Responding to a Patient’s Suicide

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Disclosures

• No conflicts of interest
Suicide as a public health problem

- Suicide rates in the US are on the rise
  - 45,000 suicides in 2016
  - 25.4% increase nationwide since 1999
  - ~50% did not have a known mental health condition

Adolescents 15-19 y/o

- 2061 suicides in 2015
  - 75% male vs 25% female
  - Males: 31% increase 2007 to 2015
    - **Females: Rates doubled 2007 to 2015.**
  - Girls more likely to have utilized healthcare services in year prior (82%)
  - Girls more likely to have received a mental health diagnosis (46%)


Adolescent suicide rates 1975-2015

![Graph showing adolescent suicide rates 1975-2015](image)

High-Risk Factors for Suicide in Adolescents

Males at much higher risk than females
Among males
  Previous suicide attempts
  Age 16 or older
  Associated mood disorder
  Associated substance abuse
Among females
  Mood disorders
  Previous suicide attempts
  Immediate risk predicted by agitation and major depressive disorder

Other Risk Factors

- Family history of suicide
- Proximal psychosocial stressor/loss
- History of impulsivity
- Access to lethal means
- Lethality of past attempts/current plan
- Online research
- Suicide in peer group
- Apathy
- Family dynamics
- Trauma history
- History of being bullied
- Recent diagnosis of primary psychotic disorder/Bipolar I
- Early sobriety
- Bipolar depression
- Cultural factors
Protective Factors

- Access to care
- Frequent contact with providers
- Family/community support
- Problem solving skills
- Religious beliefs that discourage suicide
- Feelings of responsibility toward family/friends
- No substance use
- Future orientation

Child and Adolescent Psychiatry Shortage

- 1 in 5 of those under 18 y/o in the US have a diagnosable mental illness.
- ~1/4 receive treatment
- <8300 child psychiatrists in the US
- 15 million children in the US

Mental Health: A Report of the Surgeon General 1999
It could happen to you

It happened to me
15 y/o Caucasian female with a history of major depressive disorder and ADHD presents to establish care after a psychiatric hospitalization for suicidal ideation with plan (jump from bridge or use firearm). Possible sexual assault by then boyfriend 2 weeks prior to admission. Fluoxetine 20mg started while inpatient. Denies SI.

Psychiatric Hx:
- additional psychiatric hosp age 11 for SI.
- Sees an psychotherapist in the community

Medical Hx:
- Exercise-induced asthma

Social Hx:
- Lives with father and 17 t/o step sister. Parents separated age 8, mother lives on east coast with 6 y/o brother. Father is a combat veteran, retired. Pt is not sexually active currently.

Measures:
- PHQ=13

MSE:
- Mildly disheveled, irritable. Constricted to blunted affect.

PLAN
- Continue Fluoxetine 20mg
- RTC 2 weeks.
1 week: Patient is hospitalized on the PBMU for suicide attempt (hanging). Fluoxetine discontinued 2/2 headache and sertraline initiated.

“she reported consistently that she was ‘done’ with killing herself and was resigned to living, and that seemed credible to me. I find her endearing – kind of an Eeyore, with a little bit of sass.”

Follow-up

2 weeks: Denies SI. Plan made to increase sertraline to 100mg. Continue therapy twice weekly.

6 weeks: Mood improved, “kind of back to normal.” Denies SI. However, anxiety emerges as an issue. Sertraline increased to 150mg. PHQ=12

3 months: Anxiety improved, Mood Stable. Father notices positive change. Denies SI. PHQ=3.

5 months: Mood/anxiety stable. Enjoying activities with family. PHQ=2
Follow-up

• **7 months**: Stable. Some academic struggles. In a relationship, but not sexually active. Father shares that she has attempted to wean herself off sertraline. “I just don’t want to be taking pills”. Agrees to try a dose reduction to 100mg before considering discontinuing. PHQ=4

“It is with sadness to inform you, parent of patient called the crisis line to report Pt completed suicide last night. No other details were given or special requests made.”
What I did

- **Froze**
  - Looked up my last note
  - Replied to the email, made plan to call the father that afternoon
- Saw my last 2 patients
- 5:00pm: called the father
- 5:30pm: met with the department chair

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Stages

What if it happens to you?

How to respond

1) Clear your schedule
How to respond

2) Notify appropriate individuals

How to respond

3) Offer immediate support to those who have been involved in the patient’s care
How to respond

4) Form a team

Survivor Resources

American Association of Suicidology:
http://www.suicidology.org/suicide-survivors

Suicide Prevention Resource Center:

Forefront: Innovations in Suicide Prevention:
www.intheforefront.org/help/bereaved

After A Suicide:
www.personalgriefcoach.net
How to respond

5) Contact the family
How to respond

5) Address unpaid bills

How to respond – summary

• Clear your schedule
• Notify appropriate individuals
• Offer immediate support to any staff directly involved in the patient’s care
• Form a team
• Contact the family
• Address unpaid bills
What went well in my case

- Senior leadership responded quickly, offered support.
- Staff helped to assemble resources for family
- Senior leadership had resources for me, and allowed time to access them.
- My documentation was clear, complete.
- Colleagues who knew her – decreased the sense of isolation

What could have gone better

- I did not clear my schedule
- Culture discourages open discourse about adverse events
- Despite support, an isolating experience
Lingering adverse effects

- Shame and guilt
- Isolation from colleagues
- Rumination – “What did I miss?”
- Hypervigilance vs emotional distancing
- Avoidance of depressed or suicidal patients

In Summary

- Suicide rates are rising among young people
- Make a plan!
- Attend to your own wellness
Clinician resources


Jeffrey C Sung, MD. “Clinician Survivors of Suicide Loss” 2016.  
https://www.youtube.com/watch?v=qguUTy9uJ-8