***SUICIDE   
& Other Psychiatric Emergencies***

***Objectives***

* Understand the epidemiology of suicide in the general population
* Develop skills to perform a clinical assessment and recommend treatment

***SUICIDAL BEHAVIOR IS A LIFE-THREATENING MEDICAL EMERGENCY***

***Epidemiology of Suicidal Behavior***

* Third leading cause of death - 10% of all AD deaths
* Rate:  10-12/100,000 annually
* An increase in the 15-24 age group tripled in the past three decades

***GENERAL POPULATION***

* 9/1,000 people attempt suicide
* 1/10 endorse suicidal thoughts
* actual suicide rate has remained stable (increase in the younger group offset by a decrease in the middle-aged group)
* 30,000 deaths annually in the US (attempts about 10x)
* One suicide every 20 minutes

***More Rates***

* Men commit suicide 3x more than women
* Women attempt suicide 4x more than men
* Men use more violent methods
* Except for the 15-24 age group suicide increases with age:  Men peak after 45; women after 55.  For men >65: incidence of 40/100,000
* Elderly account for 25 % of suicides and only 10% of population

***Rates Related to Race***

* 3rd leading COD for 15-24 year old males (after accidents and homicide)
* Whites 2x higher rate than nonwhites
* Religion:  suicide rates among Catholic populations are lower than the rates among Protestants and Jews
* Marital Status:  marriage with children greatly less
* single, never-married have double the rate for married
* Previously married much higher than single:
* 24/100,000 among widowed
* 40/100,000 among divorced
* 69/100,000 among divorced males; 18 for women

Occupation

* higher the social status, higher the risk
* a fall from social status increases the risk
* work protects
* Female physicians have highest rate:  41/100,000
* Male physicians no increase
* Psychiatrists>ophthalmologists>anesthe-siologists
* Other: dentists, musicians, law enforcement officers, lawyers, and insurance agents
* Physical health:  strong relationship with suicide:  postmortem studies show 25-75% of all suicide victims have some physical illness.  Health is contributing factor in 11-51%
* Mental health:
* almost 95% of all patients who commit or attempt suicide have a diagnosed mental disorder.
* 80%depression, 10% psychotic disorders, dementia 5%
* Risk in mood disorders:15%
* Risk in alcoholism: 15% (270/100,000)
* also significant in panic disorder and OC disorder

***35-80% of all suicidal behavior is alcohol-related***

10% of attempts subsequently successful suicide within 10 years

19-24% of suicides have a prior suicide attempt

45-70% of suicides have mood disorder 15% of mood disorder subsequently suicide

Suicides

***Health Promotions Instruction   
OPNAVINST 6100.2***

* Health contributes to better decisions
* Regular exercise, healthy diet contribute to stress management
* Responsible alcohol use reduces risk taking, promotes better decision making

***Suicidal Behavior                 Assessment and Management***

***Every suicide act is made with a degree of ambivalence and is a communication***

***Early Identification and Prevention***

* Causes of Suicide
* Risk Factors
* Warning Signs
* Assessment of Risk
* Management

***Causes of Suicide***

* Loss of Close Relationship
* Loss of Career and/or Employment
* Loss of Financial Security
* Loss of Social Acceptance
* Loss of Health
* Loss of Self-Control
* Loss of Freedom (Disciplinary)

***Feelings Associated with Loss   
(Bereavement)***

* “Psychache”  (Intolerable Life Pain)
* **Hopelessness\*\*\*\***(high corroboration with risk)
* Helplessness
* Depression
* Worthlessness (Self-critical)
* Shame (Self-hate)
* Agitation/Anxiety/Panic

***Risk Factors***

* Relationship Problems
* Experience with Firearms
* Alcohol Abuse
* Unexplained Mood Changes or Depressed Mood
* Male

***Risk Factors (cont.)***

* Previous suicidal behavior
* h/o psychiatric d/o
* Personality disorder
* Unexpected physical disability
* FH:
* unstable childhood/adolescence
* abuse, neglect, rejection by parent
* close relationship to someone who committed suicide

***Warning Signs***

* Suicidal Talk   “I Wish I Were Dead”                                 “If ........Happens, I’ll Kill Myself”                “No One Cares About Me”                           “I Just Want All Of This To End”

***Warning Signs***

* Suicide Preparation
* Notes
* Giving Away Personal Possessions
* Final Arrangements
* Preoccupation with Death
* Prior Suicide Gestures or Attempts
* Social Withdrawal
* Mood Changes

***Technique of Assessment***

* ***Non judgmental, objective, and empathetic***
* ***Preserve the dignity and avoid humiliating the patient***
* ***Encourage the patient to express concerns and plan***
* ***If made attempt - first stabilize***
* ***Assess aforementioned risk factors***
* ***If they have a plan:***
* ***P - what is the proximity to help?***
* ***A - what is the availability of means?***
* ***L - what is the lethality of means?***
* ***S - what is the specificity of the plan?***
* ***Assess information provided by others:***
* available support
* job stressors
* impulsive behavior
* safety of where pt will spend next 48 hours
* attitudes of family, friends,

***Management***

* If suicidal risk is found - must admit to the nearest facility.  No one who has made a suicide attempt should be sent home from a treatment facility without a psychiatric evaluation, and in most cases, inpatient evaluation (24-48h).

***Do’s and Don’ts***

* ***Clarify limitations but explore options and solutions***
* ***Avoid judgmental remarks and observe your body language***
* ***Refrain from making unrealistic reassurances, simple advice, or clichés***

***Do’s and Don’ts***

* ***Don’t leave the pt alone***
* ***Include family and friends if available***
* ***Inform the pt of your plans***
* ***Be available during the acute crisis even if hospitalized - visit - don’t abandon***
* ***Therapeutic Alliance can’t be underestimated (trust, empathy)***
* ***Contracts***:
* a verbal or written “contract” is NOT the bottom line - this can cause a false sense of security (allays the physician's anxiety without having any effect on the patient’s suicidal intent)
* much better to document that the pt  understands the resources available to him/her and document specific risk elements

***Other Psychiatric Emergencies***

Anyone at significant risk to harm themselves or someone else can be considered a

psychiatric emergency

i.e. - are they suicidal, homicidal, or psychotic?

Keep it simple - first determine the above and then sort out the

cause

***Clinical Presentations***

* subdued behavior
* agitated behavior
* bizarre behavior
* perfectly normal behavior

***How to handle a suicidal, homicidal, or psychotic patient***

* **FIRST AND FOREMOST ENSURE SAFETY**(of patient ***and*** you)
* Follow do’s/don’t already discussed
* Always err on the conservative side (at minimum contact a psychiatrist or psychologist to discuss case before releasing)
* Listen to your primary process:  if you are uncomfortable being alone with a patient,**DON’T BE ALONE WITH THEM**

***Preventive Measures***

* Review your clinic restraint plan - if it doesn’t exist get some help and develop one. Understand the principles of verbal, chemical, and physical restraint and logistics involved