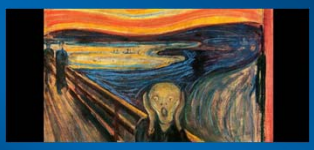
The Suicidal Patient



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Talk of suicide is scary stuff...

The stakes can be high.

And, there are no solid data to suggest that screening in primary care settings, for example, reduces mortality.

And further, there is not a high degree of sensitivity or specificity in predicting who will complete suicide.

Some Suicide Stats

Base rate ~1.1/10,000 = ~0.01%.

Most common method: Guns (M&F)

- Second most common: Hanging (M), OD (F).

More likely in those with:

- a military history,
- in younger and older males, middle aged females,
- in unpaired than in paired.

Attempts ~0.7% (all comers, ~5x higher in adolescents),

Ideation ~6.0% (all comers).

A Case to consider

A 60 y/o male says he is considering giving himself a large bolus of insulin to end his life. He has DM, HTN, HLD, and CKD. He has a long h/o CAD, undergoing CABG 3 years ago. He had a R CVA 2 yrs. ago, with residual left hemiparesis. Reports chronic L-sided pain since the CVA. One month ago had a seizure – his first. He reports feeling intermittently depressed since childhood, with intermittent SI over the years. Sleep has been increased lately but interrupted by pain; appetite unchanged. No substance abuse.

Has a MH therapist for several months, is on a long-term antidepressant via PCP. No h/o psych hospitalizations, no h/o suicide attempts. No known h/o suicide in family or friends.

Bachelors degree, no military. Never married, no long-term relationships, no kids. Worked for years in a stable job, going on SSD due to health a few years ago. An extended family member has lived with him for several years due to his health. There have been no h/o behavioral problems. He has had few contacts/friends over the years. He'd like to eventually return to school for an advanced degree.

On exam, he is in a WC, somewhat glum. He is notably weak in the left hand, having to hold it to use it. He shows no agitation. Eye contact limited. He is cooperative. Speech is unremarkable, and responses relevant. Mood is "frustrated", affect is blunted. There is no thought disorder. There is some worthlessness.

Suicidal Ideation

Talk of suicide does not always mean there is intent:

- A wish to be out of one's misery (very different from actively planning to die),
- An expression of feelings/emotions (very different from actively planning to die),
- For interpersonal effect (intended to elicit a response from others)
  - An example is conditional SI

So in addition to suicidal ideation, there is:

- Intent – that is, to take action,
- Plan - the specific method by which one would try.

5

Medicine of the Highest Order

UR Medicine

Cutting/burning

Some thoughts:

- Often, it is a means of dealing with feelings (like anger/frustration) and not an attempt to end one's life,
- More common in adolescents but can be seen in adults. When asked, such patients may well say they are frustrated or looking for ways of dealing with feelings and are not suicidal.

6

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Suicidal Ideation

*It is okay to ask about suicide, this does not 'plant the seed'.

It's better to ask and find out than not to ask and wish you would have!

7

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So what to do about suicidal ideation…?

There is a way to approach it:

- Assess Risk factors and Protective factors
  - Think both chronic and acute
- Ask patient's support people about their concerns

8

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Suicide Risk Assessment

Predisposing Factors
- Both younger and older age, unpaired
- Military history
- Childhood abuse
- Psychiatric illness
- Family history of suicide, also suicide in a known person

Previous Attempts & Degree of Impulsivity
- Frequency, context, opportunity for rescue, perceived lethality, outcome
- Degree of impulsivity

9

Suicide Risk Assessment

Current Suicidal Thinking
- Intensity relative to other times
- Intent
- Plan, and lethality of means
- Availability of means

Acute Stressors
- Significant loss – loved one, job, money, etc.
- Serious health or relationship issue

Current psychosis, Major Depression/Bipolar, or Substance Abuse

10

Suicide Risk Assessment

Current Signs and Symptoms
- Agitation/aggression, anger, hopelessness/trapped, preparatory behaviors (giving things away), won't engage in discussion

Protective Factors
- Responsibility for children, family, pets (i.e. having a purpose)
- Reasons to live,
- Future orientation,
- Religious beliefs,
- Engagement in work or school,
- Strong social supports/connections,
- Fear of death.

Seek input from patient's support people

11

IS PATH WARM?*

*Modified from American Association of Suicidology

Ideation—threatened or communicated

Substance abuse—excessive or increased

Purposeless—no reasons for living; burden

Anxiety—agitation and/or insomnia; panic attacks

Trapped—finding no way out; no one cares

Hopelessness—no improvement possible

Withdrawal—from friends, family and society

Anger—uncontrolled; rage; seeking revenge

Recklessness—risky acts; being in harm's way

Mood—intolerable changes; dramatic differences

12

Next…

Determine Level of Risk

- This is a clinical judgment based on all the information you have collected - risk factors, protective factors and review of patients thoughts about suicide.

(Remember it's possible to be at increased chronic suicide risk but not at increased acute risk)

Ultimately, 'when in doubt, chicken out', and seek help.

13

If acutely suicidal…

Outpatient – Contact 911, to get patient to the ER

Inpatient – May not leave AMA, can be detained, contact Security, contact Psychiatry

Clinicians have a legal duty to protect and so in matters of safety (to self or others) this duty supersedes patient autonomy.

14

If not acutely suicidal…

If outpatient, safety plan:

- Treat modifiable symptoms (anxiety, insomnia),
- Include social supports in the safety plan,
- Make environment safe/Removal of means,
- Can set up a 'suicide watch',
- Have a "what if" discussion and agree on contingency plans,
- Give numbers, resources (e.g. Lifeline, including for access to Monroe Mobile Crisis Team; VA Hotline; CPEP; MH options),
- Write these things out for the patient and their supports,
- Contact patient's MH provider (if present),
- Follow-up within a few days.

15

Be sure to document

Documentation

Clearly explain why you are making the decision you are making, reviewing the risk factors, protective factors, and patient's current mental state.

- Include statement about safety planning, and what patient has agreed to do if things get worse or suicidal thinking recurs.
- Include follow-up info

This is where you explain your rationale. We cannot reliably predict outcomes, but if there is a bad one, the documentation shows you've done your due diligence.

16

Documentation example

• "...while patient has some risk factors including a diagnosis of depression (chronic) and recently worsening anxiety and insomnia due to job tensions (acute), protective factors are multiple - future orientation, family support, religious convictions - and her family has rallied around her to assist with safety plan, which includes [xx]. Her chronic risk level is low-moderate and while there are acute risk factors, these are balanced by the patient's willingness to work on the safety plan, and the presence of the protective factors, including the increased show of support. Hence, an outpatient plan is reasonable. Follow-up with her psychiatrist in 2 days has been arranged. Family and patient were given resources and phone numbers and know to go to ED if suicidal ideation worsens."

17

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18

Predisposing Factors

Previous Attempts & Degree of Impulsivity

Current Suicidal Thinking

Acute Stressors

Current psychosis, Major Depression/Bipolar, or Substance Abuse

Current Signs and Symptoms

Protective Factors

Seek input from patient's support people

19

A potentially helpful reference, concise, can hang it on a wall:

SAFE-T: http://www.sprc.org/library/safe_t_pcktc rd_edc.pdf

Lifeline: 275-5151

Veterans Crisis Line: 1-800-273-8255 or text to 838255

20


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