# SUICIDE – Key Features

**1. In any patient with mental illness (i.e., not only in depressed patients), actively inquire about suicidal ideation (e.g., ideas, thoughts, a specific plan).**

Skill – Clinical Reasoning

Phase – History

Assessment of Suicidal Ideation

* **Onset** and **frequency** of thoughts – “***When*** did this start? ***How often*** do you have these thoughts?”
* **Control over** suicidal ideation – “***Can you stop*** the thoughts or ***call someone*** for help?”
* **Lethality** – “Do you want to ***end your life*** or get a ***‘release’ from*** your emotional pain?”
* **Access** to means – “***How*** will you get a gun?” “***Which*** bridge do you think you would go to?”
* **Time** and **place** – “Have you ***picked a date and place***? Is it in an ***isolated location***?”
* **Provocative** factors – “What makes you feel ***worse*** (e.g. being alone)?”
* **Protective** factors – “What ***keeps you alive*** (e.g. friends, family, pets, faith, therapist)?”
* Final **arrangements** – “Have you written a suicide ***note***? Made a ***will***? ***Given away*** your belongings?”
* **Practiced** suicide or **aborted** attempts – “Have you put the gun ***to your head***? Held the medication ***in your hand***? Stood at the bridge?”
* **Ambivalence** – “There must be a part of you that wants to live – you ***came here for help***.”
* ***>90% of patients who attempt*** suicide have a major psychiatric disorder
* ***95% of patients who commit*** suicide have a psychiatric diagnosis

Canadian Task force on Preventative Health Care (1994)

* poor evidence (expert opinion alone) to include or exclude routine evaluation of ***suicide risk in the periodic health examination***
* physicians should remain alert to the possibility of suicide in ***high-risk patients***
* routinely evaluate the risk of suicide, particularly if there is evidence of:
	+ psychiatric disorder (especially psychosis)
	+ depression
	+ substance abuse
	+ if the patient lives alone
	+ recently attempted suicide
	+ family member has committed suicide
* special attention paid to ***young Native and Aboriginal males***

**2. Given a suicidal patient, assess the degree of risk (e.g., thoughts, specific plans, access to means) in order to determine an appropriate intervention and follow-up plan (e.g., immediate hospitalization, including involuntary admission; outpatient follow-up; referral for counseling).**

Skill – Clinical Reasoning, Selectivity

Phase – Diagnosis, Treatment

* ***prior history*** of attempted suicide = strongest single factor predictive of suicide

**SAD PERSONS**

* **S**ex (male)
* **A**ge (>60 y.o.)
* **D**epression
* **P**revious attempts
* **E**thanol abuse
* **R**ational thinking loss (delusions, hallucinations, hopelessness)
* **S**uicide in family
* **O**rganized plan
* **N**o spouse (no support systems)
* **S**erious illness / intractable pain
* Scoring Guide (based on total number of risk factors present)
	+ **0-2 :** consider *sending home with family*
	+ **3-4 :** *close follow-up*, consider hospitalization
	+ **5-6 :** *strongly consider* hospitalization
	+ **7-10 :** *hospitalize*
* Suicide ***contracts*** = unreliable

Clinical Presentation

* symptoms associated with suicide
	+ hopelessness
	+ anhedonia
	+ insomnia
	+ severe anxiety
	+ impaired concentration
	+ psychomotor agitation
	+ panic attacks

In Elderly Patients

* personality disorders, ***rigid personality*** styles
* ***non-adaptive coping*** strategies
* functional ***decline***

**3. Manage low-risk patients as outpatients, but provide specific instructions for follow-up if suicidal ideation progresses/worsens (e.g., return to the emergency department [ED], call a crisis hotline, re-book an appointment).**

Skill – Clinical Reasoning

Phase – Treatment, Follow-up

Management of the Suicidal Individual

* reducing ***immediate risk***
	+ ***involve*** a family member or person close to patient, if allowed
	+ ask about availability of lethal means (e.g., firearms, medications) and ***make inaccessible***
	+ ***increase the frequency*** of contact with the patient; communicate a commitment to help
	+ begin ***aggressive treatment*** of psychiatric disorders or substance abuse
* managing ***underlying factors***
	+ referral to ***counseling***
		- ***engagement*** of community, religious, and family supports
	+ ***CBT***
	+ ***treatment*** of depression (e.g., SSRI) / bipolar disorder (e.g., lithium)
* monitoring and ***follow-up***
	+ risk ***fluctuates***, should be reassessed frequently
	+ determine if there have been changes, especially a ***reemergence*** of precipitating events, adverse life circumstances, or mental disorders
	+ assure that previously suicidal patients are ***actively engaged*** in ongoing care for any mental disorders
		- continue to receive treatment for ***prevention of relapse or recurrence*** of depression, bipolar disorder, anxiety disorders, psychosis, or other conditions
	+ for those with a history of alcohol or substance abuse, monitoring and assisting the patient in remaining in programs that promote ***adequate control***
	+ ***days and initial weeks following discharge*** from psychiatric hospitalization are a time of increased risk
		- particularly if patients perceive that they have ***lost a therapeutic support system***
		- high risk for ***non-adherence*** to medication regimens

**4. In suicidal patients presenting at the emergency department with a suspected drug overdose, always screen for acetylsalicylic acid and acetaminophen overdoses, as these are common, dangerous, and frequently overlooked.**

Skill – Clinical Reasoning

Phase – Investigation

* Other common Rx’s
	+ TCAs
	+ benzodiazepines
	+ CCBs
	+ Β-blockers
* ***Urine toxicology screen*** and ***blood alcohol level*** are the two most commonly required tests for patients transferred/admitted to psychiatric facilities from the ED
* Serum levels for other Rx may include:
	+ Mood stabilizers
		- Lithium
		- Valproic acid
	+ Antiepileptic
		- Phenytoin
		- Carbamazepine
		- Phenobarbital
	+ Digoxin
	+ Cyclosporine (for transplant patients)
	+ INR (in patients taking Coumadin)

**5. In trauma patients, consider attempted suicide as the precipitating cause.**

Skill – Clinical Reasoning

Phase – Hypothesis generation