Psychiatric Disorders and Suicidality in the Intensive Care Unit

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KEYWORDS

• Psychiatric disorders • Suicidality • Intensive care unit • Self-injury

KEY POINTS

- Suicidality assessments in those admitted to the intensive care unit, as in all other settings, consists of a comprehensive evaluation of the patient's clinical status, risk/protective factors, psychiatric history, and current degree of suicidality.
- The goal of identifying any primary psychiatric disorders is to enable appropriate treatment to be initiated and to ensure a safe environment until the patient can be transferred to an inpatient psychiatric unit.
- There are multiple challenges specific to an intensive care population.
- These challenges include the high risk of comorbid delirium, limitations in communication (ie, intubation, fatigue related to medical illness, sedative medications), and psychotropic medication issues (drug-drug interactions, limited routes of administration, reduction/elimination of deliriogenic medications, potential for medication withdrawal syndromes).

INTRODUCTION

Suicidality is a general term that describes the continuum of suicidal ideation, intent, self-injurious behavior, attempts, and completed suicide.[1] Suicidality across the entire spectrum is a public health concern with significant impact. Suicide was the tenth leading cause of death for all age groups[2] and the rate has increased since 2006.[2] Men complete suicide at 4 times the rate of women, and often use more violent, lethal means, with firearms being the most common method.[2] Women most commonly use poisoning as the method for suicide.[2] According to the Centers for Disease Control and Prevention (CDC), 9.3 million adults reported having suicidal thoughts in the past year.[2] The highest rate of suicidal ideation was found in adults aged 18 to 25 years (7.4%), then adults aged 26 to 49 years (4.0%), and adults aged more than 50 years (2.7%).

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The national economic costs of both fatal and nonfatal suicide-related injuries in 2013 were estimated to be about $58.4 billion in medical and work loss.[2,3] One retrospective study estimated that 412,000 emergency department (ED) visits were attributed to attempted suicide and self-inflicted injuries, or 0.4% of total ED visits.[4] Approximately 31% of patients who presented to ED required an intensive care unit (ICU) admission.[4] The most common methods of self-injury were poisoning in 66.5%, cutting at 22.1%, and both hanging and firearms were rare at less than 1%.[5] Intentional poisoning requiring ICU admission should be considered a serious suicide attempt and the most commonly used drugs include tranquilizers, psychotropics, analgesics, antipyretics, antirheumatics, and unspecified substances.[4]

Patients admitted after a suicide attempt require numerous precautions to be instituted to ensure a safe environment. However, the ICU has a limited ability to make drastic adjustments to its environment because many items that can be used as means of self-harm are necessary for day-to-day workings. This article reviews the prevalence of suicide attempts in different psychiatric diagnoses, conducting a suicide assessment, the role of involuntary psychiatric holds, and the most common challenges encountered in the ICU setting.

Psychiatric Disorders

According to the World Health Organization, approximately 98% of people who have completed suicide had a diagnosable mental illness.[6] The risk for suicide varies for each psychiatric diagnosis and risk often increases with additional comorbidities.

Mood Disorders

Mood disorders include unipolar depression and both bipolar I and II disorders in all mood states (depressive, manic, mixed). Presence of a mood disorders increases risk for suicide significantly, and is the most frequently identified psychiatric diagnosis (20%–35%) of people who completed suicide[6] and in those who presented to ED with self-harm at 58.5%.[7] **Table 1** provides additional details regarding suicidality in mood disorders.

Psychotic/Thought Disorders

Psychotic spectrum disorders include schizophrenia, schizoaffective disorders, brief psychotic disorder, and unspecified psychotic disorders. Most studies group disorders that are not schizophrenia into another category of schizophrenia-like disorders. Schizophrenia carries an approximately 5.6% lifetime risk of suicide.[8] The highest risk of suicide occurs in the early course of the illness and is often a focus of suicide prevention strategies for this population.[8] One study assessing the risk of suicide after first hospitalization found the absolute risk in schizophrenia to be 5.85% to 7.34% for men and 4.03% to 5.98% for women, as well as 5.21% to 6.67% for men and 3.28% to 5.04% for women with schizophrenia-like illnesses.[9] See **Table 1** for additional details regarding suicidality in psychotic disorders.

Substance Use Disorders

Substance use disorders can span the range of illicit drug use, nicotine, prescription drugs, and alcohol use disorders. In 2010, 33.4% of patients who completed suicide had alcohol in their systems.[2] The comorbid presence of an alcohol use disorder increases risk almost 10 times compared with the general population.[10,11] People who inject drugs are approximately 14 times more likely to commit suicide.[10] Up to 40% of patients with substance use disorder seeking treatment report a positive history of prior suicide attempts and often enter treatment with increased risk for suicide