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Psychiatry and Addictions Case Conference

UW Medicine | Psychiatry and Behavioral Sciences

SUICIDE ASSESSMENT AND DOCUMENTATION

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GENERAL DISCLOSURES

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SPEAKER DISCLOSURES

- ✓ Any conflicts of interest? No

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OBJECTIVES

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

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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

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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

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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

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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

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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

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RISK FACTORS—HISTORICAL, CON'T

- Characteristics of previous attempts:
  - High lethality
  - High intent to die
  - Similar circumstances
  - Intent to conceal
  - No help seeking

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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

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RISK FACTORS—PHYSICAL HEALTH

- Increased risk as physical health declines
- Chronic pain, cancer, CAD, COPD, diabetes, terminal illness

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RISK FACTORS: SITUATIONAL

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

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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

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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

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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

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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)

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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

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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

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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

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