SUICIDE ASSESSMENT AND DOCUMENTATION

AMANDA FOCHT, MD
ACTING ASSISTANT PROFESSOR
DEPARTMENT OF PSYCHIATRY AND BEHAVIORAL SCIENCES
UNIVERSITY OF WASHINGTON
MEDICAL DIRECTOR
OUTPATIENT PSYCHIATRY
UNIVERSITY OF WASHINGTON MEDICAL CENTER
GENERAL DISCLOSURES

The University of Washington School of Medicine also gratefully acknowledges receipt of educational grant support for this activity from the Washington State Legislature through the Safety-Net Hospital Assessment, working to expand access to psychiatric services throughout Washington State.
SPEAKER DISCLOSURES

✓ Any conflicts of interest? No
OBJECTIVES

1. Identify risk factors for suicide
2. Understand how to manage acute situations
3. Understand how and what to document
BACKGROUND

• 37,000 people in the US die by suicide each year. Up to 650,000 seek treatment after an attempt.

• In the US, suicide ranks 7th in causes of years of life lost

• Between 1999-2010 rate in the US in between 35 and 64 increased by 30%
  – Largest increase:
    • Men in their fifties (30 per 100,000)
    • Women ages 60-64 (7 per 100,000)

  Factors: “great recession,” opioid addiction, Iraq and Afghanistan conflicts

• In the US, 57% of suicides are accomplished with firearms. Rate is higher among veterans.

• Suicide rates in adolescents increased up to 10 times in households with a firearm
RISK FACTORS

• Psychiatric disorders
  – Depression, bipolar, substance use, schizophrenia, personality disorders, panic disorder, PTSD
  – Presence of depression and anxiety together increases the risk
  – Psychosis increases the risk regardless of diagnosis
  – 20-25% of people who commit suicide are intoxicated with alcohol
RISK FACTORS CONTINUED—SYMPTOMS

• Hopelessness, guilt, loneliness—symptoms that can persist
• Impulsivity—especially in adolescents and young adults
• Combine the above with substance use--particularly lethal.
• Panic
• Severe insomnia
RISK FACTORS—SUICIDE-SPECIFIC

• Passive vs. active
• Frequency and intensity of thoughts
• Current plan
• Access to lethal means (firearms, med stockpiles)
• Preparation—researching, assembling means
• Rehearsing
• Putting affairs in order
• Writing a note
RISK FACTORS—HISTORICAL

• History of prior attempt—strongest single risk factor—about 5 times more likely to die by suicide. Magnified if more than 1 prior attempt
• History of self harming behavior
• Family history of suicide: heritability 30-50%
• Childhood abuse, especially sexual abuse
• Adverse childhood experiences
RISK FACTORS—HISTORICAL, CON’T

• Characteristics of previous attempts:
  – High lethality
  – High intent to die
  – Similar circumstances
  – Intent to conceal
  – No help seeking
RISK FACTORS-DEMOGRAPHICS

• White men 85 yo or older: highest rate of suicide
• Risk of lethal suicide increases with age
• Young adults have more non-lethal attempts
• Marital status:
  – highest risk: never married
  – lowest risk: married with children
• Living alone
• Veterans
• Rural vs. urban setting
RISK FACTORS—PHYSICAL HEALTH

• Increased risk as physical health declines
• Chronic pain, cancer, CAD, COPD, diabetes, terminal illness
RISK FACTORS: SITUATIONAL

- Family or marital conflict
- Unemployment
- Social withdrawal
- Loss (financial, interpersonal, professional)
- Recent discharge from an inpatient unit
PROTECTIVE FACTORS

• Positive and available social support
• Positive therapeutic alliance
• Feeling of responsibility: children, family, pets
• Fear of suicide, dislike of suicide
• Religious beliefs
• Hope for the future, life satisfaction
• Intact reality testing
• Presence of positive coping skills, good judgment
PATIENT ASSESSMENT

• Ask about thoughts—often patients will not offer this information

• Screen—Note PHQ-9 question 9 score, follow up with questions

• Characterize by asking follow-up questions related to the above risk factors
MANAGEMENT

• Reduce immediate risk
  – Refer to higher level of care, if needed
  – Coordinate care with other clinicians, mental health specialists
  – Enjoin family members
  – Remove firearms
  – Increase clinical contact
  – Treat symptoms, especially insomnia
  – Safety planning
HOW TO GET AN OUTPATIENT TO THE ED

• Same management for primary care as specialty care
• Ask for support from other staff
• Call 911 (need both police and EMS)
• Manage emergency response
• Monitor patient at all times
• Trouble-shoot ambivalence (pets, car needs to be moved, one last cigarette)
• Do not allow a patient to self-transport, even with a family member
• Don’t be talked out of the above
• If there is a good chance the patient will not want hospitalization, coordinate above without alerting the patient. Have police and EMS assembled prior to informing the patient of the plan. Potentially aggressive patients: have police take the lead
• If a patient wants to leave the clinic, only police are able to detain/initiate physical restraint
• If a patient leaves prior to police arrival, or patient is not in the clinic to begin with, alert police and MHPs (mental health professionals)
WHAT TO DOCUMENT

• Review of as many of the above risk factors if possible
  – History/current presentation
  – Protective factors
  – Clinical decision making/level of risk
  – Plan to reduce risk

• If complete review is not possible/practical, document who will be responsible for this review (outpatient psychiatrist, ED, you at the next visit)

• Assessment of the level of risk
ASSESSING LEVEL OF RISK

• No standardized risk assessment scale exists that has been shown to have high predicative value (patients who attempt and those who don’t are very similar)
• Clinician are in general poor at accurately predicting risk
• Document risk level: low, medium or high
• Make sure to document clinical decision making
• “In my opinion”
• From a medical-legal standpoint you can be wrong, but you must document your assessment and decision-making
CONTRACTING FOR SAFETY

• Poor standardization of this concept
• No evidence it works
• Creates a false sense of security
• Will not stand up in court
• Instead:
  – Create a therapeutic alliance
  – Continue to ask, assess, manage and document
REFERENCES