Practice Well: Suicide Risk and Suicide Prevention

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This month's column is about suicide, a clinical topic involved in well over half the civil forensic matters I review. I will discuss it clinically, because that's the way I hope most psychiatrists and other mental health practitioners think about it. If you want to put the column into a forensic context, you could consider this risk management, malpractice vulnerability, or avoiding being sued. However, I would rather you view it as a discussion of the right thing to do.

In over 30 years of inpatient, outpatient, academic, public sector, administrative, and forensic practice, I've seen a great many examples of clinical excellence, maintaining our standard of care in difficult settings, and grace under the fire of unfair criticism. This is a reminder to keep placing patients' interests before those of virtually anything else. In this column, I use suicide risk, particularly decisions about inpatient care, as an example, but many of the principles apply to other situations as well.

An unfortunate number of clinical tragedies and malpractice lawsuits beg psychiatrists to think:

1. When a potentially suicidal patient presents for admission evaluation, don't decide against admission unless you have adequately assessed the situation and are reasonably convinced that the patient can be protected and cared for outside the hospital;
2. When a psychiatric inpatient has been admitted with serious potential for suicide, don't discharge him or her after only a few days unless you are convinced either that the risk is substantially lessened or that adequate measures have been taken to protect the patient.

Before you say to yourself, "I already do that," please read on.

Case Report 1

The patient, an established local physician, was seen on an internal medicine unit after being transferred from intensive care. He had taken a significant overdose 3 days earlier and was now demanding discharge. The overdose was precipitated by his arrest for prescribing large numbers of amphetamines to an undercover officer (he had been released on bond). There was no known history of psychiatric diagnosis or treatment, but his wife confirmed that he had shown increasing depression over the past several weeks, with great worry about the criminal charges, losing his practice, being humiliated, and forfeiting his medical license.

During the interview, the patient minimized his recent history and said he had not really meant to kill himself (although he almost died of an enormous overdose). He said the drug-selling charges were "trumped up," and that he would "beat them" at trial. He showed no immediate signs of severe depression other than the history provided by his wife and the overdose itself. His mental status examination appeared essentially normal at the time of interview. He pressed for discharge, as did his wife, and said that going to a psychiatric hospital would damage his career. He promised to come to the office for follow-up, and his wife promised to monitor him closely.

Nevertheless, and in spite of the patient's and wife's entreaties, the psychiatrist recommended against discharge and began commitment proceedings. The patient chose a private facility some distance away, with a different attending psychiatrist, and was transferred there on a 2-week temporary commitment order. After the 2 weeks were completed, the patient petitioned for, and was granted, discharge. He committed suicide within 24 hours.

Case Report 2

A woman with a long history of schizoaffective illness was brought to a psychiatric hospital because of marked agitation and threats of suicide. Her reasons included bizarre fears that Satan would burn her, guilt over imagined slights by God, and recent

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loss of custody of her children. She had discontinued her antipsychotic and antidepressant medications several weeks before. She was admitted by the on-call psychiatry resident and placed on one-to-one observation.

The morning after she was admitted, the patient was seen by another resident and an attending psychiatrist. By that time, her immediate symptoms had abated somewhat and she appeared much less agitated. Quetiapine and mirtazapine were prescribed, along with groups for supportive counseling and activities of daily living. On the second day of hospitalization, the patient continued to appear less agitated and showed no side effects from her medication. She was still somewhat delusional, with flattened affect, psychomotor retardation, and some ritualistic behaviors, but denied suicidal ideation. She signed a "contract for safety," promising to tell a staff member if she thought of harming herself. Her one-to-one monitoring was discontinued and she was placed on observation every 15 minutes.

On the fourth hospital day, with no further decrease or increase in outward symptoms, the patient was scheduled to be considered for discharge. A couple of hours before the treatment team meeting at which the decision would be made, she hanged herself in an unoccupied patient room.

It makes no sense to move at-risk patients prematurely from a relatively safe environment with constant or frequent professional observation and treatment to one in which most protections are removed, monitoring is sporadic or absent, and the stressors and stimuli associated with self-harm are still present. Yet that is exactly what happens to many patients in psychiatric units and facilities. Each situation is unique, and these comments are not meant to apply to every eventuality, but even partial hospitalization and "intensive outpatient" programs leave patients on their own most of the day and night, and usually return them to the setting in which the suicidal impulse was, quite recently, very strong.

I am not trying to drag up the old concept of "predicting suicide" (the point is *risk*, not "prediction") nor to tie the hands of good clinicians who treat very sick patients whom they can usually eventually discharge. But it is useful to point out a few things to think about when one is trying to justify early discharge of a patient 3 or 4 days after a potentially lethal suicide attempt or other evidence of serious suicide risk.

Consider the following patient on an inpatient psychiatric unit: he looks a lot better, has gotten some sleep, and has gone to a few hospital activities groups; he says he's not suicidal and wants to go home.

- ***What has changed for the patient?*** Has he been cured? Have his risk factors really decreased sufficiently to move him from a high-risk to a low-risk category? If not, can the remaining significant risk factors be managed well enough to place him—and keep him—in a low-risk group? Have the precipitating factors for admission (such as a suicide attempt) been reliably dealt with? Has the patient actually responded to treatment (e.g., medication, cognitive-behavioral therapy, electroconvulsive therapy)? Has he had *time* to respond, given, for example, the expected lag-time in responding to antidepressant medication? Or is the patient merely responding to the temporary respite of hospitalization? Does he appear better because he has learned what to say to the staff in order to gain their approval? Has a thorough suicide assessment been done since admission (especially just prior to scheduled discharge, perhaps by a separate discharge consultant)? Finally, how *reliable* is your answer to each of the above questions?

- ***If the patient says that he is ready to go home, why should you believe him?*** Suicidal patients are often inaccurate and they commonly misunderstand their illnesses and symptoms. They often can't predict their own impulses and behaviors very well. They often can't provide complete information about their histories and symptoms. Their responses to questions may be a result of poor interview technique. *And suicidal patients often lie under the influence of their mental illnesses*. Some lie to get out of the hospital (or to avoid being hospitalized in the first place or free themselves from close monitoring). Some lie to gain the opportunity to kill themselves or to have control over whether or not they do so. To make matters worse, psychiatrists and other clinicians are not very good at discerning whether or not their patients are lying about suicidal thoughts.

- ***Has collateral information about the patient been sought?*** It is a mistake to rely solely on a recently suicidal patient, whose judgment and insight are almost certainly flawed and whose motivations are often unclear, when other sources of information are available. When the patient is the only feasible source of information, doctors must be more than usu-

ally cautious about discharge, relaxing patient monitoring, or denying admission in the first place.

- ***Are substantial problems likely to reappear after discharge?*** Instability and unreliability are serious risk factors. It is not enough for the patient to appear safe on the day of discharge; the psychiatrist must be reasonably certain that the low-risk condition is stable. Many patients have waxing and waning illnesses, unpredictable symptoms, difficulty following treatment regimens, highly stressful home environments, and/or substance abuse problems. If so, how have the psychiatrist and the treatment team protected the patient from that continuing risk?

- ***Is the patient's family being asked to assume more responsibility than they can handle?*** Families are often understanding and supportive, but they aren't trained or equipped to do the jobs of doctors, nurses, and hospitals. Even those who promise to watch the patient closely cannot (and should not) be expected to do so all the time.

- ***How would you want your own child, parent, or spouse to be treated in the same situation?*** Eliminate utilization review, insurance coverage, and "average" hospital stay from the equation, since those things are not relevant until acute clinical and protective needs have been met. We sometimes forget that serious mental illness can bring with it as much morbidity and mortality as the severe conditions seen by internists, cardiologists, and trauma specialists. We expect patients with acute or suspected myocardial infarctions, for example, to be seen within a system of care that protects them from unacceptable risk. The standard of care demands, and doctors and hospitals generally provide, careful and frequent clinical assessment, attention to indicators of risk or relative safety (especially as discharge is contemplated), recovery settings with adequate monitoring, and scheduled, reliable follow-up care. Those are part of our psychiatric standard of care as well.

Conclusion

Lest some clinicians still try to reassure themselves with the fact that suicide is a fairly rare event, consider this: It is unacceptable to allow a small child to play unsupervised in the street, even when traffic is very light. It is foolhardy to let that child wade alone in a shallow surf when there is a chance of his stumbling into a deep spot or strong current. The probability of contracting rabies after a dog bite is remote, yet we insist on careful assessment and, if we cannot be reassured that the dog doesn't have rabies, we expect prophylaxis. The probability of tragedy in such examples is low, but the stakes are very high; the risk is unacceptable; and reasonable ways exist to reduce the risk. We should approach suicide risk in a similar fashion.

I am happy to send clinicians a copy of my training slides on this topic. They aren't perfect (and they don't ask clinicians for perfection), but they do not apologize for making patient risk and need our top priorities whenever possible. Just email me at reidw@reidpsychiatry.com with your name, location, and clinical position. The slides are copyrighted, but you are welcome to use them for teaching or personal review as long as you keep all text and formatting intact.