

Management of Suicidal Patients in a General Hospital Psychiatric Ward*

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ABSTRACT

Suicide is defined as an act of taking one's own life voluntarily or intentionally. In suicide cases, males outnumber females, the elderly, those with psychiatric disorders and those with chronic medical conditions are at higher risk. The most common psychiatric diagnoses are depression and schizophrenia. In the management of suicidal patients, careful assessment of suicide risk is paramount. Questions to ask to determine severity of suicide intention are described in this paper. Inpatient psychiatric treatment is indicated if there is an on-going risk of self-harm or when social support is poor. Demographic factors of persons deemed to be of high risk are also discussed. Medications, psychotherapy and social support are necessary in the management of the suicidal patient undertaken by a multidisciplinary team of mental health professionals.

Keywords: assessment, depression, risk, schizophrenia, suicide

INTRODUCTION

The World Health Organisation estimates that about one million people killed themselves in 2000, thus placing suicide as the thirteenth leading cause of death worldwide.¹ In the same year in Singapore, 204 people killed themselves, a rate of about 9.5 persons per 100,000 population, with males outnumbering females by 1.5:1.¹ Elderly persons, males, and persons who have medical disorders, or are widowed, separated, divorced or single, are more at risk of ending their lives. Medical conditions associated with an increased risk of suicide are cancers, especially of the head and neck, chronic renal failure, AIDS or HIV infection (Table 1).² The psychiatric conditions most often associated with suicide are schizophrenia and depression. In Singapore, a review of previously published studies seems to suggest that the most common methods of suicide are jumping from heights (55 to 69%), hanging (20 to 27%) and poisoning (5 to 10%), with other methods, such as drowning, knife wounds and firearms, rarer.³⁻⁵ In Singapore from 1985 to 1988, the mean annual suicide

rate was found to be highest in the Indians (20.4 per 100,000), followed by Chinese (15.8 per 100,000), and Malays (2.4 per 100,000). However, in the elderly population (65 years and above), the rate was highest in the Chinese (61.2 per 100,000), with Indians second (30.5 per 100,000), and Malays still the lowest (3.2 per 100,000). Among elderly Chinese, women had a higher suicide rate than men.⁶ Reasons for these ethnic differences are beyond the scope of this paper, but could reflect socio-economic reasons, the role of alcohol and the consequent spousal abuse as risk factors for suicide in certain races (for example in the case of the Indians) while the role of religion as a protective factor against suicide has been suggested for races such as the Malays who are predominantly Muslim.^{4,7}

Appropriate management of the suicidal patient follows a thorough evaluation of suicide risk. Although suicide risk assessment may be carried out by any member of a multi-disciplinary team of professionals such as psychiatrists, nurses, medical social workers and psychologists, management generally requires the combined expertise of several members of the team.⁸⁻¹⁰

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WHEN IS ADMISSION WARRANTED?

Table 1. Medical conditions with increased suicidal risk.²

Illness	Increased risk (×)
HIV/AIDS	6.6
Huntington's disease	2.9
Cancer (all sites)	1.8
Cancer (head and neck)	11.4
Chronic renal failure	14.5
Spinal cord injuries	3.8
SLE	4.3
Peptic ulcer	2.1
Spinal cord injuries	3.8

Admission to hospital depends on several factors such as whether:

1. the patient is in immediate risk of self-harm
2. there is an acute exacerbation of psychotic symptoms, for example, thought disorder, hallucinations or delusions
3. there are features of agitation, impulsivity, disorientation and dissociation
4. there is insufficient family support or supervision, such as when family members are away at work, leaving the patient at home alone
5. the level of stress is high and the patient is unable to cope
6. suicidal intent is high or when behaviour indirectly suggests this is the case, such as hoarding of tablets and consuming them in a locked room
7. there are medical problems consequent to the suicide attempt, thus placing the patient's life at risk. Following a suicide attempt, admission is usually indicated for the purpose of medical assessment to exclude complications arising from self-injurious behaviour

Admission to a general hospital is strictly voluntary. Where a patient is deemed suicidal but refuses treatment, compulsory treatment under the Mental Disorders and Treatment Act may be necessary. However, such treatment can only be enforced at Woodbridge Hospital. If patients or relatives refuse transfer to Woodbridge Hospital, but decide to sign an "at own risk" (AOR) discharge from the general hospital, they should be reminded that under Singapore laws, it is an offence to attempt suicide. In my view, if the patient is judged to be at immediate risk of harming himself/herself, and the patient refuses to comply with

treatment in the general hospital, under common law and in the best interests of the patient, he/she could be sedated and transferred to Woodbridge Hospital for an assessment with a view to admission. If, for instance, the patient is assessed to be not in immediate danger of harming himself/herself and if the relatives are prepared to supervise the patient at home, making sure the patient takes medications as prescribed, and are willing to take the patient back to hospital for outpatient appointments, then AOR discharges could be allowed under these circumstances. It is unclear how many of these AOR discharges have resulted in suicides. Conversely, it is also uncertain how many suicides have been prevented from timely admissions to hospital.

ASSESSMENT OF SUICIDE RISK

Psychiatric intervention should follow after emergency medical treatment has commenced and the patient well enough to be interviewed. The most important task at this stage is to evaluate the severity of suicidal risk at the time of self-harm, and whether there is any immediate, or on-going, risk of suicide. Several questions need to be answered:¹¹

1. what were the reasons for the attempt?
2. what did the patient hope to achieve? Did the patient wish to die?
3. what problems did the patient face?
4. did any event precipitate the attempt?
5. is the patient suffering from any mental illness?
6. what is the most appropriate intervention?

It is necessary to obtain an account of the sequence of events that occurred at least 48 hours preceding the attempt, the circumstances surrounding the act itself, and the events following the act.

SUICIDAL INTENTIONS

Factors suggesting a high suicidal intent are self-harm carried out in isolation with steps taken to avoid detection, leaving a suicide note, settling personal affairs such as making a will, use of lethal method and verbalisation of intention to kill oneself.

RISK FACTORS

Risk factors include male sex, age 60 and above, being widowed or divorced, unemployment, recent adverse life events such as loss of job, or death of a significant person in his/her life, previous suicide attempts,

feelings of hopelessness, substance abuse and inability to feel any sense of enjoyment.¹²

Patients deemed to be suffering from a psychiatric disorder and fit for discharge from the medical ward should be transferred to a psychiatric ward for further management. Those who had been admitted for acts of self-harm but assessed to be not a suicide risk in the immediate term could be discharged home and, if necessary, given a psychiatric outpatient appointment.

PSYCHIATRIC INPATIENT MANAGEMENT

Management in a psychiatric ward gives staff time to interview suitable informants, and for psychotropic medications to be administered and for their beneficial effects or side effects to be closely monitored. Antidepressant medications may take between one to two weeks or more to take effect.

PSYCHOTHERAPY

Psychotherapy in its various modalities (individual, group, family or marital) can be commenced when the patient is able to hold a conversation and is able to describe his/her problems, feelings and thoughts in a coherent manner. Usually, supportive psychotherapy or brief problem-oriented psychotherapeutic approaches are indicated.¹³ Individual sessions of cognitive behaviour therapy, interpersonal or dynamic psychotherapy would also be beneficial, but only when the patient's mental state has stabilised, the acute crisis having been resolved. Where there are family or marital issues, meetings could be organised by medical social workers with family members or spouse during the course of the inpatient stay.

“SUICIDE CAUTION”

Patients judged to be an immediate risk of suicide should be placed on “suicide caution”. The patient's belongings should be searched for dangerous objects that might be used for suicide. Any tablets, weapons, blades found in the possession of the patient should be removed for safekeeping. The ward environment should be cleared of unnecessary tubes, wires, or sharp objects. Shower units should be wall mounted to avoid the use of hand-held hoses. If metal utensils such as forks and knives are used, these should be accounted for at the end of every meal. Windows should be protected with grills and ward doors lockable. The patient should be assigned a bed closest to the nurses' station to enable discreet observations to be carried out.

These observations of the patients should be made at frequent, regular intervals and recorded in a “suicide observation chart”. Attention should be paid to neuro-vegetative symptoms such as appetite and sleep disturbances. It should not be assumed that when patients are lying motionless in bed they are sleeping. Subjective reports of poor sleep should be checked against objective observations by night duty staff. Such patients should be closely observed for acts of self-harm. They should not be allowed to leave the ward unless permission has been granted by the medical staff in charge. Appearance and affect can reveal whether mood is improving. During each shift, nurses should spend a few minutes speaking to the patients, as even letting them describe their difficulties and patiently listening in an empathetic manner would considerably reduce their sense of isolation and hopelessness.

MEDICATIONS

Medications to ameliorate symptoms should be titrated against improvements and/or side effects. Antidepressant, anxiolytic and hypnotic medications are necessary to ameliorate anxiety and depressive symptoms and to promote sleep. Tricyclic antidepressant medications are unsafe in overdose in view of their potential for cardiotoxicity and arrhythmias, which could prove fatal. Hence, they are less preferred in the treatment of suicidal patients. Instead, safer alternatives, such as selective serotonin reuptake inhibitors, serotonin noradrenaline reuptake inhibitors and noradrenaline specific serotonin antagonists which are better tolerated and have excellent side effect profiles, should be considered. Antipsychotic medications should be used when psychotic symptoms are associated with depression. The new generation antipsychotic, such as olanzapine which has mild mood elevating properties and others like risperidone and quetiapine, could be preferred over the conventional antipsychotics in view of their low propensity for causing extrapyramidal side effects. Mood stabilisers such as lithium carbonate, carbamazepine and sodium valproate, are often prescribed but might prove dangerous when ingested in overdose. Sedation is important in an agitated patient and a short course of benzodiazepines such as diazepam, lorazepam, alprazolam or bromazepam, may be used. Suicidal patients should be given adequate night sedation to ensure good sleep. It is during early hours of the morning when patients who still harbour suicidal wishes are able to take advantage of reduced staffing levels to harm themselves. Hence, night staff are advised to be especially vigilant, be informed of the names of all patients placed on “suicide caution” under their care and to observe these patients closely.

ELECTROCONVULSIVE THERAPY

Electroconvulsive therapy is safe and effective in the treatment of depression, especially where suicide risk is high or when the patient refuses to eat or drink. It should also be considered when the patient is unable to tolerate the side effects of medications or when there is delayed or poor response to antidepressants.

DISCHARGE

Following discharge from hospital, outpatient appointment intervals should be kept short to avoid the danger of overdose of medications. It is suggested that not more than one week's medications should be dispensed. Paradoxically, when depressive symptoms improve, energy and drive are restored, at times even before suicidal ideation has diminished, and this could herald an increase in suicidal behaviour. Hence, it is unwise to discharge patients prematurely unless they are carefully assessed to be no longer a suicidal risk. If the patient is living alone, greater caution should be exercised when discharging home. Thus, it would be preferable if the patient returns to live with family members or friends who can provide supervision and support. Any defaulting of outpatient treatment should be brought to the attention of the attending psychiatrist who should arrange for the patient to be contacted and given another (preferably early) appointment. Similarly, patients should be given telephone numbers to call in times of crisis, and be asked to attend an earlier rescheduled outpatient appointment.

CONCLUSION

The assessment of suicide risk requires knowledge of risk factors and assessment of severity of suicidality. Suicidal patients should be closely observed and vigilance is essential during periods when staffing levels are at their lowest. Management requires a multidisciplinary team approach. Hospital staff should

acquaint themselves with the suicide prevention policies in their respective hospitals. These policies should be regularly revised and tested. New staff should be trained in these policies. Despite the best measures, suicidal patients who are really bent on ending their lives will still succeed in doing so. Notwithstanding, we should still persevere in our efforts, for in so doing, we might save many from an untimely death.

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