Psychiatric Emergencies: Suicide and Agitation

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Disclosures/Disclaimers/Acknowledgments

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How to use this material

- Review slides individually or as a self study group.
- For questions, go to normal view and read the notes.

Learning Objectives:

- Identify prevalence of suicide in postpartum patients
- Describe risk factors for suicide
- Learn how to assess a patient's acute suicide risk
- Identify appropriate level of care for a patient
- Learn how to manage agitation

Outline:

- Introduction
- Epidemiology: rates/incidence, risk factors and screening
- Clinical Features: clinical presentation and course/prognosis
- Assessment
- Treatment: psychopharmacology and non-pharmacology
- Key Clinical Points
- Conclusion

Introduction

- Suicide is a leading cause of death for postpartum patients
- Screening for postpartum depression may uncover suicidal ideation
- It is vital to evaluate further and determine most appropriate level of care

Roadmap to Evaluate Acute Risk

Non-Urgent

- Depression or Anxiety but no suicidal ideation/intent/plan
- Medication management
- Outpatient consultation

Urgent

(non-violent, non-deregulated with potential for decompensation)

- Low lethality suicide attempts without current plan
- Alcohol or substance abuse without delirium or altered sensorium
- Pregnant patient requesting detoxification

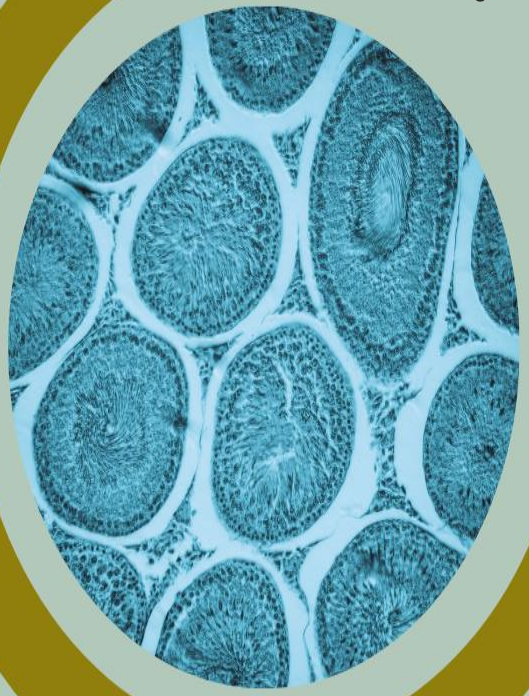
Emergent

(violent, deregulated, imminently unsafe)

- Acute suicidality – plan/intent/means, unable to contract for safety
- Acute withdrawal with alteration in mental status
- Homicidally or other aggressive behavior against others
- Agitated/Aggressive/Non-redirectable (e.g. Manic/Psychotic/Intoxicated)
- Postpartum Psychosis
- Acute alteration in mental status

(Courtesy of Neda Hudepohl, MD)

Epidemiology



- Suicide is one of the leading causes of maternal mortality
- Suicide prevalence ranges from approximately 1 to 5 per 100,000 live births
- Most common at 9-12 months postpartum
- Infanticide is approximately 2 to 7 per 100,000 live births
- Prior to suicide, many patients (45%) have contact with a primary care provider

Perinatal suicide risk factors

- Postpartum psychosis
- Major mental illness, especially bipolar disorder
- Intent or plan
- Access to lethal means
- Personal history of suicide attempts
- Family history of completed suicide
- Intimate partner violence
- Stillbirth
- Poor sleep
- Self-neglect
- Lack of interest in child

Screening

- Edinburgh Postnatal Depression Score
  - (Question 10: “The thought of harming myself has occurred to me”)
- PHQ-9
  - (Question 9: “Thoughts you would be better off dead or of hurting yourself in some way”)
- Mood Disorder Questionnaire - screen for bipolar disorder
- Columbia Suicide Severity Rating Scale
- Screen for suicide at every visit in first year postpartum – while many women come only for their 6-week visit, others may present for routine gyn or primary care visits later in that year and should be screened

Case Presentation:

- Lucy B. is a 24-year-old woman who presents to her OB for her 2 week postpartum visit
- She breaks down and starts crying, noting that she is feeling down and unable to laugh and enjoy herself as much as she used to.
- You screen her for depression; her total score on the EPDS is just 11, but she answers “yes quite often” regarding thoughts of harming herself.

Next steps….

Ask follow-up questions to assess her acute risk

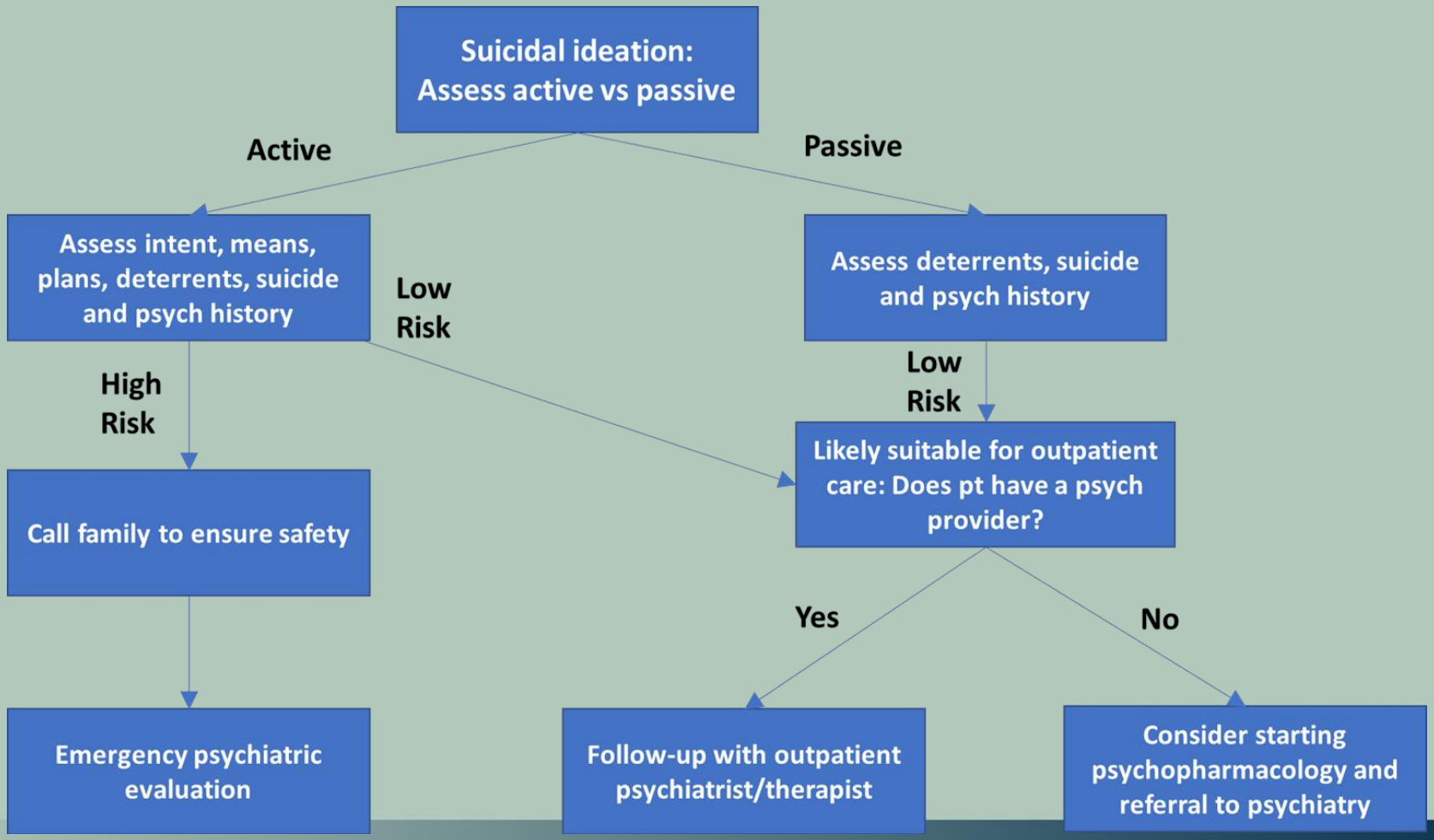
Suicide Risk Assessment

- Clarify question 10 on Edinburgh, clarify timing of suicidal thoughts (current vs past)
- Identify active (I want to overdose on pills) vs. passive (I would like to go to sleep and never wake up)
- Identify plan: Do you have thoughts of a specific plan, timing, place or method?
- Identify means: Do you have access to guns, pills, etc.?
- Identify intent: Do you plan to follow through with this? What reasons do you have to be alive? How close have you come to following through on your plan?
- Identify history: Have you tried to commit suicide in the past? Have your family members committed suicide in the past?
- Identify deterrents: Are you religious? What are reasons to be alive?

Suicide Risk Assessment

- Passive suicidal ideation -> assess time course, acute vs. chronic, is patient engaged with mental health provider? Consider follow-up with mental health provider or further increased follow-up if not engaged in treatment
- Active suicidal ideation -> will require further psychiatric evaluation, send to ER, potentially will need psychiatric hospitalization
- If unsure -> obtain further collateral from family, err on the side of obtaining a psychiatric evaluation
- Rules surrounding Involuntary evaluation vary by state, but usually appropriate if patient is at imminent risk of self-harm/suicide

Suicide Risk Assessment



Assessment

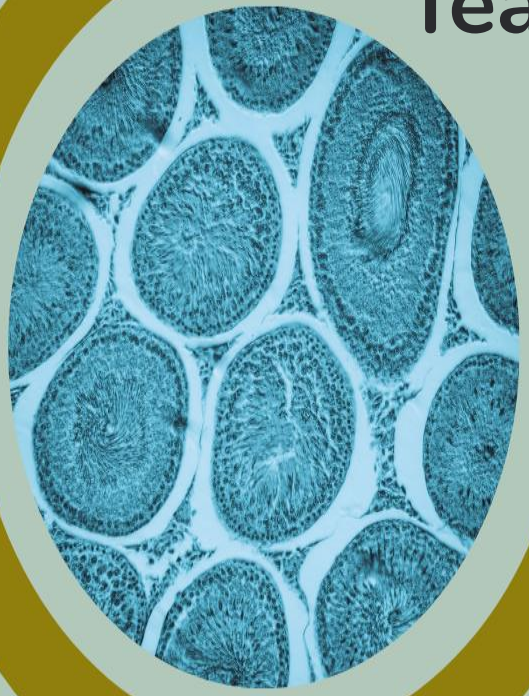
- Screen for signs and symptoms of mania and psychosis
  - How are you sleeping? Do you feel like you need less sleep these days?
  - Are your thoughts racing?
  - Are you talking faster than normal?
  - Are you hearing or seeing things?
  - Are you worried people are after you or out to get you?
  - Are you having thoughts of hurting your baby?
- Speak with family to assess for changes in behavior

Assessment: Clinical features of mania

- Elevated or irritable mood
- Increased self esteem or grandiosity
- Decreased need for sleep
- Rapid speech
- Racing thoughts or flight of ideas
- Distractible
- Increased goal directed activity (such as cleaning, cooking)
- Increased dangerous behavior (spending lots of money, using substances, high-risk sexual behaviors)

Mania	Hypomania
lasts 1 week or more	lasts at least 4 days
psychosis	no psychosis
impairs functioning or requires hospitalization	doesn't impair functioning

Assessment: Clinical features of psychosis



- Psychosis:
  - delusions (fixed false beliefs)
  - paranoia
  - hallucinations (hearing or seeing things that are not there)
  - disorganized thoughts or behavior
- Mood symptoms with psychosis:
  - mania with psychotic features
  - depression with psychotic features
- Postpartum psychosis:
  - delirium-like presentation
  - insomnia
  - delusions regarding the baby

Assessment: Emergency evaluation protocol

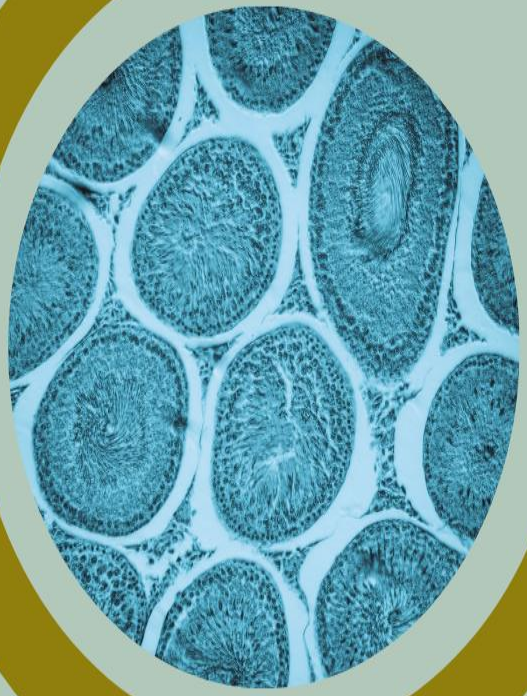
1. Identify working diagnosis: suicidal or homicidal ideation, psychosis, mania, delirium
2. Trigger emergency psych evaluation, including transportation
    - Consider state-specific regulations regarding involuntary emergency psych evaluation; your team should know what these regulations are
3. Collaborate with psychiatric team and family and identify roles within the perinatal and psychiatric team in relation to treatment and follow-up care
4. Identify resources, support staff, and treatment needed at each step

This protocol should be in place PRIOR to an emergency!

Treatment

- Depending on severity of suicidal ideation, including plan, intent, means, may require psychiatric hospitalization
- Medication management for underlying mood disorder
  - Depression - SSRI
    - Screen for bipolar disorder
  - Bipolar disorder - mood stabilizer or antipsychotic
  - Schizophrenia/schizoaffective disorder - antipsychotic
- Psychotherapy
- ECT

Case continued:



- Upon further questioning, Lucy B. endorses active suicidal ideation as well as
  - decreased need for sleep
  - delusions
  - thoughts of harming her baby
- She becomes increasingly agitated about waiting for further evaluation and starts banging on the door to leave
- She is yelling and becomes physically aggressive towards staff

Identifying agitation

- Agitation - increased arousal, uncooperative or combative behavior, physical restlessness, increased verbal and motor activity, and extreme irritability
  - Can range from mild to severe
  - Various etiologies
    - Psychiatric illness
    - Medical illness
    - Withdrawal or intoxication
    - Delirium
- Aggression - behaviors that have the potential to harm another person, regardless of intent or whether harm actually occurs

Identifying bias in agitation management

- Utilize a trauma informed care framework when managing patients with agitation
- Racial bias may increase perceived dangerousness in patients with psychiatric comorbidities
- Stressful situations (such as an agitated patient) may exacerbate implicit bias
- Identify potential biases when assessing for dangerousness
- Attempt verbal de-escalation for all patients

Handling Agitation

Verbal de-escalation

Consider need for medication according to patient's symptoms, as you would with any other patient

Suit the medication to the symptoms – why is the patient agitated?

High-potency typical antipsychotics have extensive safety data and work quickly

Good safety data now on second-generation as well

Remember that HIGHER doses may be needed in pregnancy

- When possible, minimize exposures to the fetus – but remember that frank psychosis and agitation are ALSO an exposure

Physical restraints

- Avoid when possible
- If restraints are necessary-
  - NEVER use 4-point restraints when a pregnant patient is on their back or right side
- Inferior vena cava syndrome
  - Turn body part way to left
  - Frequent monitoring

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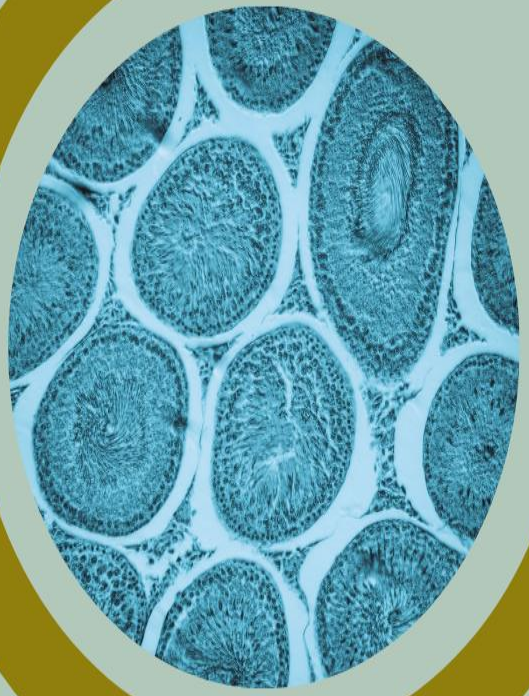
Key Clinical Points



- Identify risk factors for suicide
- Screen patients for depression and suicide to appropriately triage level of care
- Rule out psychosis and mania
- Manage agitation with psychiatric medications if indicated
- Use restraints safely when necessary

Reflection questions

- Has a patient reported suicidal ideation to you in the clinic? If so, how did you screen them further and manage this in the outpatient setting?
- Does your clinic have an emergency referral protocol in the case of an agitated or suicidal patient?
- Describe a scenario where you needed to de-escalate an agitated patient. What worked well in that scenario and what could have gone better?

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Resources

Postpartum Support International

MGH Women's Mental Health Center:
www.womensmentalhealth.org

LactMed

Mothertobaby.org

National Suicide Prevention Hotline: 1-800-273-8255
www.suicidepreventionlifeline.org