HARMONY
ADDICTION & PSYCHIATRIC CARE

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Assessment & management of suicide risk

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TRIGGER WARNING

Some viewers may find the following slide evocative

"There are two kinds of clinicians, those who have had patients complete suicide, and those who will."

(Simon, 1998)

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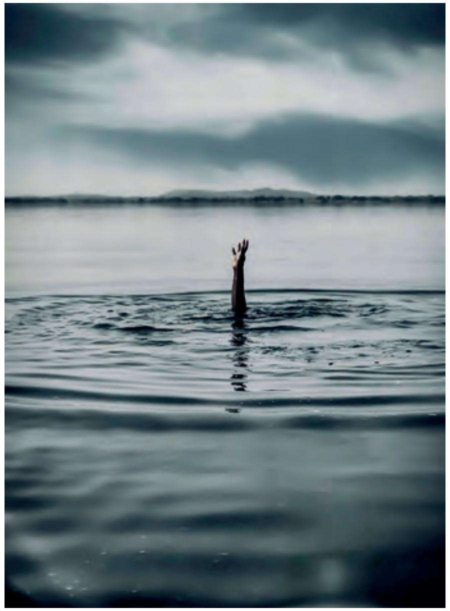

How common is suicide in South Africa?

Suicide accounts for 11% of unnatural deaths in SA.

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Lifetime prevalence

9.1% Suicidal ideation
3.8% Suicide plans
2.9% Suicide attempts

This translates to:

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This translates to:

18 Suicides per day.

20 Attempts for each successful attempt.

♂ 80% of whom are men who have completed suicide.

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Suicidal behaviour is often undiagnosed, or untreated in clinical settings because it is poorly understood.

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Most individuals who die by suicide have:

- Communicated their intention to others.
- Visited / been treated by occupational therapists, psychologists, psychiatrists, social workers or GP’s during the weeks / months preceding their death.

Definitions:

Suicide:

Is defined as a death where:

- The injury is self-inflicted.
- There was intent to die.

Suicidal behaviour:

Refers to a range of emotions, cognitions & actions characterised by a desire to die.

Self-Harm / Deliberate Self-harm:

- Deliberate Self-harm with intent to die.
- Deliberate Self-harm without intent to die.

Deliberate self-harm without intent to die:

Associated with emotional regulation (to reduce anger, sadness, anxiety, shame, punish oneself).

Deliberate Self-harm without intent can progress to Deliberate Self-harm with intent.

Most common form is lacerations (70%) followed by burning, stabbing, self-hitting & self-poisoning (less frequently).

One study showed 2% complete suicide within 1 year & 7% complete suicide within 10 years.

7% within 10yrs

Relationship between attempted suicide and completed suicide:

One study showed that of 302 individuals admitted for medically serious suicide attempts:

- 3.7% made at least 1 further attempt.
- 6.7% died by suicide.

An older UK study found that at least 1% of patients referred to general hospitals in the UK for Deliberate Self-harm die by suicide within 1 year of the episode of Deliberate Self-harm and 3-5% within 5-10 years.

These findings have been replicated in a number of subsequent studies.

Thus:

- A prior suicide attempt is statistically the best predictor of future suicide attempts and eventual death by suicide.
- A history of repeated attempts further increases the risk.

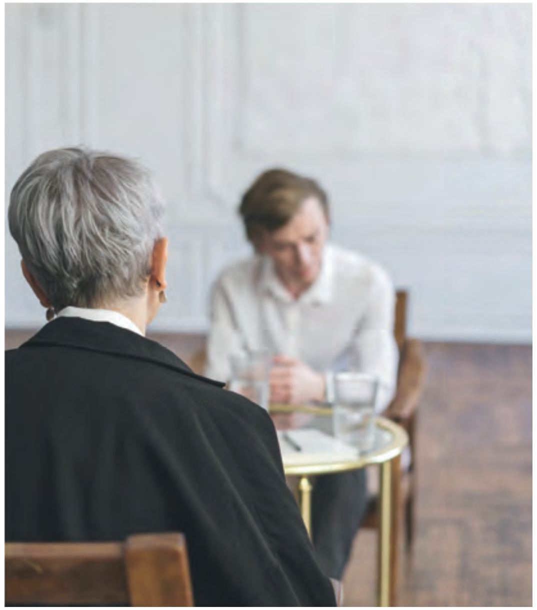
Clinical implications for assessing deliberate self-harm:

- The presence or absence of intention to die should be directly assessed.
- Many individuals deny intent to die.
- A negative answer should not be taken at face value – absence of evidence is not evidence of absence.
- These patients require on-going monitoring & treatment.

Assessing suicidal ideation and intention:

Suicidal individuals rarely talk about their suicidal intent because of:

- The fear of not being understood / taken seriously.
- The fear of getting ineffectual advice.
- The fear of being labelled mentally ill and admitted to a psychiatric hospital against one's will.
- The fear of giving away the seemingly only possibility of escape.



Questions to Ask Patients with Suicidal Ideation

Delineate extent of Suicidal Ideation

- When did you begin to have suicidal thoughts?
- Did any event (stressor) precipitate the suicidal thoughts?
- How often do you think about suicide? Do you feel as if you're a burden? Or that life isn't worth living?
- What makes you feel better? (e.g. contact with family, use of substance)?
- What makes you feel worse (e.g. being alone)?
- Do you have a plan to end your life?
- How much control of your suicidal ideas do you have? Can you suppress them or call someone for help?
- What stops you from killing yourself (e.g. family, religious beliefs)?

Questions to Ask Patients with Suicidal Ideation

Ascertain plans for furtherance and lethality

- Do you own a gun or have access to firearms?
- Do you have access to potentially harmful medications?
- Have you imagined your funeral and how people will react to your death?
- Have you "practiced" your suicide (e.g. put the gun to your head or held the medication in your hand)?
- Have you changed your will or life insurance policy or given away your possessions?

Assessment tools:

- Suicide Risk Assessment Interview Schedule (SRAIS) – Bandjies & van Ommen, 2007
- Collaborative Assessment & Management of Suicidality (CAMS) Approach – Jobes, Wong, Conrad, Drozd, Neal-Walden, 2005
- SAD PERSONS Scale – Patterson, et al & Juhnke, 1996
- Columbia Suicide Severity Rating Scale, 2008
- Adapted Becks Suicide Scale, 1991

Continuum of suicidal behaviour:

- Ideation
- Intention
- Formulating a plan
- Rehearsing the plan
- Enacting the plan
- Suicide

Ideation, intent & plan can be assessed along specific dimensions:

- Frequency
- Intensity
- Duration
- Detail
- Content
- Lethality

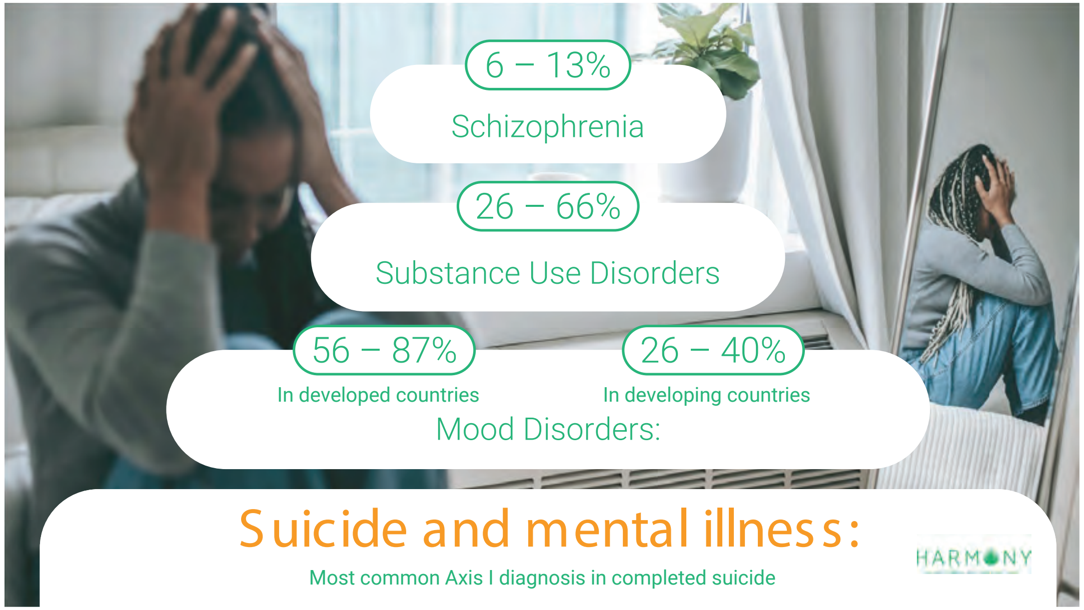
Assessing suicide plans using the SLAPP criteria:

- Specificity of plan
- Lethality of plan
- Availability of means to enact the plan
- Proximity to others & help
- Previous attempt to enact

Pierce Suicide Intent Scale – should be completed after a suicide attempt

The phenomenology of suicidal individuals:

- A lack of ambivalence
- An absence of anxiety
- Bland emptiness
- Cold contempt
- Incongruous matter-of-factness
- Eerie resignation



6 – 13%
Schizophrenia

26 – 66%
Substance Use Disorders

56 – 87%
In developed countries

26 – 40%
In developing countries

Mood Disorders:

Suicide and mental illness:

Most common Axis I diagnosis in completed suicide

Most common Axis II diagnosis associated with suicidal behaviour:

Borderline personality disorder:

- 10% die by suicide
- Typically have a mean of 3 lifetime attempts.
- In clinical samples, there are more women with BPD, but this is not the case in community samples (women are help-seeking, whilst men are not).
- Young men with BPD are particularly at risk of completing suicide – 1 study found that 1/3 of youth suicides (which are mostly male) have BPD – few of whom were in treatment at the time of death.

Anti-social personality disorder:

- 5% complete suicide

Most common Axis I diagnosis associated with suicidal behaviour

Mood disorders and suicide:

- Major Depressive Disorder – 50% will make an attempt & 15% will complete suicide.
- Bipolar Mood Disorder – 8.2% will complete suicide.
- Suicidal behaviour occurs almost exclusively during an acute severe major depressive episode, less frequently in a mixed episode and very seldom in states of euphoric mania.

Addiction and suicide:

- Substance Use Disorders are the 2nd most common Axis I diagnosis associated with completed suicide.

There is a well-established link between suicidality and addiction.

Several factors contribute to this connection:

1

Mental health conditions: Addiction and suicidality often co-occur with depression, anxiety, bipolar disorder, and PTSD. Substance abuse may be a way for individuals to self-medicate.

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There is a well-established link between suicidality and addiction, referred to as comorbidity.

Several factors contribute to this connection:

2

Impulsivity and risk-taking behaviours: Addiction is associated with impulsivity and high-risk decision-making.

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Several factors contribute to this connection:

3

Neurochemistry: Substance abuse can alter brain chemistry, leading to changes in mood regulation.

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There is a well-established link between suicidality and addiction, referred to as comorbidity.

Several factors contribute to this connection:

4

Psychosocial factors: Addiction can lead to strained relationships, financial problems, legal issues, and loss of employment, all of which can contribute to feelings of hopelessness and despair.

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There is a well-established link between suicidality and addiction, referred to as comorbidity.

Several factors contribute to this connection:

5

Withdrawal: During withdrawal from certain substances, individuals may experience intense psychological and physical symptoms, including depression and anxiety.

There is a well-established link between suicidality and addiction, referred to as comorbidity.

Several factors contribute to this connection:

6

Genetic and environmental influences: There may be shared genetic and environmental factors that contribute to both addiction and suicidality, such as a family history of substance abuse or suicidal behaviours.

There is a well-established link between suicidality and addiction, referred to as comorbidity.

Several factors contribute to this connection:

7

Chronic pain and illness: Individuals may turn to substances to alleviate their symptoms, leading to addiction. The combination of chronic pain, substance abuse, and associated psychosocial stressors can significantly increase the risk.

There is a well-established link between suicidality and addiction, referred to as comorbidity.

Several factors contribute to this connection:

8

Access to lethal means: Certain substances can serve as readily available lethal means for suicide attempts.

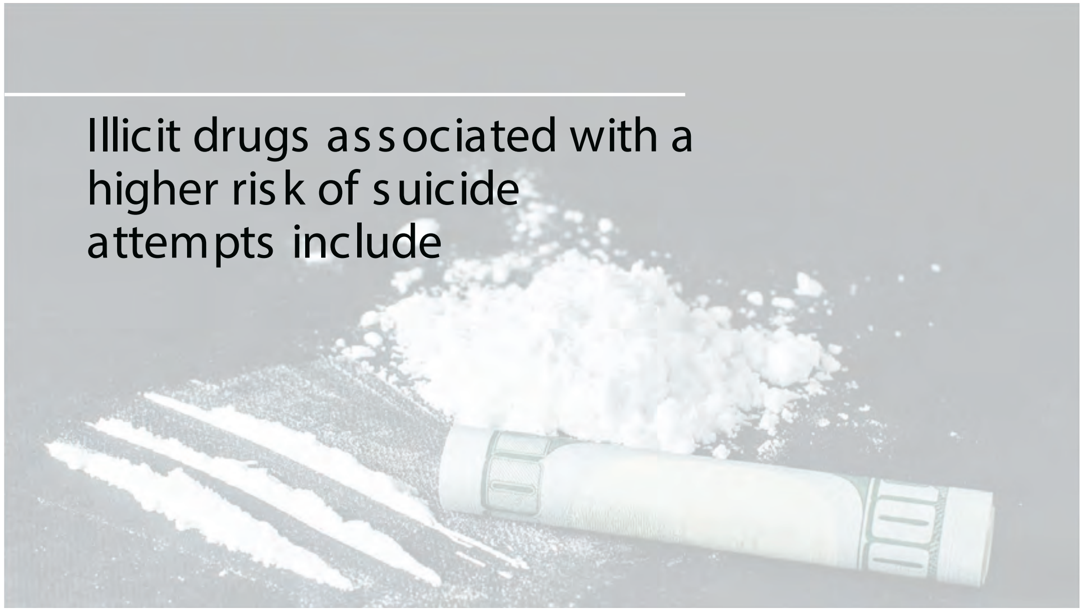
Alcohol use disorder is most commonly linked to suicidality:

Distal risk factors

- Age of onset of AUD
- Pattern of binge drinking
- Co-morbid drug use
- Co-morbid medical condition (chronic illness)
- Negative affect
- Agitation & impulsivity
- Borderline Personality Disorder

Proximal risk factors

- Active severe alcohol use
- Severe depressive symptoms
- Acute disruptions in relationships
- Chronic interpersonal stress
- Low perceived belonging
- Death of a family member / confidant



Illicit drugs associated with a higher risk of suicide attempts include







1. Cocaine: Cocaine use can lead to impulsivity, agitation, and paranoia. Additionally, withdrawal from cocaine can cause severe depressive symptoms.
2. Methamphetamine: Methamphetamine use is associated with increased impulsivity, aggression and psychosis. Chronic methamphetamine use can also lead to mood disorders such as depression and anxiety.
3. Heroin and other opioids: Opioid dependence and withdrawal can lead to profound feelings of hopelessness and despair.
4. Synthetic cannabinoids: Synthetic cannabinoids can cause severe agitation, hallucinations, and paranoia.
5. Bath salts (synthetic cathinones): Bath salts are synthetic stimulants that can induce psychosis, agitation, and paranoia.
6. Ketamine: Ketamine is a dissociative anaesthetic with hallucinogenic properties. While ketamine itself may not directly increase suicide risk, it's dissociative effects can exacerbate underlying psychiatric conditions such as depression or PTSD.
7. Hallucinogens (e.g., LSD, psilocybin): While hallucinogens are not typically associated with suicide risk, individuals with pre-existing mental health conditions or a history of trauma may experience exacerbation of symptoms during hallucinogenic experiences.
8. Ecstasy (MDMA): MDMA use can cause serotonin depletion and mood disturbances.

Managing suicidal behaviours in patients:

Protective factors:

- Family & social support
- Pregnancy & post-partum period
- Having a large number of children
- Strong religious beliefs
- Restricted access to means
- Relief from depressive symptoms
- Acute & long-term pharmacological treatment

Management strategies for all suicidal patients:

Comprehensive assessment: Conduct a thorough assessment to evaluate the severity of addiction, any co-occurring mental health disorders (such as depression, bipolar disorder, or PTSD), and the presence of suicidal ideation or behaviours.

This assessment should include an evaluation of risk factors for suicide:

- Previous suicide attempts
- Family history of suicide
- Access to lethal means
- Current social support

Management strategies cont.

Integrated treatment approach: Implement an integrated treatment approach that addresses both addiction and mental health issues concurrently.

This may involve:

- Medication management
- Psychotherapy (Such as cognitive-behavioural therapy or dialectical behaviour therapy.)
- Support groups tailored to individuals with co-occurring disorders.

Management strategies cont.

Safety planning:

- Clinician & patient collaboratively develop a list of hierarchically coping mechanisms that the patient can use during a suicidal crisis.
- Usually formatted like a cue card / flowchart that the patient can quickly refer to - include warning signs, coping mechanisms that patient can use independently, people whom the patient can contact for support, contact information for mental health professionals / hospitals / suicide hotlines.
- Safety plans are deemed so effective at lowering suicide risk that it has been developed as a stand-alone crisis intervention strategy. A patient unable to follow their safety plan, would likely be hospitalised to remain safe. It is revisited each week until suicidality has resolved (3 consecutive clinical consults).

Management strategies cont.

Monitoring and follow-up: Regularly monitor the patient's symptoms, substance use, and suicidal behaviours throughout treatment.

Schedule follow-up appointments to assess progress, adjust treatment plans and provide ongoing support.

Education and support for families: Can be crucial in supporting the patient's recovery and safety, as well as recognizing warning signs of relapse or suicidal behaviour.

Collaboration: Coordinated care with mental health professionals ensures a comprehensive approach to treatment and ongoing monitoring.

Management strategies cont.

Addressing trauma: Many individuals with addiction have experienced trauma.

Incorporate trauma-informed care principles into treatment and trauma-focused therapies where appropriate.

Encouraging social support: Facilitate connections to peer support groups or other community resources where individuals can receive support from others who have experienced similar challenges.

This can help reduce feelings of isolation and hopelessness.

Management strategies cont.

Pharmacological management: Consider the use of medication, such as antidepressants or mood stabilizers, to address co-occurring mental health disorders.

No Harm Contracts (NHC):

- Well-accepted & widely practiced.
- Many clinicians believe that these contracts are ineffective in reducing suicide attempts but continue to use them in order to protect themselves from malpractice lawsuits.

No Harm Contracts (NHC):

Research:

- There is no empirical evidence supporting the use of NHC alone.
- In fact, there are studies that show that NHC's are harmful.
- One study showed that clients with a NHC were more likely to make suicide attempts than those without.
- Another study showed that it is not uncommon for individuals who complete suicide to have a NHC.
- APA recommends not using a NHC with individuals who are actively suicidal.
- When they have been effective, it is with clients who have no previous history & who do not have severe psychopathology.
- Their use is contra-indicated with psychotic patients.

Ethical considerations

- Autonomy
- Beneficence
- Non-maleficence
- Confidentiality
- Informed consent
- Cultural competence
- Collaboration and consultation
- Ongoing assessment and monitoring

Self-care for the clinician:

Self-care for the clinician:

Spiritual self

- Meditate / pray
- Connect with higher power
- Connect with self
- Spend time in nature

Self-care for the clinician:

Intellectual self

- Intellectual stimulation

e.g. Reading, studying, podcasts etc.

Self-care for the clinician:

- Exercise
- Balanced diet
- Enough water
- Enough sleep
- Physical check-ups

Physical self

Self-care for the clinician:

- Get support
- Ask for help
- Spend time with loved ones
- Leisure
- Forming new friendships

Social self

(Friends, family, colleagues)

Self-care for the clinician:

Emotional self

- Express feelings: talk, journal, art, music, etc.
- Interpersonal effectiveness: communication skills & conflict management
- Emotional regulation & distress tolerance

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