Assessment and Management of the Suicidal Patient

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Learning Goals/Objectives

- **Develop an initial approach to the evaluation of the suicidal patient**
- **Improve knowledge of risk factors for suicide and risk stratification of the suicidal patient**
- **Learn evidence based management strategies to reduce suicide risk and prevent suicide**

Background

- Suicide is a frequent cause of death
  - Over 41,000 deaths in the U.S. in 2013
    - A suicide death every 12.8 minutes
  - 2nd leading cause of death among 25-34 year olds
  - 3rd leading cause of death among 15-24 year olds
  - 4th leading cause of death among 18-65 year olds

- 45% of suicide decedents seek contact with a primary care provider in the month before death

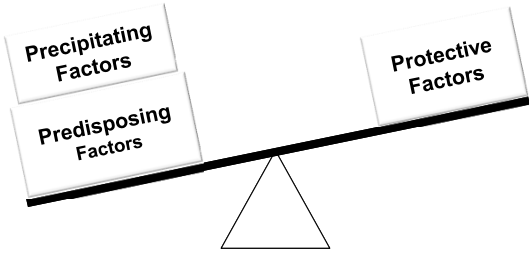
  (Luomo et al, Am J Psych, 2002)

Suicide intervention

- The Good News...
  - Knowledge about best practices in the assessment and management of suicidal individuals is growing
- The Bad News…
  - Most individuals at risk for suicide are unrecognized and/or receive no treatment
  - Barriers include low perceived patient need, stigma, geography, lack of service availability, and finances
- Challenge
  - Distinguishing true cases from “false positives” while “false negatives” remain undetected

Suicide risk assessment

- Learn the specific content of suicidal thoughts
- Consider this against the background of the patient's level of risk, including:
  - Predisposing risk factors
  - Precipitating risk factors
  - Protective factors



How to assess the suicidal patient

- Ask for detailed description of patient's experience with collaborative approach
- Seek multiple sources of information
  - Patient
  - Family members
  - Friends and co-workers
  - Health care professionals and records

How to assess the suicidal patient

- Appreciate the emergent nature of problem
  - Confidentiality balanced by need for safety
  - Balance "necessary efficiency" against "dangerous expediency"
    - Need for flexibility and practicality
    - Need to resist inappropriate compromise
    - Need for humility in face of uncertainty

Keys to a successful assessment

- Knowledge of suicide risk/protective factors
- Proper interview technique
  - Collaborative and non-adversarial stance
  - Systematic, biopsychosocial approach
  - Ability to empathize with the suicidal wish
- Clinician self-awareness regarding attitudes, beliefs, and reactions to suicide

Spectrum of suicidal ideation

- Suicide attempt
- Aborted attempt
- Suicide intent with specific plan
- Suicide intent with ideation about means
- Self harm behaviors
- Active suicidal thoughts
- Chronic suicidal thoughts
- Passive suicidal thoughts
- Passive death wish

Elicit Suicidal Thinking, Plans, and Behaviors

- Assess for suicidal ideation
  - Intensity
  - Frequency of suicidal thoughts
  - Presence of active plan
- Intent to act on suicidal thoughts
- Prior attempts
- Lethality of method(s)
- History of non-suicidal self-injury
- “Wish to die” vs. “Wish to live”

Questions that may be helpful

- **"What keeps you from acting on those thoughts?"**
- **"How likely do you think you are to act on those thoughts / that plan?"**
- **"If you get to feeling that way again, what do you think you would do?"**
  - **Help-seeking vs. self-harm behavior**

Assessment: Elicit Risk Factors

- **Mental and addictive disorders**
  - **Present in ~ 90% of completed suicides**
    - **Mood disorders (MDD, Bipolar disorder)**
    - **Alcohol and Substance use disorders**
    - **Anxiety disorders**
    - **Schizophrenia**
    - **Personality disorders (e.g., Borderline PD)**
  - **Active substance use/intoxication**
  - **Important remediable risk factors for suicide**

Assessment: Elicit Risk Factors (cont.)

- Demographic factors
  - Male gender
  - White/Native American
  - Increasing age into adolescence
- History of psychological trauma
  - Especially maltreatment early in life
- Family factors
  - FH of completed suicide*
  - FH mood and/or substance use
  - Family conflict and domestic violence

Assessment: Elicit Risk Factors (cont.)

- Previous suicide attempts *
  - Especially in prior 6 months
  - Especially high lethality attempts
- High suicidal intent – Wish to die
  - Plan, preparatory behaviors
- Contagion/Imitation
  - Exposure to suicide, media influences
- History of violence/impulsive aggression
- Access to lethal agents
  - Especially firearms

Assessment: Elicit Risk Factors (cont.)

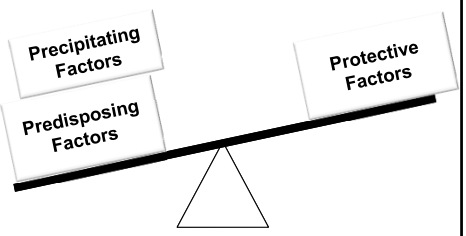
- Individual characteristics
  - Hopelessness/helplessness
  - LGBT
  - Perceived burden on others
  - Poor social skills/social isolation
  - Lack of religious commitment
- Physical illness
  - Special risk for conditions affecting brain such as traumatic brain injury, epilepsy
  - Chronic conditions and HIV
  - Medications

Assessment: Precipitating factors

- Many risk factors are predisposing factors increasing overall risk
  - "Trait" factors that may not be modifiable or are only modifiable in the long run
- Precipitating factors increase short-term risk
  - "State" factors
  - E.g., significant loss (of relationship, health)
  - Some offer an opportunity to intervene to decrease risk

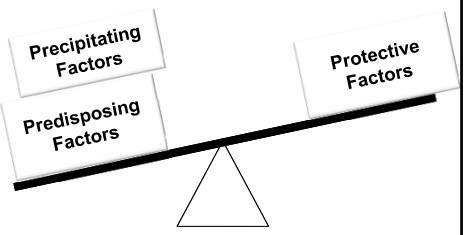
Assessment: Precipitating factors

- Interpersonal conflict or loss
- Disrupted attachments
- Legal/discipline problems
- Substance abuse
- Symptoms of mental illness, e.g. insomnia, anxiety
- Physical pain
- Access to lethal means



Assessment: Elicit Protective Factors

- Protective factors enhance wish to live
  - Connectedness and engagement
  - Social supports
  - Core values/beliefs
  - Patient and family motivation
  - Sense of purpose
  - Plans for the future



Understanding Level of Risk

- Integrate and prioritize collected information
- Assess motivation to minimize/exaggerate risk
- Assess acute/imminent suicidality
- Assess chronic/ongoing suicidality
- Willingness to pursue treatment
- Willingness to secure lethal agents
- Access to 24 hour emergency care
- Document formulation and rationale

Example 1

- A 35 year old woman presents to her PCP with an increase in suicidal thoughts in the context of worsening depressive symptoms and recent death of her mother. She has no specific plan to act on her suicide thoughts. She is married and reports a supportive relationship with her husband. She identifies her two young children and her religious faith as protective factors. She has had no previous suicide attempts. She has not been sleeping well and presents to the PCP office seeking treatment.

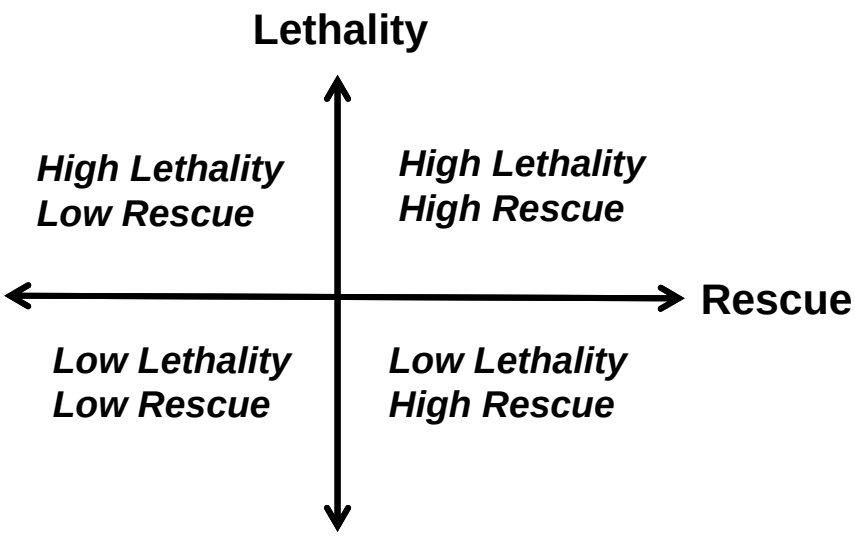
Example 2

- **A 35 year old woman presents to her PCP with an increase in suicidal thoughts in the context of worsening depressive symptoms and recent death of her mother. She has had thoughts of overdosing on her antidepressants. She is separated from her husband. Her only social support had been her mother, who passed away last month. She has not been sleeping well and has been abusing alcohol nightly. She is irritable during the interview. She had a past suicide attempt at age 21.**

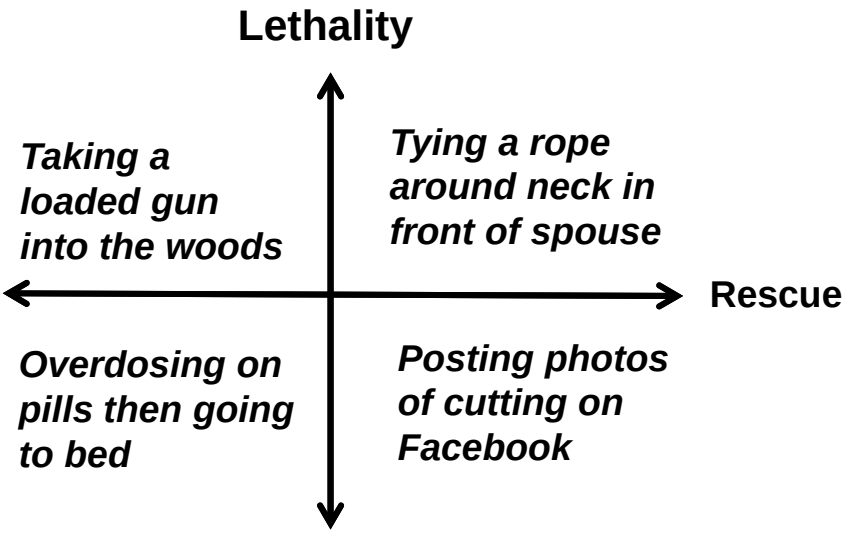
Example 3

- **A 35 year old woman presents to her PCP with an increase in suicidal thoughts in the context of worsening depressive symptoms and recent death of her mother. Last week she took about 10 tablets of her antidepressant with the hope that she would not wake up. Now she has thoughts that it might be easiest to use a belt to hang herself. She is separated from her husband. Her only social support had been her mother, who passed away last month. She has not been sleeping well and has been abusing alcohol nightly. She is irritable during the interview. She has had two previous suicide attempts.**

Suicide risk



Suicide risk



Management

- In the general medical or primary care setting:
  - Treat modifiable risk factors
  - Diagnose and treat underlying mental illness and addictive disorders
  - Identify drivers to suicidal thoughts → develop plan to manage those drivers
- Beyond the general medical setting:
  - High risk patients → Consider hospitalization
  - Refer to specific mental health treatment interventions that can decrease risk

Management of suicidal patient

- Immediate risk reduction should focus on removing access to lethal means
  - Means restriction reduces risk
  - Inquire about the presence of guns in the home
  - Inquire about access to supplies particular to patient's suicide plan (e.g. if thoughts to overdose, ask about access to medications)
- Risk reduction also involves active safety planning
  - Little evidence for "no harm" contracts
  - Better to ask patient what help-seeking behaviors they will do

Safety Planning

- Establish safety plan
  - Emergency contacts
  - Encourage removal of lethal agents
  - Establish adequate supervision
- Communicate with relevant professionals
- Address modifiable risk/protective factors
- Determine disposition and arrange follow-up

CAMS approach to suicide management

- Collaborative Assessment and Management of Suicidality (CAMS)
- Monitors suicide risk over time by looking at:
  - Psychological pain
  - Stress
  - Agitation
  - Hopelessness
  - Self-hate
- "Wish to Live" and reasons to live
- "Wish to Die" and reasons to die

CAMS approach to suicide management

- **Focuses on identifying two key drivers for suicide risk and specific interventions for each driver**
- **The patient identifies the key drivers**

Problem	Goals	Intervention
Marital Conflict	Get along better with wife	Marital counseling
Physical pain	Improved pain control or improved quality of life despite pain	Referral to pain management clinic
Incapacitating depression	Symptom resolution	Antidepressants and individual therapy

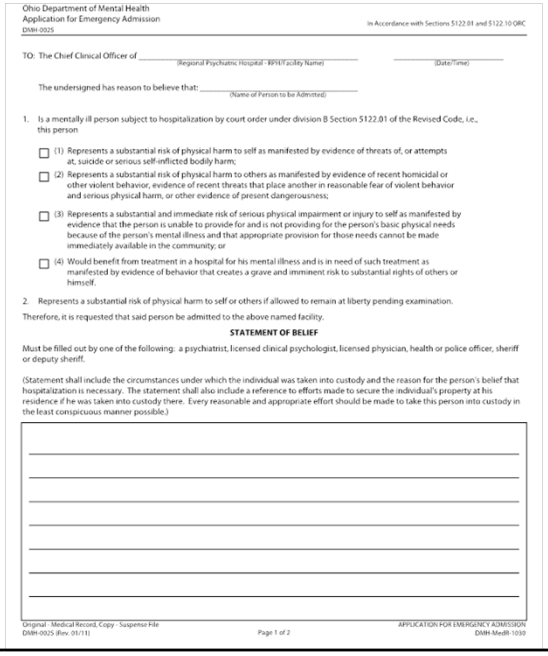
When to consider Hospitalization

- **Attempt with high lethality/intent**
- **Active suicidal ideation with plan and intent**
- **Previous suicide attempts**
- **Serious psychiatric disorder**
  - **Psychosis**
  - **Bipolar disorder**
  - **Substance abuse**
- **Family unable to protect and monitor**
- **Prior noncompliance/failure of other Rx**

"Application for Emergency Admission"

- **In Ohio, a physician can issue an involuntary hold for up to 72 hours for patients who pose a threat of harm to self, to others, or grave disability on the basis of mental illness**
- **"Pink slip" or "psych hold"**
- **Application form is available online through OMHAS web site**

"Application for Emergency Admission"



Ohio Department of Mental Health
Application for Emergency Admission
DMH-0025

In Accordance with Sections 5122.01 and 5122.10 ORC

TO: The Chief Clinical Officer of _____ _____
(Regional Psychiatric Hospital - RPH/Facility Name) (Date/Time)

The undersigned has reason to believe that: _____
(Name of Person to be Admitted)

1. Is a mentally ill person subject to hospitalization by court order under division B Section 5122.01 of the Revised Code, i.e., this person

☐ (1) Represents a substantial risk of physical harm to self as manifested by evidence of threats of, or attempts at, suicide or serious self-inflicted bodily harm;

☐ (2) Represents a substantial risk of physical harm to others as manifested by evidence of recent homicidal or other violent behavior, evidence of recent threats that place another in reasonable fear of violent behavior and serious physical harm, or other evidence of present dangerousness;

☐ (3) Represents a substantial and immediate risk of serious physical impairment or injury to self as manifested by evidence that the person is unable to provide for and is not providing for the person's basic physical needs because of the person's mental illness and that appropriate provision for those needs cannot be made immediately available in the community; or

☐ (4) Would benefit from treatment in a hospital for his mental illness and is in need of such treatment as manifested by evidence of behavior that creates a grave and imminent risk to substantial rights of others or himself.

2. Represents a substantial risk of physical harm to self or others if allowed to remain at liberty pending examination.

Therefore, it is requested that said person be admitted to the above named facility.

STATEMENT OF BELIEF

Must be filled out by one of the following: a psychiatrist, licensed clinical psychologist, licensed physician, health or police officer, sheriff or deputy sheriff.

(Statement shall include the circumstances under which the individual was taken into custody and the reason for the person's belief that hospitalization is necessary. The statement shall also include a reference to efforts made to secure the individual's property at his residence if he was taken into custody there. Every reasonable and appropriate effort should be made to take this person into custody in the least conspicuous manner possible.)

Original - Medical Record, Copy - Suspense File
DMH-0025 (Rev. 01/11)

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APPLICATION FOR EMERGENCY ADMISSION
DMH-MedR-1030

Access to mental health care

- Mental and addictive disorders are present in ~90% of completed suicides
  - Important remediable risk factors for suicide
- Many patients seek help before completing suicide
  - 45% of suicide decedents contact PCP in the month before suicide
  - 20% of suicide decedents contact mental health provider in same interval

Mental heath care and risk reduction

- Substantial body of evidence supports an association between risk reduction and:
  - Access to mental health services
  - Specific psychotherapeutic interventions
  - Use of medications for specific indications

Access to Care: Observational Evidence

- Suicide rates negatively correlated with indicators of access to health and MH services
  - ↓suicide rates associated with ↑ funding for MH services and ↑ per capita density of physicians, psychiatrists, and therapists
    - Tondo et al., 2006; Kapusta et al., 2009
  - Access to outpatient MH services and 24 hour crisis services associated with ↓ suicide rates
    - Pirkola et al., 2009
  - Residence in region with at least "minimal" MH safety net associated with ↓suicide rates
    - Cooper et al., 2006

Access to Care: Observational Evidence

- Negative correlation between antidepressant prescriptions and suicide rates across regions
  - ↑ Antidepressant use on the population level associated with ↓ suicide rates
  - Gibbons et al., 2005; Olfson et al., 2003
  - Isaacson et al., 2009; Ludwig et al, 2009
- ↑ population density associated with ↓suicide
  - Suicide rates typically higher in rural settings
  - Relationship holds within and across countries
- Evidence suggests that treatment matters…

Target Individuals at Risk with Psychotherapy RCTs

- Cognitive Behavioral Therapy (CBT)*
  - CBT for suicide attempters ↓ suicidal behaviors
  - Specific CBT elements focus on suicidality
    - Brown et al., 2005
- Dialectical Behavior Therapy (DBT)*
  - ↓ rate of repeat suicide attempts in adults
    - » Linehan et al., 2006
- Attachment Based Family Therapy (ABFT)
  - ↓ suicidal ideation /improved parent-child relations
  - Larger trial targeting suicidal behavior in progress
    - Diamond et al., 2010

Target Individuals at Risk with Psychotherapy RCTs

- Promising strategies include:
  - Augmenting familial and non-familial social support
    - ↓ family conflict, expressed emotion, and criticism
    - ↓ patient sensitivity to conflict and criticism
      - Wedig and Nock, 2007
  - "Front-loading" treatment in proximity to suicidal crisis
  - Encouraging positive affect, healthy sleep, and sobriety
    - Brent et al., 2013

Target Individuals at Risk with Pharmacotherapy RCTs

- Antidepressants*
  - ↓suicidal ideation and behavior in adults
    - Mediated by reductions in depressive symptoms
      - Gibbons et al., 2012
  - Observational data suggest benefit
- Clozapine*
  - ↓ suicide risk/aggression in schizophrenia RCTs
  - FDA suicide prevention indication in schizophrenia
- Lithium*
  - ↓ suicide risk in adults with mood disorders
  - Meta-analysis (Cipriani et al., 2013)

Target Individuals at Risk with Pharmacotherapy and Somatic Treatments

- Electroconvulsive therapy (ECT)
- Other neuromodulation strategies
  - Transcranial Magnetic Stimulation (TMS)
- Ketamine
  - NMDA glutamate receptor antagonist
  - ↓ suicidal cognition vs. midazolam & in open trials
    - Price et al., 2014; DiazGranados et al., 2010; Price et al., 2009

Target At Risk Groups -- Continuity of Care

- Improving linkages between levels of care
  - Mandatory 7-day MH f/u after psychiatric discharge ↓ suicide rate in UK observational study
    - While et al., 2012
      - ~ 40% of suicides in year after psychiatric hospitalization occur within first 30 days
      - Only ½ of discharges get MH care in 7-days
      - Only 2/3 in 1st month
- Specialty crisis assessment and management
  - ~ ½ of suicide attempters do not get specialty MH assessment in ED, yet risk of repeat attempt is lower in those discharged with a MH diagnosis…
    - Olfson et al., 2013

Implications of Available Research

- Encourage evidence-based psychotherapy
  - Foster access to suicide specific interventions
- Optimize antidepressant Rx
- ↑ appropriate use of clozapine
- ↑ appropriate use of lithium
- Research treatments to rapidly ↓suicidality

Suicide Prevention

- **Suicide intervention = Suicide prevention**
- **Suicide prevention can target individuals at risk, groups at risk, population-wide approaches**
  - **Focused today on targeting at-risk individual**
- **Sound scientific support for the following:**
  - **Education and training of health care providers in an effective model of depression care**
  - **Restriction of access to lethal means**
  - **Media guidelines for reporting on suicide**

Summary

- **Suicide risk assessment:**
  - **Learn specific content of suicidal thoughts**
  - **Consider this against the patient's risk/protective factors**
- **Management of suicide risk:**
  - **Address modifiable risk factors**
  - **Remove access to lethal means**
  - **Engage patient in evidence-based treatments**
  - **High risk patients may require voluntary or involuntary hospitalization**

Local and National Resources

- **OSU Behavioral Health**
  - **Crisis Team** **614-293-8205**
  - **Outpatient Services** **614-293-9600**
- **Nationwide Children's Hospital BH**
  - **Intake** **614-355-8080**
- **Netcare Access**
  - **Crisis Hotline** **614-276-2273**
- **If the above options are unavailable, call 911 or the National Suicide Prevention Lifeline at 1-800-273-TALK (8255)**

Selected References

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