

Assessing and Managing Potentially Suicidal Patients Practical Guidelines for Doctors



THE HONG KONG JOCKEY CLUB
Centre for Suicide Research
and Prevention
THE UNIVERSITY OF HONG KONG



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Table of contents

Foreword	2 - 3
1. Objectives of the guidelines	4
2. Severity of the problem	4
3. Myths and facts about suicide	5
4. Why involve doctors?	6
5. Role of doctors	7
6. How to detect and engage potentially suicidal patients?	8 - 9
7. How to assess suicidal risk?	10 - 12
<i>Preliminary screening for depression and suicidal risk</i>	
<i>Common risk factors</i>	
<i>Warning signs</i>	
8. When & how to refer to mental health services?	13 - 14
9. The do and don'ts	15
10. Resource information	16
11. Quick reference flip chart	17
12. References	18 - 19
13. Acknowledgements	20

Foreword

Medicine today embraces not only treatment of diseases, but also prevention of sickness. Doctors today not only have to provide medication, but are also expected to adopt a holistic care approach that includes psychosocial intervention. This is the expectation of medical care in the new Millennium. In response, curricula of many medical schools around the world have been revised and reformed putting emphasis on whole-person care, integrated approach, clinical interpersonal skill and communication skill. Such emphasis occurs in postgraduate training as well.

Suicide can be considered a preventable condition. It is astounding to learn the finding that some 30 - 70% of suicidal people have consulted a doctor within one month prior to their suicide death. How were they managed? What were the complaints? What were the diagnoses? Did the doctor realize that the patient whom (s)he saw had recently attempted suicide? These are mind boggling questions that doctors must try to address. They owe it to their patients to render the appropriate assistance.

This manual provides simple yet useful information, guide and skills to doctors to detect patients at risk of suicide. Doctors working at whatever levels, be they generalists or specialists, should be aware of the "diagnostic tools" included in this manual, and if need be, make referrals.

Doctors must help their patients and curb the climbing number of suicides in Hong Kong that is associated with much wastage of resources. Human resources is the most treasured resources in Hong Kong and every effort should be made to preserve it. After all, doctors have a duty of care, holistic care, to their patients.



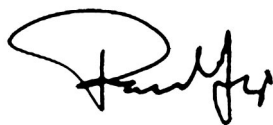
Professor Grace W. K. Tang
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Foreword

Suicide has become an important public health concern world wide. It is currently one of the most important causes of death in Europe and North America [e.g. World Health Organization (WHO), 2002]. Mortality by many common diseases and accidents has been steadily declining in recent decades, but suicide has increased among the teenager in some European countries (WHO,2002). In Hong Kong, suicide is the sixth leading cause of death (Census and Statistics Department, 1981 - 2003). Moreover, it has been the fourth leading causes of death in terms of years of life lost since 1981 (Yip, Law & Law, 2003). The suicide rate in 2003 was 18.6 per 100,000, which is a historical high. Since suicide is multi-causal in nature, its prevention is not easy. It calls for multidisciplinary efforts of professionals who provide evidence based information for suicide prevention.

Research findings in both western and local studies show that as many as 30% - 70% of those who died by suicide had consulted a doctor within one month prior to their death (e.g. Luoma, Martine & Pearson, 2002; Pfaff & Almeida, 2004; Vassilas & Morgan, 1994;Yim, Yip, Li, Dunn, Yeung & Miao,2004; Yip, Chi & Yu, 1998). Hence, doctors can play an important role in suicide prevention and intervention as echoed by the World Health Organization. If suicidal patients can be identified during their visits to doctors, timely and effective treatment can save many precious lives. This is the primary impetus behind the preparation of the present manual.

In the spirit of holistic care in medicine advocated by the Academy's President and the medical and health care community, doctors' care for their patients should be extended beyond treating bodily illnesses, also to attending to patients' psychological pains. Both local and overseas studies show that many suicidal people do not seek help from mental health professionals. Hence, primary care professionals are one of the important gatekeepers to identify these suicidal patients. We hope the evidence-based and practical guidelines provided in this manual can assist doctors to raise the awareness and strengthen their knowledge and skills in assessing and managing suicidal patients; thereby making a significant contribution in suicide prevention.



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Objectives of the guidelines

The primary objective of this manual is to provide practical guidelines for doctors in assessing and managing potentially suicidal patients.

The manual also provides basic facts and practical skills about suicide that are relevant to medical practice. Hence, it is brief and pragmatic in its approach. It does not aim to cover everything related to the topic.

Resource information and reference list have been included to provide the reader with further information beyond this manual.

An overall objective of the manual is to align doctors in the early detection, assessment, intervention and prevention of suicide.

Severity of the problem

Suicide has become a major public health problem globally. Every year, there are almost one million deaths resulting from suicide. This costs billions of dollars annually (WHO, 2004).

Globally, the number of suicide deaths surpassed those of homicide (500 000) and war (230 000) (WHO, 2004).

Locally, it has been the sixth leading cause of death since 2001 (Census and Statistics Department, 1981-2003; The Hong Kong Jockey Club Centre for Suicide Research and Prevention CSRP, 2005a).

The number of suicide deaths has exceeded those caused by infectious and parasitic diseases, diseases of blood, and injury and poisoning resulted from accidents [Census and Statistics Department, 1981-2003; (CSRP), 2005a].

The loss in labour productivity due to suicide amounted to HK\$1.4 billion in 2003 alone (CSRP, 2005a).

In terms of costs of medical services incurred by patients of deliberate self harm to the Hospital Authority, it amounted to HK\$4.8 million in 2003 (CSRP, 2005b).

What is worst is the fact that the rate of suicide death has been increasing rapidly in Hong Kong in recent years. The figure in 2003 (1264 suicide deaths; 18.6 per 100,000) is a record high.

Myths and Facts about suicide

Myths	Facts
Patients who talk about suicide will not go on to commit suicide.	Patients who commit suicide usually show warning signs and clues. Threats should be taken seriously.
Patients who die by suicide are very determined and will die anyway.	Suicidal patients are often ambivalent. Timely intervention can save precious lives.
Asking patients about suicide may provoke them to carry out the plan.	In the context of empathetic understanding and concern, asking patients about suicide will often make patients feel understood and relieved -- physicians' caring question shows them that someone wants to help.
Patients that have previously attempted suicide will have a smaller chance to try again.	On the contrary, patients with previous attempt history have a higher probability of re-attempt. Our recent Prevalence Study (CSRP, 2005a) shows that 55.3% of the suicidal attempters have made previous attempts.
Once patients feel less depressed, it implies that they are less troubled with their problems and will be less likely to attempt suicide.	Depressed patients who now show improvement may in fact be more at risk -- they may have regained the energy which they once lacked to commit suicide.
Female patients talk about suicide just to manipulate people and seek attention. They usually do not have the courage to harm themselves.	Although more males die by suicide than females, there are more female suicide attempters than males. However, it must be noted that the gender ratio is not as pronounced locally as it is in the western world (Yip, 1996). Moreover, there is evidence to show that the gender gap is narrowing in recent years (CSRP, 2005b)
Only psychiatric patients are at risk of suicide.	Although about 60 % - 80% (e.g. CSRP, 2005a; Haste, Charlton & Jenkins, 1998) of the suicidal people suffer from some kind of psychiatric disorders, not all suicidal patients are psychiatric. Physicians need to watch out for non-psychiatric patients that may be suicidal.
Only trained mental health professionals can help suicidal patients.	Most suicidal patients do not seek help from mental health professionals. Data from our Prevalence Study, for example, show that only 18.4% of the suicidal attempters and 14.5% of those with suicidal ideation or a plan to commit suicide have actually sought help (CSRP, 2005c). Therefore, physicians play an important role as gatekeepers, supporters, and referrers.

Why involve doctors?

As many as 30 - 70% of those who died by suicide consult a doctor within 1 month prior to their death (e.g. Appleby, Amos, Doyle, Tomenson & Woodman, 1996; Ho, 2003; Ho & Tay, 2004; Houston, Haw, Townsend & Hawton, 2003; Leung, Chan & Cheng, 1992; Luoma, Martin & Pearson, 2002). Therefore, physicians have a good chance of seeing suicidal patients in their clinics. Hence, they need to be equipped with the knowledge and practical skills in detecting these patients, providing early intervention and treatment, and thereby contributing in suicide prevention and saving precious lives.

As few as one quarter of the suicidal population received psychiatric care in Hong Kong (Ho, 2003). These patients may end up in the general ward (Leung, Chan & Cheng, 1992) or in the doctor's office.

A recent local study showed that of all the hospital records of suicidal acts reviewed, nearly two-third of the completed suicides occurred in medical wards of general hospitals. (Ho & Tay, 2004). Hence, physicians working in the medical wards should not rule out the possibility of seeing suicidal patients in the wards. Moreover, physicians must be on the alert especially when treating patients that are admitted to the general wards because of attempted suicide. It is because the likelihood of re-attempt among these patients was found to be about 68 times higher than other patients (Yip, Yang & Law (2005).

Compared with findings in western studies, local research found that discharged psychiatric patients have increased contact with primary health care before death (Yim, Yip, Li, Dunn, Yeung & Miao, 2004). However, local patients were found to be less likely to express their suicidal intent (Yim, Yip, Li, Dunn, Yeung & Miao, 2004). Hence, doctors need to be more alert when discharged psychiatric patients consult them, even when their presenting problems were solely physical complaints. Doctors who are knowledgeable about suicide and sensitive to its warning signs play an important role in detecting and treating suicidal patients.

Role of doctors

Maintain a high degree of awareness of all patient features and risk factors for suicide

Aim at early detection and prevention of potentially suicidal patients

Enhance knowledge and skills in treating suicidal patients

Keep detailed documentation of case notes to track and monitor patients' progress

Intervene and support for suicidal patients, especially in patients' critical period

Provide practical information about medication to solicit suicidal patients' better compliance with medication and counselling

Where possible, enlist suicidal patient*s family to share responsibility as caregivers

Refer patients and collaborate with mental health professionals in treating suicidal patients

How to detect and engage potentially suicidal patients?

General patient features

Patients with mood disorders (such as depression and anxiety disorders), alcoholism, schizophrenia and chronic illnesses (such as neoplasm, heart diseases, cancer and stroke) are associated with increased risk for suicide. It has been found that about one in every five cardiac patients and as many as 50% of cancer patients experience depression (National Institute of Mental Health, 2002), which is an important factor in suicide. Hence, patients with three or more unrelated medical concerns should be screened for depression (Dantz et al., 2003).

Patients with suicidal risks often present themselves with somatic complaints. They may complain of vague aches and pains, having problems with their sleep, feeling moody, lethargic or lack of interest.

However, these patients often do not readily disclose their psychological problems during consultation. It is therefore important that doctors try to establish good rapport with patients and make use of effective communication skills to facilitate diagnosis and treatment.

Skills to engage patients

Skill 1 Use of open-ended questions

Allow time for patients to describe their complaints using open-ended questions.

Examples:

How can I help you?

What is bothering you today?

These questions are general and open-ended. They can invite patients to explain their problems, be they somatic or psychological in nature, in their own words. If patients feel secure, they may disclose any personal problems that are present.

Skill 2 Don't interrupt prematurely

Allow adequate time for patients to describe their problems, and do not give the impression that you are in a hurry (although you may have many patients in queue).

This also makes it possible for the physicians to gather adequate data and minimize diagnostic errors.

Skill 3 Use of empathetic listening

Listen to patient's exact wordings, and look for the central idea(s). Be sensitive about any underlying messages, especially those that are emotionally-loaded.

Example:

If a patient says, "I have been having such a terrible headache for the past weeks that I lose all my interest in everything."

The complaint is NOT just about a bad headache.

The key words are

1. terrible headache
2. past weeks
3. lose all interests
4. everything

This suggests the need to probe further and screen for psychological problems.

Skill 4 Use of non-verbal cues

Observe patient's general presentation, facial expressions, posture, tone, choice of words and appearance.

Where appropriate, use such cues to prompt patient to discuss further concerns.

Research shows that only a minority of suicidal patients will actively express their suicidal thoughts to their doctors (Yim, Yip, Li, Dunn, Yeung & Miao, 2004).

Doctors can respond to patient's non-verbal cues in a manner that conveys your empathy and care.

Examples:

You look very sad to me; is there anything besides your headache that is bothering you?

I have the impression that you are feeling down; I'd like to know if there is anything else besides your headache that upsets you.

Doctors can minimize patient's feelings of discomfort or shame in discussing their psychological problems by the use of non-verbal attending skills.

Examples of non-verbal attending skills:

Positive eye contact, smile, leaning a little bit forward to signal your concern and care, nodding from time to time to show that you are listening attentively or that you understand the patient's situation.

Patients may feel uneasy if the doctor is preoccupied by note-taking. Don't jot down every word the patient says without looking at him/ her.

Skill 5 Encouraging verbal responses

Use of voice:

Speak in a soft voice using moderate pace to make your patient feel more relaxed.

Hasty and brief utterances may give your patient the impression that you are very busy and do not have time to listen to him/ her.

Loud speech and interrogative tone can be threatening to the patient.

Some minimal verbal responses signal to patient that you are listening and can encourage the patients to continue talking.

Examples:

"Uh, huh"

"I see."

"I know how you feel."

"Please go on."

"Tell me more, please."

Once patient is engaged, it saves time later on in the diagnostic process and it will also be easier to solicit patient's cooperation in the treatment plan that follows.

How to assess suicidal risk?

Few patients will explicitly inform their doctors that they have suicidal thoughts or plan. If a patient has one or several precipitating problems, you need to be on the alert. The following are examples of such problems:

Recent losses of jobs or relationships, financial problems, chronic ill health, school or work problems, unwanted pregnancy, recent reminders of past deaths of significant others

Once you suspect that a patient may be suffering from depression or have some suicidal risks, you should proceed to do a screening for depression first, as depression is an important risk factor and often a co-morbid condition of other risk factors (such as schizophrenia) for suicide. However, doctors should also bear in mind that **not all** suicidal people are depressed.

Two Question Screen for Depression

Question One:

During the past month, are you often bothered because you have little interest in doing things?

Question Two:

During the past month, are you often bothered because you feel down, depressed or hopeless?

If the patient's answer to either or both questions is "yes", then the screen for depression is "positive". You need to proceed with a brief diagnostic interview of depression. You also need to take note of other presentations of depression:

Multiple somatic complaints or unexplained somatic complaints

Miserable or depressed facial expressions

Non-verbal cues, such as down cast eyes, psychomotor retardation.

Patient's failure to attend to personal appearance

Complaints of insomnia

Rapid and/ or unexplainable cognitive decline in elders

Diagnostic Criteria for Major Depressive Disorder

The following are the diagnostic criteria for major depressive disorder:

A total of at least five symptoms from category (I) and (II) AND at least ONE symptom must be from category (I). The symptoms must be present for most part of the day, nearly every day, for at least TWO weeks.

Category (I) symptoms

Depressed mood

Markedly diminished interest in usual activities

Category (II) symptoms

Significant increase/ loss in appetite or weight

Insomnia/ hypersomnia

Psychomotor agitation/ retardation

Fatigue or loss of energy

Feelings of worthlessness or guilt

Difficulty with thinking, concentrating, or making decisions

Recurrent thoughts of death or suicide

If a patient is identified as suffering from depression, the following questions can be asked to screen for suicidal risk:

Preliminary screening for suicide risk

Have you had any thoughts that life is not worth living?

Have you thought that you might be better off dead?

Have you thought about hurting or killing yourself? If yes, have you actually done anything to hurt yourself?

If the patient's answer(s) is/are "yes", you should assess suicide risk further by checking the presence of any suicide risk factors, warning signs and suicidal behaviours.

Common suicide risk factors

Previous suicide attempt(s)

Past or current psychiatric history

Suicide deaths of close family members

Recent losses, such as death in the family, loss of job, relationship break-up

Chronic pain/ illnesses

Drug or alcohol abuse

Social isolation or lack of social support

Financial debt

Unemployed

Being never married

Demographic variables - e.g. middle-aged or elderly

Cognitive rigidity or poor problem-solving skills

Warning signs for suicide

Below are some examples of common warning signs:

	Examples
Behavioural	gives possessions away, has written a will, plans to buy / has recently bought a life insurance, has problems with eating, sleeping or work, suddenly withdraws from friends and family
Cognitive	cannot think clearly, sees no sense of worth of own self, becomes hopeless, difficulty concentrating, cannot see any way out of the "mess", sees no sense of purpose in life, finds no reason for living.
Affective	experiences unbearable psychological pain, weepy, irritable, extreme sadness, fiery temper, dramatic mood changes

Initial assessment of suicidality

Suicidal ideation/ thoughts

e.g. **How often do you have these suicidal thoughts?**

Suicidal plan

e.g. **Do you have any plans to harm yourself?**

When will you do that?

What has kept you from acting on these (suicidal) thoughts?

Suicidal acts/ attempt history/ method/ lethality/ availability of means

e.g. **How will you kill yourself?**

Have you attempted suicide before? (If yes, when was it?)

Did you use the same method in your last attempt?

When to refer to mental health services?

Depending on the patient's problem, referral needs to be appropriate to his/her need. If the patient has no depression, nor any suicide risk, there is no apparent need to make referral.

Consider referring the patient to a mental health specialist (i.e. psychiatrist, psychologist, psychotherapist, counsellor, clinical social worker) for a confirmatory diagnosis and/ or further treatment and support in the following cases:

Diagnostic impression	Patient's need(s)
Your initial diagnosis shows that the patient may be suffering from depression,	(s)he may need a confirmatory diagnosis and appropriate treatment and/ or some support to work with his/ her problem.
The patient has some degree of current suicidal thoughts, no major risk factor and warning signs,	(s)he may need support from a social service agency personnel to work with the suicidal ideation
The patient has current suicidal thoughts and some major risk factors,	(s)he may need professional help to work out an appropriate management plan
The patient has current suicidal thoughts, some major risk factors, and some suicide plan,	(s)he needs urgent professional help
The patient has current suicidal thoughts, has a definite plan, and has the means to do it immediately,	(s)he may need emergency escort and admission to the hospital
The patient has current suicidal thoughts and becomes very emotional when discussing his/her problem,	(s)he may need emergency escort and admission to the hospital if imminent suicidal risk is perceived

In the case of immediate hospitalization, explain the recommendation and solicit the patient's consent; also remember to inform the family to enlist its support. In this situation, the patient's safety overrides and confidentiality can be breached.

How to refer a patient?

In making a referral, it will be very helpful for the doctors to communicate some basic information with the mental health professionals. The following are some items to include in a referral letter or a referral communication form:

Patient's background information, e.g. name, sex, age, address, phone numbers, marital status, years in Hong Kong (or whether the patient is a newly-arrived immigrant), etc.

Current and present professional services received by patient, e.g. whether patient is already a known case of a psychiatrist or a social welfare organization

Patient's presenting problem (and medical history, if relevant)

Diagnostic impression

Treatment information, e.g. type and dosage of medication prescribed, patient's response to treatment

Reasons for referral

Recommendation(s) for what kind of mental health care, e.g. Is the patient seeking a psychiatrist's or a psychologist's treatment? What are the goals of treatment? Is the patient in need of counselling and support by a social worker to comply with psychiatric care?

(Note: For referrals to social service organizations that have diversified services, this information will be particularly useful.)

How to explain to a patient about the referral ?

To reduce patient's resistance to perceived stigma associated with mental health services, you can explain in the following manner:

Examples:

"Referring to psychiatric or mental health assessment is just a standard practice to give us another professional opinion (to help you better)."

"Similar to other fields of medicine, such as cardiology or orthopaedics, referral to specialist care gives us more in-depth information to help you."

In some cases, you can assure your patient of your continual care and support.

Example:

"Assessment by an expert can advise me on appropriate management strategies. I shall communicate with this expert to work out what treatment and follow-up plan suits you best."

Some suicidal patients are rather sensitive; they may perceive your referral as a sign of rejection. In such cases, your reassurance of care and continual support is all the more important.

The do and don'ts

Things to do	Things not to do
listen with empathy	cut short the patient's responses abruptly
be objective	hear the facts, and nothing more
be supportive	challenge the patient
be caring and calm	react with strong emotions on hearing the patient's personal problems
explore the patient's symptoms and risks systematically	be insincere and say: e.g. "Pull yourself together." "Time will heal." "You must be joking, you don't really mean what you say /you don't really want to kill yourself!"
identify the patient's internal and external resources	give empty promises
remove lethal means calmly, if possible	assure confidentiality instantly
enlist the patient's support network, if possible	give false hope that help is everywhere
in a case of high suicidal risk, stay with the patient and convey continual support until (s)he is received by other appropriate professionals.	in a case of high suicidal risk, send the patient away to rid of your own responsibility

Resource information (For reference only)

Government

Social Welfare Department Hotline: 2343 2255

Elderly Health Services Hotline: 2121 8080

Hospital Authority (Psychiatric Services) Hotline: 2466 7350

Non-Government Organizations

Hotlines

Family Caritas Crisis: 18288

The Samaritans: 2896 0000

Samaritan Befrienders: 2389 2222

Suicide Prevention Services: 2382 0000

Counselling and Psychological Services

Baptist Oi Kwan Social Service: 34130 1500

Breakthrough Counselling Centre: 2736 6999

Christian Family Service Centre: 2861 0283

Hong Kong Caritas Family Service: 2843 4670

Hong Kong Christian Service: 2731 6316

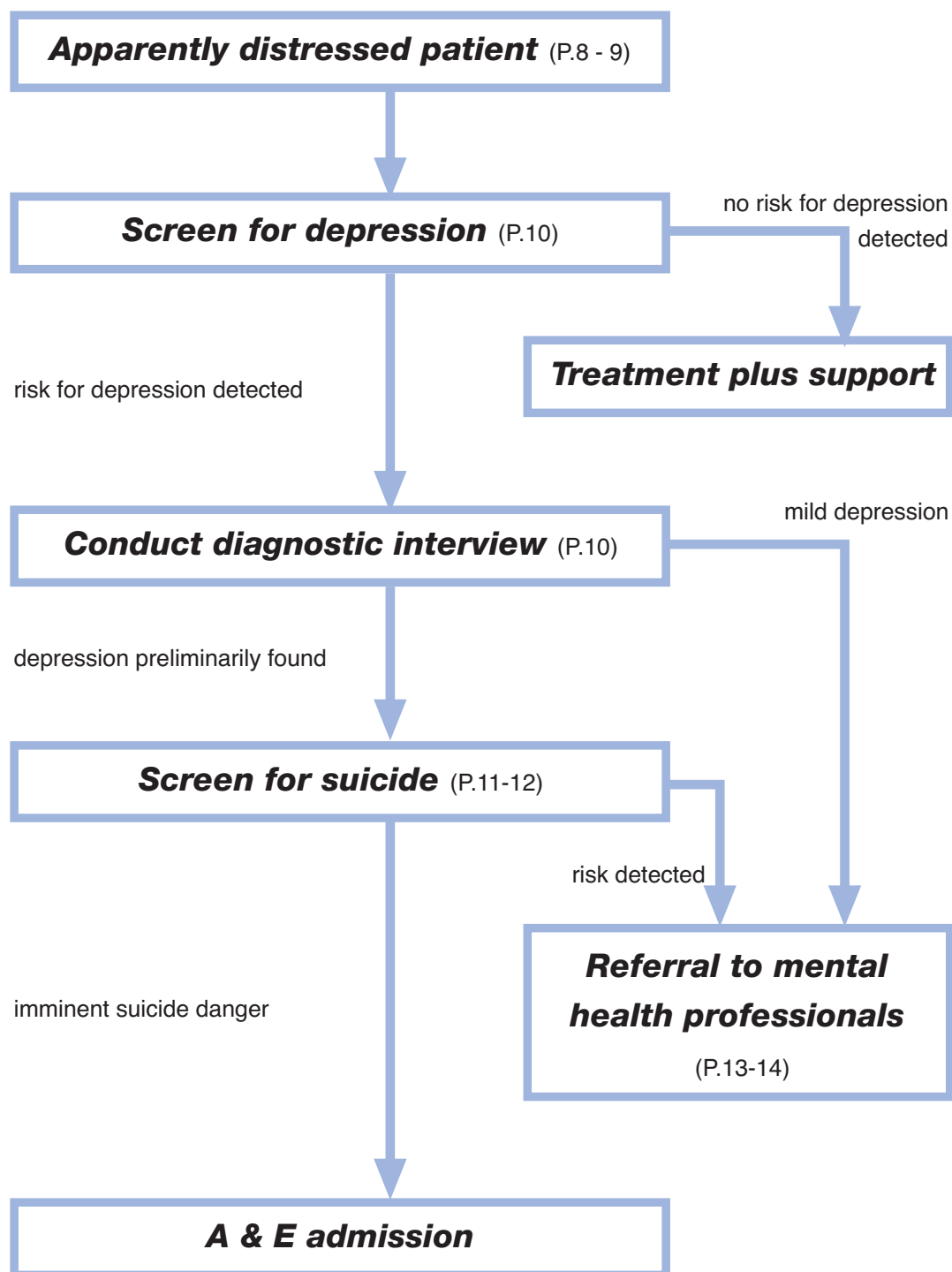
Hong Kong Family Welfare Society: 25279171

Yang Memorial Methodist Social Service: 2388 7141

Useful websites related to suicide

American Association of Suicidology	http://www.suicidology.org/
American Foundation for Suicide Prevention	http://www.afsp.org/index-1.htm
Canadian Association for Suicide Prevention	http://www.suicideprevention.ca/
European Network for Suicidology	http://www.uke.uni-hamburg.de/extern/ens/
The Hong Kong Jockey Club Centre for Suicide Research and Prevention	http://csrp.hku.hk
International Association for Suicide Prevention	http://www.med.uio.no/iasp/
New Zealand Guidelines Group -- Guidelines on Suicide	http://www.nzgg.org.nz/index.cfm
National Institute of Mental Health	http://www.nimh.nih.gov/
World Health Organization (mental health)	http://www.who.int/mental_health/en/

Quick reference guide



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