Risk Assessment and Management in Suicidal Medical Patients

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Take Home Messages

- We have no valid way of predicting who will commit suicide
- The only two risk factors consistently shown are depressed mood and past attempts
- We do a risk assessment on most patients, and categorize them as low, medium or high risk, but this process is widely questioned and probably not valid.
- Risk assessment screening tools are relatively new, poorly studied, not yet established as useful, and possibly drain resources from established useful programs
- Predicting human behaviour is very difficult, and not one of our strong points.

Working with risk

- No one can predict the future!!
- Some areas of medicine are less predictable than others.
- Predicting suicide risk is particularly stressful.
- Even if you get the risk assessment right, the patient may still commit suicide

Recent Vic Health Dept Review (2010)

- 40+% of people who commit or attempt suicide had contact with a health professional in the preceding month
- There are few well validated screening measures
- Even the best ones have specificity below 40%, hence require lots of management of false positives, therefore needs to be done in parallel with psychiatric assessment to better establish needs

Psychiatric Risk Assessment

- Done in the context of an assessment
- A brief assessment can still include a risk assessment if attention is paid to the key elements
- Corroborative history especially useful
- Documentation of the risk assessment to justify the management is essential

Risk Assessment:
Four Key Elements

- Patients current statement & attempt
- Past History
- Presence of a psych disorder
- Risk Factors

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Current Statement

- Engage patient in escalating questions
  - “Do you fell that life is not worth living”
  - “Would you rather be dead”
  - “Do you think about killing yourself” (suicidal ideation)
  - “Do you plan on killing yourself…. How?” (suicide plans)
- How lethal was the attempt?
- Was the person determined not to be stopped?

Current Statement

No suicidal ideas

↓

Suicidal ideas, no plans, no intention

↓

Plans, but vague/unrealistic, unclear intention

↓

Realistic plans & Intention to complete

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Past History

- The best predictor of future behaviour is past behaviour
- Serious suicide attempts in similar circumstances in the past versus multiple minor attempts in various circumstances
- First ever attempt is always significant

Risk Assessment:
Four Key Elements

- Patients current statement & attempt
- Past History
- *Presence of a psych disorder*
- Risk Factors

Presence of psychiatric disorder

- Most psychiatric disorders carry an increase risk of suicide.
- A psych systems review includes depression, mania, psychosis, drugs & alcohol, anxiety, eating, and memory.
- It is particularly important to screen for depression, psychosis, and ***delirium***

Risk Assessment:
Four Key Elements

- Patients current statement & attempt
- Past History
- Presence of a psych disorder
- *Risk Factors*

Risk Factors

- Suicide is a rare event, even amongst psychiatric patients, and risk factors alone will identify many more patients potentially at risk than imminently in danger of dying
- Suicide rate is 12-15 per 100,000 per year, about 8th commonest cause of death, about 2000 deaths per year.

Risk Factors

- Risk factors provide a context in which to consider the individual patient and their history, and so formulate a risk for this patient on this day.
- Risk factors are based on epidemiological surveys of completed suicide (mostly) so give an indication of long term risk rather than acute risk

Risk Factors

- Medical Risk Factors:
  - Chronic or terminal illness, especially cancer, chronic renal failure, AIDS.
  - Painful or disfiguring illness
  - 25% of suicides have a physical illness at post mortem
- Family History - Suicide 8 times more likely in 1st degree relatives of psych patients than controls

Risk Factors cont.

- Psychosocial
  - Social isolation
  - Unemployment
  - Div/separated/widowed>single>married
  - Low/high > middle social class

- Demographic
  - Male:female = 3:1
  - Increases with age?
    - > Males risk also high in late adolescence
    - > There is no real low risk age!!

Suicide Rates

- WHO reported suicide rates in Australia
  - 10.4% of the population seriously consider suicide in their lifetime
  - 4.2% attempt suicide
  - 21 suicide deaths per 100 000 males (increased in age 15-24 and >75)
  - 5.5 suicide deaths per 100 000 females (but more highly represented in attempts)

Challenge of Predicting Rare Outcome

- Hypothetical
  - Asking a question about suicide which has a sensitivity 80% to identify a high risk individual, and specificity of 70%
  - In a population of 10 000, 10 of whom will commit suicide.
  - Results – 8 true positives, 2 false negatives but will show 2997 false positive results. And have a positive predictive value of 0.3%

Screening Tools

- Generally low sensitivity and specificity
- Example
  - Risk of Suicide Questionnaire – 4 questions
    - Are you here because you tried to hurt yourself
    - In the past week have you had thoughts of killing yourself
    - Have you ever tried to hurt yourself in the past
    - Has something very stressful happened in the past few weeks.
- 37% specific for High Risk cases in Adolescents presenting to ED, leading to large number of low risk cases progressing to full assessment

Screening Tools

- Extrapolating from other high risk groups the ability to screen remains poor.
- People followed up one year post admission to Inpatient Psychiatric Unit
- Risk categorised along known risk factors
    - History of self harm, depressive symptoms, unplanned discharge, social difficulty, Dx MDE, loss of contact with services, male gender
- Only 3% of patients categorised as high risk commit suicide
- 60% of patients who suicide categorised as low risk

Interventions

- Risk Containment
  - Environment
  - Observations – frequency, personnel
  - Restraint? Controversial.
  - Symptom reduction – medication
  - Commence definitive treatment
  - Time to review

Interventions

- Specific Psychiatric treatments
  - Lithium for Bipolar Affective Disorder
  - Clozapine for Schizophrenia
  - DBT for Borderline Personality Disorder
- Population based interventions
  - Gun control
  - Bridge barriers (car park barriers)
  - Replacement of coal gas with natural gas

Clinical Issues

- When to do a risk assessment?
- Risk assmt's at various clinical stages, and at transfers between places of care.
- Who should do the risk assessment?
  - ED Doctor
  - Psych triage nurse (where available)
  - Psychiatrist or registrar

Risk Assmt Vs Risk Management

- The management plan for a patient at risk is the management plan for the psychiatric disorder, with the risk taken into account.
- The risk will influence care in a number of ways: venue of care, choice of Tx etc
- Sometimes there is a conflict between the best Mx of risk and best Mx of the disorder

Should we do risk assessment?

- Probably, but only in certain circumstances: current psychiatric symptoms, presence of suicidal ideation, any self harm attempt, ?other
- Should it be structured? Probably, but there is no current agreed tool.
- Who should do it? All staff, not just psychiatry, and it should help inform the urgency of psychiatric assessment.
- What are the potential dangers: That resources will be directed towards risk management (of which outcomes are not established) at the expense of evidence based treatments for disorders (depression, anxiety etc)

Minimum standard for medical units?

- Be competent and comfortable asking about self harm
- Basic psychiatric screen for depression
- Routine MMSE or equivalent for delirium recognition

What to do about delirium & suicide risk

- Delirium poses a particularly challenging problem
- The risk assessment is particularly poor, as the patients mental state fluctuates, and therefore assessment is unreliable
- Paranoid and other psychotic symptoms occur in 30%, and these often lead to ideas of being attacked (like in a nightmare) and attempts to escape and sometimes harm self
- Many delirious patients are either unrecognised, or recognised but ‘hypoactive’ therefore not closely observed, and can’t observe all delirious patients, there are too many.
- Basic precautions: recognition, check for paranoia, nurse in a safe environment (visible, no hanging points/windows, etc), appropriate tranquiliser use, good handover/communication, escalate care if failing to improve.