

SECOND OF 2 PARTS

Suicide assessment and management self-test: How do you score?

15 case-based questions to evaluate your skills at managing suicide risk

As explained in the first part of this article in the October 2014 issue of *CURRENT PSYCHIATRY*, assessing and managing suicide risk are complex, difficult tasks without clear-cut, easy solutions. The case-based, multiple-choice self-test, with accompanying commentary, presented here is designed to enhance one's ability to provide care for patients at risk for suicide. Part 2 of this article poses the remaining 7 of 15 questions, which are based on clinical experience and the referenced work of others.

Question 9

Mr. N, age 62, will be discharged from the psychiatric unit tomorrow. He was admitted after an overdose suicide attempt. Mr. N was depressed after the loss of his business and was "treating" his depression and anxiety with alcohol. He is successfully withdrawn from alcohol and responds to medication and supportive psychotherapy. During a family meeting with staff, Mr. N's wife states that he keeps a gun by his bedside. Mr. N has improved and is eager to go home.

Before discharging Mr. N, the psychiatrist or staff should:

- instruct Mr. N to remove the gun from his bedside
- instruct his wife to remove the gun from the home
- instruct the wife to look for >1 gun
- instruct the wife, before Mr. N's discharge, to call the staff once guns and ammunition are safely removed according to the pre-arranged safety plan

Disclosure

Dr. Simon reports no financial relationship with any company whose products are mentioned in this article or with manufacturers of competing products.

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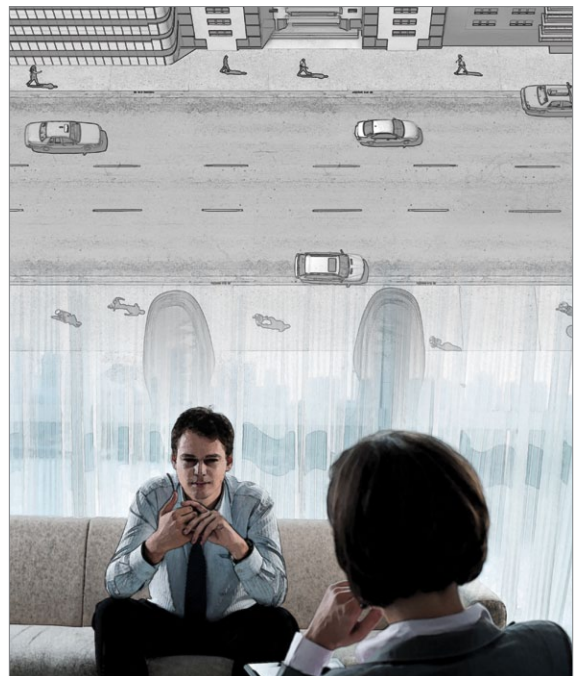


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Suicide risk assessment

Clinical Point

The essence of gun safety management is verification. Trust but verify or, better yet, verify then trust

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for a video on asking about guns in a patient's home

e) instruct the wife to lock up the gun in a place that is not known to the patient

The best response option is D

Guns in the home are associated with a significant increase in suicide. All patients at risk for suicide must be asked if guns are available at home or easily accessible elsewhere, or if they intend to purchase a gun. Gun safety management requires a collaborative team approach including the clinician, patient, and person designated responsible for removing guns from the home.¹ The responsible person should be required to call the clinician to confirm that the guns have been removed and secured according to the plan. The principles of gun safety management apply to outpatients, inpatients, and emergency patients, although implementation varies according to the clinical setting.

Asking the patient to remove guns from the home is too risky. Guns must be safely secured before the patient is discharged. Asking a spouse, other family member, or partner is necessary. The person asked must be willing to remove guns and ammunition according to a pre-arranged plan requiring a callback upon completion. A callback is essential because a family member in denial may do nothing to remove the guns or lock or "hide" them in the home where they will be found by a determined suicidal patient. Guns may be available outside the home, such as in the car, at the work place, or for purchase.

The essence of gun safety management is verification. Trust but verify or, better yet, verify, then trust.

Question 10

A recently admitted 56-year-old inpatient was discovered wrapping a towel around her neck. She denied suicidal intent; however, the treatment team viewed the incident as a suicide rehearsal. She was placed on one-to-one close observation.

Inpatient suicides frequently occur:

- a) shortly after admission
- b) during staff shift changes
- c) at meal times
- d) shortly after discharge
- e) all of the above

The best response option is E

Inpatient suicides also occur at increased frequency when psychiatric residents finish their rotations and in understaffed psychiatric units.² Undue delay in the evaluation of a newly admitted acute, high-risk patient might allow the patient to commit suicide.

Most patient suicides occur shortly after hospital discharge (a few hours, days, or weeks later). Appleby et al³ found that the highest number of suicides occurred during the first week after discharge. Meehan et al⁴ found that suicide occurred most frequently during the first 2 weeks post-discharge; the highest number of suicides occurred on the first day after discharge.

Question 11

Ms. G, a 43-year-old, single woman in acute suicide crisis, is admitted to the psychiatric unit of a general hospital. She is diagnosed with bipolar I disorder, most recent episode depressed, and borderline personality disorder. She has had multiple psychiatric hospitalizations, all precipitated by a suicide crisis. The average length of stay on the psychiatric unit is 6.3 days. After 7 days of intensive treatment, Ms. G is stabilized and suicide risk is reduced. The treatment team prepares for her discharge.

Ms. G's suicide risk at discharge is most likely at:

- a) indeterminate risk
- b) low risk
- c) moderate risk
- d) chronic high risk
- e) acute high risk

The best response option is D

The length of stay in many acute care psychiatric facilities is <7 days. The goal of hospitalization is to stabilize the patient and discharge to appropriate community mental health resources. Discharge planning begins at the time of admission.

Reducing Ms. G's suicide risk to low or moderate is unlikely because of her diagnoses, frequent hospitalizations, and acute high risk for suicide on admission. After acute, high-risk suicidal patients are treated, many revert to chronic high risk for suicide.



Suicide risk assessment

Clinical Point

The family's role is important, but it is not a substitute for constant safety management provided on an inpatient unit

Patients at chronic high risk for suicide often are treated as outpatients, except when an acute suicidal crisis requires hospitalization.⁵ At discharge from the hospital, the goal is to return the patient to outpatient treatment.

A discharge note identifies the acute suicide risk factors that have abated and the chronic (long-term) suicide risk factors that remain. The discharge note also addresses a patient's chronic vulnerability to suicide. For example, a patient can become acutely suicidal again, depending on a number of factors, including the nature and cause of the psychiatric illness, adequacy of future treatment, adherence to treatment recommendations, and unforeseeable life vicissitudes.

Question 12

A 20-year-old college student is hospitalized after an overdose suicide attempt. Failing grades, panic attacks, and depression precipitated the suicide attempt. After 8 days of hospitalization, she is much improved and ready for discharge. She is assessed to be at low to moderate suicide risk. The treating psychiatrist and social worker convene a family meeting with both parents and an older brother. The family's role after discharge is discussed.

All of the following options are helpful family roles except:

- a) provide constant 24-hour family supervision
- b) provide emotional support
- c) observe and report symptoms and behaviors of concern
- d) encourage adherence with treatment
- e) provide helpful feedback about the patient's thoughts and behavior

The best response option is A

The family's role is important, but it is not a substitute for constant safety management provided by trained mental health professionals on an inpatient psychiatric unit.⁵ Early discharge of an inpatient by relying on family supervision can be precarious. Most inpatients are discharged at some level of suicide risk, given the short length of hospital stay. If an outpatient at risk of suicide requires constant 24-hour family supervi-

sion, then psychiatric hospitalization is indicated.

Patients who are intent on killing themselves can find ingenious ways to attempt or commit suicide. Asking family members to keep a constant watch often fails. Most family members will not follow the patient into the bathroom or be able to stay up all night to observe the patient. Moreover, family members find reasons to make exceptions to constant surveillance because of denial, fatigue, or the need to attend to other pressing matters.

Question 13

During the initial evaluation of a patient, it is the psychiatrist's practice to routinely inquire about current and past suicide ideation. An affirmative answer prompts a systematic suicide risk assessment. In the absence of current risk, if exploration of the patient's history reveals chronic suicide risk factors, the psychiatrist conducts a systematic suicide risk assessment.

The chronic risk factor that has the highest association with suicide is:

- a) family history of mental illness or suicide
- b) childhood abuse
- c) history of a suicide attempt
- d) impulsivity or aggression
- e) prior psychiatric hospitalization

The best response option is C

A comprehensive suicide risk assessment may not be required at the initial outpatient evaluation in the absence of acute suicide risk factors. However, chronic suicide risk factors may be present.

The Standard Mortality Ratio (SMR) for prior suicide attempts by any method was 38.61.⁶ Suicide risk was highest in the 2 years after the first attempt. The SMR is a measure of the relative risk of suicide compared with the expected rate in the general population (SMR of 1).

Some chronic suicide risk factors are static: for example, a family history of psychiatric illness or earlier suicide attempt. Other chronic risk factors, usually a trait characteristic, can become acute: for example, impulsivity or aggression, or deliberate self-harm. The presence of chronic suicide



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risk factors should prompt a systematic suicide risk assessment. Evaluation of chronic suicide risk factors is an essential component of comprehensive assessment.⁵

Question 14

A psychiatrist is treating Dr. R, a 43-year-old physician, for anxiety and depression. The psychiatrist sees Dr. R twice a week for psychotherapy and medication management. A recent lawsuit filed against Dr. R has severely exacerbated her symptoms. She can sleep for only a few hours. Suicide ideation has emerged, frightening Dr. R and her family. The psychiatrist performs a systematic suicide risk assessment and determines that Dr. R is at acute high risk for suicide.

The psychiatrist recommends immediate hospitalization, but Dr. R adamantly refuses. The psychiatrist decides not to involuntarily hospitalize her because she does not meet the substantive criteria of the state involuntary commitment statute (eg, overt suicidal behaviors). The psychiatrist chooses to continue outpatient treatment.

Clinical interventions to reduce Dr. R's suicide risk include:

- a) see her more often
- b) adjust medications
- c) obtain a consult
- d) refer her to an intensive outpatient program
- e) all of the above

The best response option is E

To hospitalize or not to hospitalize—that is the conundrum that psychiatrists often face with high-risk suicidal patients. The decision is more complicated when the need for hospitalization is clear but the patient refuses. The decisions that the psychiatrist makes at this point are crucial for treatment and risk management.⁵

If the patient disagrees with the psychiatrist's recommendation to hospitalize, refusal should be addressed as a treatment issue. When the need for hospitalization is acute, a prolonged inquiry is not possible. In addition, the therapeutic alliance may become strained. This clinical situation tries a clinician's professional mettle.

Consultation and referral are options to consider if time and the patient's condition allows. A psychiatric clinician should never worry alone; sleepless nights benefit neither the psychiatrist nor the patient.

As Dr. R's case shows, a psychiatrist might decide not to hospitalize a patient who is assessed to be at moderate or high risk of suicide. Protective factors may allow continuing outpatient treatment. A good therapeutic alliance may be present if the psychiatrist has worked with the patient for some time. Family support also may be available.

The clinician must determine if the patient's suicide risk can be managed by more frequent visits and treatment adjustments. Also, supportive family members can help by providing observational data. Protective factors can be overwhelmed by a severe mental illness. In contrast, a patient assessed as being at moderate risk of suicide might need to be hospitalized when protective factors are few or absent.

The psychiatrist may determine that a patient at high risk of suicide who refuses hospitalization does not meet criteria for involuntary hospitalization. For example, criteria might require that the patient must have made a suicide attempt within a specified period of time. States have provisions in their commitment statutes granting immunity from liability if the clinician uses reasonable clinical judgment and acts in good faith when involuntarily hospitalizing a patient.⁷

Question 15

Mr. U, a 39-year-old, married engineer, is ready to be discharged from the inpatient unit. He was admitted 7 days earlier for acute alcohol intoxication and suicidal threats. He has undergone successful detoxification. Mr. U has had 2 similar episodes within the past year.

The treatment team conducts a risk-benefit analysis for both discharge and continued hospitalization. A consultation also is obtained.

The discharge decision will be most influenced by:

- a) presence of family support
- b) compliance with follow-up care
- c) availability of dual diagnosis programs

Clinical Point

If a patient disagrees with the psychiatrist's recommendation to hospitalize, refusal should be addressed as a treatment issue



Suicide risk assessment

Clinical Point

Follow-up appointments should be made close to time of discharge; suicide often occurs on the first day after discharge

Related Resources

- Practice guideline for the assessment and treatment of patients with suicidal behaviors. Washington DC: American Psychiatric Association; 2003. doi: 10.1176/appi.books.9780890423363.56008.
- Sakinofsky I. Preventing suicide among inpatients. *Can J Psychiatry*. 2014;59(3):131-140.

- d) systematic suicide risk assessment
- e) consultation

The best answer option is D

All of the options in Question 15 concerning discharge planning of patients at risk for suicide are important. However, conducting a systematic suicide risk assessment to inform discharge planning is the most critical. Mr. U had 2 previous psychiatric admissions for alcohol abuse and suicidal ideation. He is a chronic suicide risk who becomes high risk when intoxicated.

Discharge planning begins at admission and is refined during the patient's stay. Before a patient is discharged, a final post-discharge treatment and aftercare plan is necessary. After discharge, suicide risk increases as the intensity of treatment decreases.⁸

The patient's willingness to cooperate with discharge and aftercare planning is critical in establishing contact with follow-up treaters. The treatment team should structure the follow-up plan to encourage compliance. For example, psychotic patients at risk of suicide who have a history of stopping medications after discharge can be given a long-acting IM antipsychotic that will last until they reach aftercare. Patients with comorbid drug and alcohol abuse disorders are referred to agencies equipped to manage dual-diagnosis patients.

Bottom Line

Fully commit time and effort to the ongoing assessment, treatment, and management of patients at suicide risk. Suicide risk assessment is a process, not an event. Conduct a suicide risk assessment at important clinical junctures (eg, initial evaluation, discharge, changing observation levels). Contemporaneously, document suicide risk assessments. This self-assessment helps clinicians gauge their strengths and identify skills that need further development.

Psychiatrists' ability to ensure follow-up treatment is limited, a fact that must be acknowledged by the psychiatric and legal communities. Beyond patient stabilization, a clinician's options to bring about positive changes can be limited or nonexistent. Also, the patient's failure to adhere to post-discharge plans and treatment often leads to rehospitalization, hopelessness, and greater suicide risk.

Psychiatric patients at moderate or moderate-to-high risk for suicide increasingly are treated in outpatient settings. It is the responsibility of the clinician and the treatment team to competently hand off the patient to appropriate outpatient aftercare. With the patient's permission, the psychiatrist or social worker should call the follow-up agency or therapist before discharge to provide information about the patient's diagnosis, treatment, and hospital course.

Last, follow-up appointments should be made as close to the time of discharge as possible. Suicide often occurs on the first day after discharge.³

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