has declined over 40% in this time and 78% since CY 94.

Functional communities, commanders, first sergeants and supervisors have all contributed to this outcome by creating a more caring and supportive environment in the workplace, increasing recognition of personnel who need help and reducing stigma to obtaining that help.

*An individual who seeks help from Mental Health for complaints of depression must be assured that he or she will receive thorough and comprehensive diagnosis, necessary treatment, and relief from suffering.*

The soon to be published DOD-VA Clinical Practice Guideline for the Management of Major Depressive Disorder in Primary care, Outpatient Mental Health and Inpatient Mental Health, summarizes current evidence-based, best practice recommendations from the clinical

literature as well as from senior clinicians' expertise. The resulting algorithms and annotations summarize the steps that should be followed to effectively evaluate and treat individuals who present in these settings with possible depressive illness. The Practice Guideline standardizes practice and facilitates thoroughness of clinical activity to ensure that evaluation and treatment of depressed individuals meets recognized standards of care.

## DIAGNOSING DEPRESSION

Following an initial assessment to determine the need for immediate intervention (imminent dangerousness, need for acute medical evaluation or hospitalization) the inquiry should focus on obtaining a careful mental health history that identifies current signs and symptoms of depression as well as characterizing prior episodes of illness. The diagnosis of depression is based on the assessment of the patient's mood, behavior, history, and specific symptoms.

*Many clinicians use structured interviews and questionnaires to assist in the screening and/or diagnosis of depression. It is imperative that all data derived from such tools or aids be reviewed systematically during the diagnostic evaluation process.*

Patients will often endorse items or present information in a written format that they may not verbally disclose during an interview. There is no excuse for failing to incorporate data from all sources when conducting a diagnostic interview.

An important question to ask all patients with complaints of depression is "Why are you seeking help **now**?" In the instance of someone who has struggled for years with chronic mild depression, the search for help or relief **now** may signal the development of a more serious depression superimposed on a milder illness. Individuals with "double depression" and suicidal ideation are complex and may require pharmacotherapy and close follow-up. This line of questioning facilitates an exploration of precipitants to depression and the possibility of hopelessness and suicidality.

There are generally a number of "red flags" in depressed patients to suggest a need for increased attention to suicide risk. Although not all-inclusive, some common areas of concern are:

### History of Abuse

- Alcohol and other substance abuse have a strong association as both a cause and an exacerbant for depression. Even "light to moderate" and/or "social drinking" should be pursued in a patient who presents with depression.
- **There is a high likelihood of depression in individuals with a past or present abuse history.** All patients should be asked directly about physical and sexual abuse. Clearly a history of recent loss, whether of a significant relationship or work, economic or social status, is critical.

### Prior Episodes of Depression

- While making a diagnostic assessment of depression it is important to bear in mind that some patients present features which require more involved management. These complicating factors may influence treatment decisions.
- Prior episodes of depression and treatment episodes are crucial. Patients with histories of chronic depression may benefit from multiple therapies. Comorbid mental health problems and significant maladaptive personality traits may make treatment less effective and dictate the need for more complex treatment modalities.

### Any History of Suicidality

- Any history of suicidality (both behavior and thoughts) must be clarified. **The presence of sustained suicidal thinking in a depressed patient with a family history of depression and suicide, particularly in a first degree relative, heightens the risk of suicide for that individual and will more likely direct the clinician to recommend antidepressant medication.**

*Following a diagnostic evaluation, the patient must be EDUCATED about the nature of the depressive illness, available treatment options, their expected positive and negative effects and the potential consequences of untreated depression.*

*The process of informed consent is crucial to treatment and should be reflected in the chart. Whenever possible, family members should be included in the educational discussion.*

## TREATING DEPRESSION

Currently there are three main treatment options for major depressive illness: pharmacotherapy alone, psychotherapy alone, and a combination of pharmacotherapy and psychotherapy. These options are also applicable to milder chronic forms of depression, such as dysthymia. Treatment recommendations must consider the severity of illness and potential complicating variables prior to selecting an initial course of treatment. **The selection of treatment in the outpatient setting should be based on clinical judgement, patient preference, and individual risks/benefits for each treatment option considered. The discussion, recommendations and treatment decisions have to be documented in the clinical record.**

Often a patient is given antidepressant medication if he or she is suffering from moderate to severe symptoms of depression, experiencing significant impairment in social or occupational suffering, and suicidal ideation. A past history of positive response to medications, a negative response to psychotherapeutic interventions, recurrent depressive episodes, and/or family history of depression are strong indicators for treatment with antidepressant medications.

Specific forms of short-term, structured psychotherapies with established efficacy for treatment of major depression include cognitive, behavioral and interpersonal psychotherapies. Referral should be made to a therapist experienced in the use of such psychotherapy (ies) for the treatment of major depression that may be provided in individual, group or couples format.

**Psychotherapy for the treatment of depression is not simply unstructured, brief support.**

**Patients who present for help with symptoms of depression and suicidal thoughts, not requiring hospitalization, should be followed closely.** An initial follow-up appointment for a patient initiating treatment for depression with either medication or psychotherapy should be offered within a week. Similarly, patients requiring a more extended evaluation, or patients awaiting an assignment to a provider for treatment should be seen again in a week or at the latest within two weeks. Availability of the provider and emergency access options should be reviewed with all patients during their first appointment.

Depression is a common illness with significant morbidity and mortality risk. 90-95% of individuals successfully completing suicide suffer from a diagnosable mental illness. Affective illness or depression is the most likely diagnosis (45-70%), followed by alcoholism (25%). Effective treatments do exist. Individuals presenting for care with symptoms of depression should be assessed thoroughly with attention to all indicators of suicide risk. Many data sources including collateral history should be evaluated during a diagnostic assessment. Efficacious treatment options must be presented to the patient with recommendations addressing the risks and benefits dictated by the specific clinical circumstances.

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