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Psychiatry and Addictions Case Conference

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SUICIDE ASSESSMENT AND DOCUMENTATION

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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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CASE EXAMPLE:

- JA is a 33 yo woman who presents for a follow-up with you to discuss her response to Zoloft. She has been on 100 mg for about a month. Her PHQ-9 score was 21 when she started and is now 27. She has consistently responded to questions about suicidal thinking and hopelessness by saying she feels like she is a burden to her family. She is feeling much worse today after being told by her boss she is performing poorly at work and may be fired. How would we approach assessing JA's risk of suicide?

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—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—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—PHYSICAL HEALTH

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

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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

RISK FACTORS: SITUATIONAL

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

WHAT DO YOU WANT TO ASK JA ABOUT HER HOPELESS/SUICIDAL THINKING?

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RISK FACTORS—SUICIDE-SPECIFIC

- Passive vs. active
- Frequency and intensity of thoughts—and how this compares to past history
- 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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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

BACK TO OUR PATIENT:

You determine that JA had an initial positive response to Zoloft. She was sleeping better and her mood was improved. She was not feeling more activated, impulsive or anxious with the medication. She is consistently sleeping 7-8 hours. The negative feedback from her boss really put her in a tail-spin and she has been feeling worse since then. When she got back from work that day, she found herself going on the internet after her 8 and 6 yo were in bed and researching drug overdose. She tried to OD once before when she was 16 on a bottle of aspirin after an argument with her mom, but has never had thoughts of OD since then.

WHAT ARE YOUR NEXT STEPS?

- Think through the following:
  - What else do you want to know?
  - Can you make her home environment safer? How?
  - What kind of support does she have?
  - Can you ease her symptoms quickly, or will it take time?
  - Can you send her home?

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ED VS. HOME

- What factors may make it safe to send a suicidal patient home rather than to the ED:
  - Support of family/friends (involved others):
    - Optimal if you can speak with the involved other with the patient at the same to time make a plan (make sure there is an ROI)
    - Involved other needs to be actively involved, able to be physically present and easily reachable by both you and patient
    - Clear plan for what to do if involved other is concerned, needs help managing patient (plan for during business hours and beyond)—default is call 911
    - Clear plan for what you will do if you cannot reach patient or involved other to check in

ED VS. HOME, CON'T

- Availability of increased frequency of clinic appointments, telephone calls to check in
  - Be realistic, enjoin other clinic staff to help
  - Clear expectations about next steps if patient does not improve, no-shows, cannot be reached at appointed times

ED VS. HOME, CON'T

- Availability of effective after-hours clinical support:
  - Clinic emergency system: know in advance if this system is able to act quickly and effectively in helping a suicidal patient, sign out if possible
  - Community crisis line: understand what this resource will actually do
  - 911—always the default

COMPLICATING FACTORS

- Who else is in the home?
- Are children involved?
- Children can be a major protective factor for many patients, but actively suicidal patients are not good caretakers. CPS referral needs to be considered if children are involved.
- Minor children should not be in a roll of caretaker, calling 911, etc.
- Similarly, if a patient is the caretaker of an older adult, their wellbeing needs to be considered.

WHAT IF THIS DOESN'T WORK?

- 911 vs. MHP referral
  - 911
    - Pros: Immediate, able to send an emergency response into the field right away. Equipt to contain violent situations.
    - Cons: Will not necessarily follow up if patient is not answering the door, not home etc. Requires you to find out what happened.
  - MHPs:
    - Pros: More thorough evaluation by a mental health professional, essentially a mental health visit in the field.
    - Pros: Will follow up if patient not at home.
    - Pros: Able to access records throughout the state.
    - Cons: Not immediate, delays of up to a day or more before evaluation.
  - Bottom line: you may need to activate both 911 and MHPs

WHEN GOING HOME IS NOT AN OPTION: 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

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

REFERENCES

- Reducing suicide: A national imperative. Goldsmith, SK, Pellmar, TC, Kleinman, AM, Bunney, WE (Eds). Institute of Medicine National Academies Press, Washington 2002.
- Suicide among adults aged 35-64 years--United States, 1999-2010. Centers for Disease Control and Prevention (CDC) MMWR Morb Mortal Wkly Rep. 2013;62(17):321.
- The role of alcohol in suicides in Erie County, NY, 1972-84.Welte JW, Abel EL, Wieczorek W Public Health Rep. 1988;103(6):648.
- Social factors in suicide. Heikkinen ME, IsometsäET, Marttunen MJ, Aro HM, Lönnqvist JK Br J Psychiatry. 1995;167(6):747.
- Suicide in twins. Roy A, Segal NL, Centerwall BS, Robinette CD. Arch Gen Psychiatry. 1991;48(1):29.
- Screening for and treatment of suicide risk relevant to primary care: a systematic review for the U.S. Preventive Services Task Force. O'Connor E, Gaynes BN, Burda BU, Soh C, Whitlock EP. Ann Intern Med. 2013;158(10):741.
- Assessment and treatment of suicidal patients. Hirschfeld RM, Russell JM. N Engl J Med. 1997;337(13):910.
- Focusing suicide prevention on periods of high risk. Olfson M, Marcus SC, Bridge JA. JAMA. 2014 Mar;311(11):1107-8.

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