Pretest and Objectives

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This educational activity is eligible for CME credit through October 31, 2005. The latest review of this material was September 2003.

Educational Objectives
After studying the article by Carrigan and Lynch, participants should be able to:

- Appropriately manage the patient who has recently attempted suicide.

This pretest is designed to facilitate your study of the material.

1. **If suicidal patients are hospitalized:**
   a. Postdischarge follow-up is usually not necessary
   b. The risk of suicide still exists
   c. They can leave whenever they feel like it
   d. There is no longer need to worry about suicidal behavior

Pretest answer and Posttest on page 175.

Disclosure of Off-Label Usage
The authors have determined that, to the best of their knowledge, no investigational information about pharmaceutical agents has been presented in this article that is outside U.S. Food and Drug Administration–approved labeling.

Managing Suicide Attempts: Guidelines for the Primary Care Physician

Catherine Goertemiller Carrigan, M.D., M.B.A., and Denis J. Lynch, Ph.D.

The management of patients who have made suicide attempts is a responsibility that frequently falls to the primary care physician. For this reason, it is important that the physician have a clear strategy for dealing with the suicidal patient in the office, hospital, and emergency room. In the acute situation, the first priority is to stabilize the patient and ensure his or her medical safety. Once this is accomplished, history and circumstances of the attempt can be assessed, along with likelihood of recurrence of the attempt. This article reviews guidelines for evaluating suicide risk. The importance of the patient-physician relationship is noted, particularly in regard to prevention of future suicide attempts. With a focused, thorough approach to the suicidal patient, which incorporates both medical and psychiatric considerations, the primary care physician can ameliorate the patient's acute situation and facilitate the coordination of care with appropriate psychiatric resources.

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In the spirit of full disclosure and in compliance with all ACCME Essential Areas and Policies, the faculty for this CME activity were asked to complete a full disclosure statement. The information received is as follows: Drs. Carrigan and Lynch have no significant commercial relationships to disclose relative to the presentation.

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Primary care physicians are frequently called upon to evaluate and manage a patient who has attempted suicide. Services may be provided in the emergency department (ED) of the hospital immediately after the attempt or later in the office after the patient has been stabilized and is recovering. A comprehensive plan can aid the physician in both meeting the immediate, potentially life-threatening challenges of caring for the patient, as well as providing the patient with needed support and guidance in the follow-up phase. An effective and collaborative patient-physician relationship can provide a mechanism to reduce the likelihood of another suicide attempt. Our goal in this article is to recognize the frequency and severity of suicide attempts in primary care patients and to offer guidelines for stabilization and safety, including possible interview strategies and procedures. Areas to explore in assessing the suicidal patient, especially risk factors for subsequent attempts, will be presented. Finally, some general issues in providing continuity care for a patient who has made a suicide attempt will also be addressed.

BACKGROUND: EXTENT AND DESCRIPTION OF THE PROBLEM

The incidence of suicide surpasses homicide and is the eighth leading cause of death in the United States. About 1% of total deaths are a result of suicide. Unsuccessful attempts outnumber completed suicides by a multiple of 16.[1] It has been estimated that the average number of suicide attempts in a family practice is 10 to 15 yearly, although the family physician may be aware of only 1 or 2.[2] Multiple attempts are more likely to occur in the adolescent and young adult age groups. Frequently, the geriatric patient who commits suicide has not made previous attempts.[3]

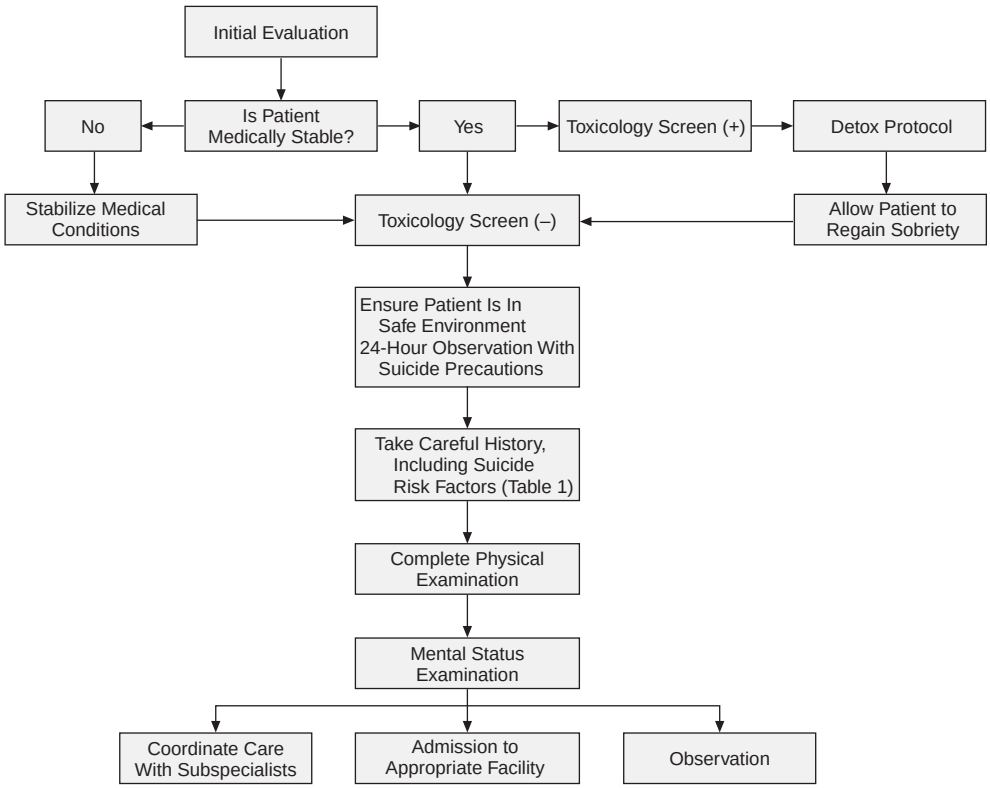
Differentiation between a suicide attempt and a parasuicide has been suggested.[4] Parasuicide refers to an act of self-harm without the realistic expectation of death. These behaviors have also been referred to as suicidal gestures and viewed as different from a "true attempt" in which there is a clear intent and expectation of death. However, gestures can also lead to death when there are miscalculations or unexpected effects of the harmful behavior. In addition, it is difficult and sometimes impossible to discern accurately the patient's intent. As a result, parasuicides or gestures should be taken seriously and deserve the same intensive intervention as unambiguous suicide attempts.

Managing the patient who has attempted suicide requires a comprehensive plan. The algorithm in Figure 1 describes an overall assessment and management strategy. The following sections detail the recommended steps.

STABILIZATION AND SAFETY

Some suicidal patients present to the primary care physician with the chief complaint of suicidal thoughts. However, more often, patients come in for other complaints

Figure 1. Algorithm for the Management of Patients With a Recent Suicide Attempt



and are later found to be suicidal following thorough questioning about their thoughts of hurting or killing themselves. In either case, the physician needs to gather information about the patient's intent, plan, support system, and past medical/psychiatric history. The patient should not be allowed to leave the office until the physician can thoroughly assess his or her condition. A staff member should be assigned to stay with the patient while treatment arrangements are made. If the patient is hostile or demands to leave, law enforcement should be called. However, if a patient is threatening to the clinician or office staff, heroic measures should not be used to restrain the patient; instead, providing law enforcement with a description of the patient's vehicle and direction of travel may be helpful.

Physician knowledge of local mental health resources is necessary so that the patient can be directed to appropriate treatment. Some communities have mental health crisis centers that take suicidal patients referred from physicians. Another option is to call emergency medical services for ambulance transport to the nearest ED for evaluation. Suicidal patients cannot be discharged from the office alone. In unusual circumstances, if the patient is not intoxicated or impulsive and a reliable friend or family member is with the patient, that person can accompany the patient to the ED or crisis center, but it is safest for medical staff or law enforcement to assist with transport.

During the initial encounter with the patient who has attempted suicide, whether in the ED, office, or hospital room, the physician should focus first on the stabilization of the patient's medical condition. This includes the protocols for medical resuscitation such as Advanced Cardiac Life Support and vital sign stabilization. Signs and symptoms must be evaluated carefully and should not automatically be attributed to a psychiatric origin. Intoxication and delirium should be ruled out. The patient must be sober before the formal suicide evaluation can take place.

A patient being evaluated in the ED should not be allowed to leave prior to a full evaluation. If there is acute danger to the patient or others, then he or she should be restrained chemically or physically. The physician and medical staff must be cognizant of their own safety. If the caregiver feels threatened by the suicidal patient, a security guard should be present in the patient's room.[5]

It is important to ensure that the area where the patient is observed, both in the ED and as an inpatient if admitted, is safe and that there are no available means for self-harm. This precaution is often overlooked when patients are admitted to intensive care units for observation, especially if the patient is comatose when first admitted. All sharp

objects, belts, drugs, and medical equipment should be isolated from the patient. The patient should be easily observable from the nurses' station and a guard should be assigned to watch the patient on a one-to-one basis. An attendant should accompany the patient to all procedures and tests.

PATIENT HISTORY

After the patient is stabilized and his or her safety ensured, establishing a history becomes the next priority. To begin the interview, set the appropriate environment. Ask family and friends to step out of the room, requesting to talk with them later.[5] It is important to remain calm, nonjudgmental, and nonthreatening. Medical history should include review of current medications, past and recent substance use, history of seizures or head injuries, and HIV risk factors. Information should be gathered about prior suicide attempts and psychiatric illnesses because both are associated with an increased risk of suicide.[3] Those with bipolar disorder, depression complicated by comorbid anxiety disorders, and impulse control and substance abuse disorders, as well as those with psychotic or delusional ideation, are at particular risk. Over 90% of persons who commit suicide have diagnosable psychiatric illness at the time of death, often depression, alcohol abuse, or both.[6] Hopelessness, while often accompanying depression, is an independent predictor of suicide and should be specifically probed.

Physicians should determine if a suicide note exists and, if so, make an effort to copy it for inclusion in the medical record. Collateral data from paramedics, police, friends, and family are valuable and can provide clues to the timing and sequence of events.[6] It is important to establish the temporal details, especially in cases of ingestion or overdose. The length of time since ingestion can alter decisions regarding methods of treatment. Care must be taken, however, since confidentiality laws require patients' permission to discuss health care information with others. The American Psychiatric Association has developed a "Position Statement on Confidentiality" that supports the breaching of confidentiality if necessary to protect the patient or the community from imminent danger.[7,8]

The importance of confidentiality was underscored in the "Minimum Necessary" standard of the Health Insurance Portability and Accountability Act (HIPPA).[9] Covered entities, such as physicians and hospitals, are required to review their privacy practices and enhance safeguards to protect patients' health information. Only the medical staff directly involved in the care of the patient should receive details or have access to the patient's health information. History of suicide attempts can be particularly sensitive, and if publicly known, can have a profound impact on the patient's life.[10] Of note, while HIPPA regulations and basic medical ethics prohibit the clinician from divulging patient health information, they do not prohibit a clinician from interviewing others and obtaining and recording information about the patient.

The use of basic interviewing techniques can optimize the encounter with the suicidal patient. This involves expressing empathic curiosity, active engagement, and morally nonjudgmental relatedness with the patient. It can begin with a simple question like "How can I help you today?" Listen carefully to the precise answer. The physician should try to understand what crisis would have prompted the patient to attempt suicide. For patients who are reluctant to be open, focus should be on the reason for that reluctance. Asking the simple question "Why now?" can often lead the interviewer directly to the precipitant of the crisis. Ask whom the patient would be leaving behind to gain the identity, relationship, and significance of key people. Listen carefully to ascertain the patient's emotional state and reiterate it for them, putting the problem in a broader context. For example, say, "You seem very sad about this, and it seems to you that there is no way out."[6] Addressing the patient's sense of hopelessness may be an important part of beginning to help them.

Although hopelessness is usually associated with depression, it can occur in other diagnostic conditions as well and is frequently involved in suicide attempts.[11] The patient cannot see how things will improve and dreads continuing with things as they are. Death is seen as an escape, a way to avoid a pain that will never go away.[12] While empathizing with the patient's pain helps them feel more trusting and understood, the physician can subtly begin inculcating hope with a positive attitude, a belief that the patient's circumstances and depression can improve and be treated successfully. The goal is for the patient to believe their situation and distress are appreciated, while at the same time perceive that the physician is confident that things can get better.

The patient's problem solving and coping skills should be evaluated and stressors and support systems identified. Knowledge of the patient's current and past prescription medications and access to drugs, alcohol, and firearms is vital. This information will be helpful in establishing an understanding of the environment that the patient may be returning to upon discharge. For the adolescent attempter, ask about changes in school performance or attendance. It is assumed that the physician will also obtain a detailed medical history for the patient, including comorbidities, allergies, and family history.

MENTAL STATUS AND PHYSICAL EXAMINATION

The physical examination is a critical element in the evaluation of patients who have attempted suicide. This is an area where primary care physicians can greatly add to the care given the patient. Only 17% of psychiatrists rou-

tinely perform physical examinations on their inpatients, and the rate for outpatients is even lower.[13] Up to 50% of patients with psychiatric complaints have been found to harbor unrecognized medical illnesses that may have contributed to their mental deterioration.[14]

Throughout the initial encounter, the physician will be collecting observational data about the patient's mental status. Was he able to spell his name when first asked? Did she remember the day of the week? Does she know where she is? Who brought him to the hospital/clinic? During the initial moments of the interview, these simple, directed questions should be asked to establish the patient's level of alertness and orientation. The goal is to gain insight into the patient's mental status, including any indication that the patient is delusional, psychotic, or substance impaired. Findings from the mental status examination[6] can be used to facilitate discussions with psychiatric consultants and will be valuable additions to the medical record.

The physical examination should be thorough and complete. Special attention should be given to physical findings associated with chronic disease, alcoholism, and substance abuse.[15] Include observation of appearance, level of attention, affect, dress, grooming, and hygiene. Look for needle marks, unusual odors, or excoriations suggestive of past abuse or injury. Vital signs should be obtained from all patients; in combative patients, wait until after they have calmed down. Observe interactions of the patient with family, friends, and hospital staff. Tests such as toxicology screens, electrolytes, complete blood cell count, blood glucose, liver function tests, and electrocardiography (ECG) are appropriate and should be obtained to establish any comorbid conditions.

The physician who is responsible for writing medical admission orders for the suicidal patient should take the following considerations into account in addition to the medical orders needed to stabilize the patient (e.g., activated charcoal, mannitol, ECG, routine labs). The patient should be placed on suicide precautions. In 1 study, 6 out of 57 people who were inpatients or patients in a day hospital committed suicide while in the hospital and 3 of those 6 patients were thought to be improving based on chart notes.[16] Consider the possibility of comorbid substance abuse. Monitor for delirium tremens and supplement folate and thiamin if the patient has neurologic deficits or is malnourished. Ancillary testing such as thyroid function tests, lead levels, liver panel, serum osmolality, ammonia level, chest x-ray, and lumbar puncture should be considered in patients with corresponding physical examination findings or in patients presenting with new onset of psychiatric symptoms.[13]

Patients presenting with overdose need aggressive initial treatment and close monitoring for the first 12 to 24 hours. The patient may withhold, underestimate, or be physically unable to give accurate estimates of type or quantity of pills ingested. The physician should maintain a high index of suspicion for occult overdose and should be prepared to use reversal agents (i.e., naloxone in narcotic overdose, flumazenil in benzodiazepine ingestion) and gastrointestinal tract decontamination via emesis, gastric lavage, or activated charcoal with a cathartic.

Historically, ipecac has been used to induce emesis in cases of overdose; however, its use is declining.[17] Induced emesis can be attempted only in a fully alert patient who has not ingested a caustic, petroleum product, or antiemetic. Gastric lavage is performed using a large bore gastric tube (37ºF [3ºC] to 40ºF [4ºC]) inserted into the stomach and flushed with 200 mL of warmed water and aspirate suctioned. The procedure is repeated until the aspirate returns clear fluid. Care must be taken to ensure airway protection. In patients that do not have a gag reflex, intubation must be considered. Activated charcoal can be given orally following lavage in a dose of 1 g/kg of patient body weight. To avoid constipation and increase gastrointestinal motility, charcoal is used in combination with the cathartic sorbitol in a dose titrated to achieve consistent loose stools.[18]

Reliable knowledge of the agent(s) for overdose may require specific antidotes that are outside the scope of this discussion. Help with management can be obtained from the pharmacy staff in the hospital and from poison control centers. The national number for poison control is 1-800-222-1222 and is available in the front pages of most phone books and directories.

Finally, document the encounter, including the assessment (based on the interview and the collateral information), differential diagnosis, working diagnosis, and treatment plan. The treatment plan should include evaluation by a psychiatrist, preferably while in the hospital. If the patient refuses to be evaluated or his insurance plan declines referral, then the patient should be involuntarily hospitalized. Suicide is against the law, and the police will escort the patient to the psychiatric facility if necessary.[19]

If the patient is to be discharged, be sure to ask about and document the availability of firearms, potentially lethal medications, and other means of suicide. Handgun ownership in the United States is estimated at 16% to 19% of the population. Handguns are commonly used in suicide, accounting for 62% of suicides among men and 39% among women. Therefore, steps must be taken to make guns inaccessible to the at-risk patient.[20] Ask a friend or family member to remove all firearms from the patient's home. Inform close contacts of the patient to remove all guns from other households accessible to the patient.

Establish a follow-up plan, including frequent close contacts or visits during the days after the attempt.[21] Follow-up is especially important for adolescents since they frequently repeat attempts, and as many as 50% of adolescents who have attempted suicide are not referred for follow-up at the time of emergency care.[22] It is

Table 1. High-Risk Factors in Assessing Suicide Risk

1. Past suicide attempts
2. Seriousness of previous attempts
3. Family history of suicide
4. Feelings of hopelessness
5. Substance abuse
6. Social isolation
7. Personal or family history of psychiatric disorders (eg, major depression, bipolar disorder)
8. Burden of physical health problems
9. History of loss
10. Preoccupation with death

necessary to involve the patient's family and support system. It is beneficial for a family member or close contact to monitor the patient and provide support following the acute phase of the suicide attempt.

MANAGING CONTINUITY PATIENTS WHO HAVE ATTEMPTED SUICIDE

The primary care physician may not be the one to immediately treat and stabilize the patient following the suicide attempt. However, responsibility may be turned over to them at some point, and special considerations and guidelines will aid the primary care physician in the patient's care.

A close working relationship between the patient and physician will foster the patient's recovery and minimize the chance of another suicide attempt. Failure to adhere to discharge recommendations is common in patients who have attempted suicide.[4] This tendency may be reduced by a good therapeutic relationship with the primary care physician.[23] In particular, the physician's knowledge over time not only of the patient's physical condition but also of their psychosocial circumstances may alert the physician to levels of patient stress and warning signs. Because of the high incidence of chronic health problems in depressed and suicidal patients, especially among the elderly,[24] knowledge of the patient's attitudes and feelings about their illness may be very relevant.

Several studies have reported that between 20% and 76% of patients who commit suicide have seen their primary care physician in the prior month.[25] Frequent monitoring of suicidal thoughts in high-risk patients, especially those who have made recent attempts, may reduce the number of completed suicides. Knowledge of high-risk factors (Table 1)[21–23,26] will make the primary care physician more effective in identifying vulnerable patients.

It has been suggested that "no-suicide" contracts may be helpful in managing suicidal patients.[27] Basically, this approach asks the patient to commit either verbally or in writing to not act on suicidal impulses but instead contact a source of help, such as a suicide hotline or the primary care physician, if they feel suicidal. This approach not only conveys the concern and regard of the primary care physician but also gives the patient a concrete plan to follow when feeling in crisis and despondent. Agreement to a no-suicide contract does not ensure patient safety, but if the patient cannot agree to this contract, hospitalization should be seriously considered. The potential for substance abuse, history of impulsive behavior, and social isolation all might limit the value of such contracting.

Close follow-up is important when treating a patient who has recently made a suicide attempt. While office visits will be the basic intervention, brief telephone calls can provide support contact and help identify if an urgent appointment needs to be scheduled. If hospital discharge planning did not include psychiatric referral, this should be a priority. Prompt communication and coordination with the mental health professional will promote efficient and effective care. Since many patients are still averse to seeing a psychiatrist because of misconceptions and fear of stigma, encouragement and education from the primary care physician about the importance of treatment will make it more likely the patient will follow through on the referral.

Medication may play an important role in the ongoing management of patients who have attempted suicide. The pharmacologic treatment depends on the underlying psychiatric diagnosis. Most clinicians choose a selective serotonin reuptake inhibitor as first-line treatment of depressive disorders.[28] These medications are generally well tolerated and safe for use in the depressed patient and have been found to decrease suicidal ideation.[29] There are many choices available for depression, and a review of these medications is outside the scope of this article. Many excellent reviews of pharmacotherapy are available.[28] Patients who fail first-line treatment or have other psychiatric disorders, such as bipolar disorder or schizophrenia, may benefit from consultation with a psychiatrist.

It has been suggested that antidepressant medications may activate depressed individuals, thus increasing the risk of suicidal behavior.[30] Close monitoring of the patient recently started on any antidepressant will help the primary care physician assess whether suicidal risk has been increased as a result of activation effects from the medicine.

CONCLUSION

When evaluating a suicidal patient, first and foremost, keep the patient safe. Stabilize the presenting medical condition and treat any comorbid conditions. Ask for collateral information from police, emergency medical staff, and any witnesses to the suicidal events. When the patient is able to participate in an interview, the physician should ask the question, "Why now?" and listen intently for any clues to the patient's current situation. Perform a thorough and detailed physical examination. Obtain a psychi-

atric consultation and/or contact the patient's existing physician(s) and make sure a follow-up plan is in place. If the primary care physician sees the suicidal patient on a continuity basis, the therapeutic patient-physician relationship as well as attention to suicidal risk factors and general health status will be important. Finally, coordination with and support for specialized psychiatric care by the primary care physician is recommended.

Drug names: mannitol (Osmitrol), naloxone (Suboxone, Narcan, and others), flumazenil (Romazicon).

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For the CME Posttest for this article, see pages 175–176.