Closing Treatment gaps in management of suicide behaviour: New Understanding- new hope

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Clinical Psychiatry of Suicide prevention

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Learning objectives

• To review challenges of managing and preventing suicide in clinical practice

• To identify treatment gaps

• To examine possibilities of ‘maximizing outcome’ in management of suicide behaviour
Every day in Canada, 11 people die by suicide and 211 people attempt suicide.
Patient’s with suicidal ideations re returned back.

ER
General Hospital
Mental health facilities
Canadian have No Access to mental health Care

Suicide rate has been rising Globally

Suicide rate in Canada has remained stable in last 10 years (10 to 13/100 K)
Suicide behaviour key feature of patients hospitalized

35% Attempt
35% crisis

First admission
19 >1 past admission
72
Suicidality of patients in psychiatric practice

- Hospitalization due to suicidal attempt: 39
- Hospitalization due to Sui. Crisis: 35
- Sui. Ideation in Admitted patients: 50
- Sui. Ideation in ambulatory care: 35
- Patients with Ideation Not hospitalized: 60

Patients with sui, Ideation discharged from ER: 40
Prevention is a possibility by identifying the challenges.

- Dropouts
- Returned back
- Not assessed

- Identification: 60%
- Assessment: 50%
- Intervention: 40%
- Prevention: 30%
Course of illness and its presentation across settings

Low risk

Risk ratio

Gaps

Attempted suicide

3% 49% 15% 30% 20% 20% 25%
Predicting suicidality

- Suicide ideation
- Recent attempt
- Multiple attempt

3 to 27%
Managing within the means

Response to Treatment Gaps

Strengthen existing program

Developing Newer programs: Interventions and innovations
Maximizing outcome

Skill development

Program development

Treatment development

Most important programs
Skill development

New programs
Screening and risk assessment
Interdisciplinary collaboration

Networking
Education
Communication
Observation,
Ambulatory care
Inter-personal
Skill development

Community mental health

Policy, planning and implementation

Developing preventive models
Skill development

Health service research
Early intervention
Post discharge management program
Surveillance for vulnerable candidates
Treatment development

Evidence based  Collaborative care

Treatment of suicidality,

Precipitating, perpetuating and potentiating factors

Crisis intervention and  Bed-side intervention
Most significant measures for suicide prevention

1. Hospitalization
2. Education
3. Screening
4. Continuity of medication
5. Integrated community
6. Hospital management
Most significant measures for suicide prevention

1. Low Risk and
2. Vulnerable candidates
3. Risk assessment
4. Drop outs
5. Networking
6. Models of care
7. Evidence based treatment
Program Development

1. Policy planning
2. Implementation
3. Review
4. Evaluation
5. Audit
6. Research
Strengthen existing programs

Program-based intervention → Hospitalization

Combined methods → Model of intervention
Strengthen existing programs

Medication → Mental disorders

Model of intervention → Community care
Strengthen existing programs

Identification → GP

Education → PCP

New risk factors → Economics

Screening → Ideation
Suicide behaviour

- Early onset
- Window to mental health
- Continuation from childhood-adolescence-young-and old ages
- Persists throughout illness course
- Affects short and long-term outcome of SMI
Attempted suicide across course of mental disorders
Co-exist

common feature of all minor and major mental disorder
Suicide behaviour

- Reduced functioning and social outcome
- Variability in clinical presentation
- Unpredictable
- Geo-cultural
- Patient-specific
- Treatment resistant
Identify vulnerable conditions

1. Ideation
2. First
3. Early age
4. Low risk
5. No follow-up
6. With First episode mental disorder
Parameters of successful management is undetermined

Outcome: Attempted suicide

9/10
Attempters who survive for long term

37 Years Study
13% Completed suicide
Outcome criteria for management of suicide

Education

Screening

Treatment of suicidality
Duration of illness: and suicide attempt

Duration of illness (in months) does not determine the possibility of suicide attempt or not.

$t(236)=48.247, p < .001$

$\chi^2(1) = 0.257, p = \text{n.s.}$
Suicidality at 10 Years follow up in first episode psychosis

Suicide behaviour and mental disorder

Suicide prevention as a prerequisite for recovery of SMI

Mental disorder and suicide

Co-exist

Presence of a mental disorder: 90%
No apparent mental disorder in suicide: 10%
Mental disorder in attempted suicide: 75%
At-risk; emotional disorder: 15%
No mental disorder in attempted suicide: 25%
Psychiatric comorbidity: 70%
Suicide Attempt increases when Atypical Antipsychotic Therapy is Interrupted.

Compliance

Interruption or stop treatment with Olanzapine or Risperidone

Hering RM, Erkens JA, Pharmacoepidemiol Dru 2003, 12, 423 - 424
Suicide Attempt increases when Atypical Antipsychotic Therapy is Interrupted.

Suicide rate per 1000 person years

Compliance

Interruption or stop treatment with Olanzapine or Risperidone

Hering RM, Erkens JA, Pharmacoepidemiol Dru 2003, 12, 423 - 424
Clinical conditions requiring Add-on therapy

Psychiatric comorbidity

- Any Anxiety: 51%
- PTSD: 43%
- Panic Disorder: 24%
- Social Anxiety: 36%
- OCD: 13%
- Any SUD: 47%
- Alcohol: 34%
- Drug Abuse: 28%

References:
Low risk

Factors responsible for precipitating or facilitating conversion from ideas to attempt
Small numbers convert to attempt

Ideation to attempt N=6646

Life-time prevalence

- Ideation: 8.3
- Plan: 3
- Attempt: 2.2

Prevalence and risk factors for first onset of suicidal behaviors in the Netherlands Mental Health Survey and Incidence Study-2.
Ten Have M, van Dorsselaer S, de Graaf R
Risk of suicide and suicide attempt
Risk Assessment

Evolving concept
Spectrum of severity

Assess Multidimensional risk

Protective factors
# Risk Assessment

Qualitative & quantitative risk assessment

<table>
<thead>
<tr>
<th>Modifiable: non-modifiable</th>
<th>Reason for living</th>
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<tbody>
<tr>
<td>Trait and State risk</td>
<td>Attitude towards life</td>
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<tr>
<td>Dynamic &amp; Static Risk</td>
<td>Religious believes</td>
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Suicidality is a spectrum and risk is variable and therefore it needs continuous treatment.

- **Psychopathology**: Low risk
- **Psychosocial stress**: High risk
- **Treatment**: As well as no treatment
- **No monitoring, no treatment**: High risk
- **Non-compliance**: High risk

Mental disorder may improve but suicide may not and vice-versa.
Recognized late
Referral late
Treated late

Poor outcome

Barrier to suicide prevention

Early intervention
Rates of suicide in early psychosis

- Aust.NZJ 2009
- Act.Psy.scand.2004
- BJP,2008
- BJP,2007

Prior to contact:
- 4.3
- 11.3
- 4.5
- 15
- 18.8

Attempt during treatment:
- 8.7
- 2.9
- 0.4

Death:
- 12.2
Outcome of early intervention (Melle’s Study)

N=400, 24 Months follow-up

Rate of suicidal ideation and attempt

EI program: 39
without EI program: 56

AJP 2006
Multidisciplinary Approach

US military program for suicide prevention

sustained decline in suicide and suicide related adverse outcomes.

1995: 15.8
2001: 6

6 years

suicide rate/ 100,000
High risk approach

Population approach

Risk Reduction

Public health

Clinical approach
Suicide is an independent diagnosis

Clinically Well-described
Epidemiological:
Reliability and validity
Longitudinal follow-

Strict Differential Diagnosis
Associated with Biological marker

DSM-5 Proposal
An outcome criteria for mental disorder

1. Mortality and morbidity
2. Present through course
3. Distinct psychopathology

1. Present since onset of the illness
2. An integral part of the illness
3. A diagnostic entity
Suicide prevention is everybody’s business

1 Suicide Every 40 Seconds

Preventing suicide
A global imperative