

Intensive suicide prevention: Provide Intensive Contact and Start 2 antidepressants

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'No other branch of medicine would tell a patient with a life-threatening illness to come back in a week'. This is a quote from Patient A, a doctor who recovered and returned to practice after 15 years of suicidal depression, reflecting on her treatment by multiple colleagues. It prompts the question – could daily contact with suicidal patients significantly reduce the main cause of death and injury to Australians in their prime of life? This paper

discusses intensive crisis intervention in acute life-threatening situations, designed to keep moribund patients alive, while simultaneous aggressive psychopharmacology is used to combat the underlying illness. Analogous to the use of two antibiotics or two anti-asthma medications simultaneously in life-threatening physical illnesses, why not begin with two antidepressants from the start of treatment in high-risk suicidal patients?

Suicide statistics

Outpatient management of the suicidal patient, especially over a prolonged period of time, is perhaps the most important and challenging role of the modern-day psychiatrist. The prevalence of suicidal ideas in the Australian population at any point in time is about 2% of the population; a staggering 3% of Australians have attempted suicide, and 13% have contemplated suicide in their

Case histories.

'If you had not called me when I was on the bridge that night ...' said Patient B, a young medical specialist. It was 1:00 a.m. on Easter Sunday morning this year when one of the authors (D.H.) found a suicide email (to be read next day presumably) from this young doctor he had been asked to treat. She had been suffering depression for about 15 years and made several determined suicide attempts during this time. She had been given all the appropriate care from the two psychiatrists and the psychologist diligently treating her. What turned the clinical scenario from suicide off a freeway bridge (with notes of apology and explanation to various people left behind) into scores of 0–2 out of 10 on self-ratings of suicidality, anxiety and depression 2 months later was not only just rapidly changing combinations of drugs but also the therapeutic emphasis that 'You Are Not Alone', the theme of www.youthsuicide.com. Implementing this strategy, D.H. initiated text and/or telephone video contact twice a day, 7 days a week, because financial factors prevented the patient travelling interstate to a standard consultation.

Mental health professionals are aware of the pivotal factors driving suicide, particularly hopelessness, access to means (including information on how to suicide) and a sense of being a burden on other people, or even alienating other people, exacerbated by insomnia. This patient, who happened to be a doctor, emphasised that another significant risk factor was the depressive belief, 'You are not worth it'. Insistence on twice daily contact, 7 days a week, demonstrably challenged this belief and diminished this lethal component of her suicidal drive.

Patients C and D are young women, each with a history of multiple admissions and suicide attempts being managed by multiple psychiatrists. Indeed, patient D had seen 30 psychiatrists and had a 6-month admission before being referred to D.H. Patient E has a history of years of severe depression and suicidal ideas, unresponsive to a vast range of treatments by multiple psychiatrists. She is adamant she resists suicide only because of the daily contact with her psychiatrist. Patient F is a psychiatrist who used to be bedridden due to depression for 3 months a year. The recovered patients went back to normal lives after some months of daily therapy, together with combinations of antidepressants and supplements.

Patients receiving daily therapy by video call or in person are better equipped to refute depressive beliefs as they perceive and recognise the effort and concern of the mental health therapist(s) treating them. If such calls need to be made out of normal business hours, or late at night in distress, and also with calls being made at weekends and on holidays, this demonstrable care sends a powerful message to patients that they are indeed 'worth it'.

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life. Many professionals do not know that suicide is the commonest killer of Australians at any age between 15 and 44. Whether due to lack of access to hospital beds or due to patient insistence, hospitalisation of all suicidal patients is not feasible, not even in a First World country such as Australia.

Intensive intervention

Evidence-based medicine offers best medical practice, but we need alternatives when such models of care have failed to produce the necessary outcome and survival. We report a small number of examples who have had the best of care, but still remained at risk of death, but who have responded to frequent/daily visits combining intense personal support with trials of pharmacology. Ideally, this is what patients receive as inpatients. However, in reality, at times, inpatient care fails to produce these ideal outcomes. This is distressing to patients and families in many cases and is very expensive to the taxpayer. Inpatient care for months is not feasible for any of the parties involved. One of the highest risk periods for completed suicide is in the first few days after discharge from a psychiatric unit. Yet, how many patients are called on the day of discharge, to ensure the 'life-saving therapeutic relationship' remains in play?

On the other side of the equation, providing intensive therapeutic contact is not for everyone. Mental health care, especially of the suicidal, is highly stressful. A number of psychiatrists leave private psychiatry each year in favour of the mutual support of mental health teams in the public sector, avoiding being responsible 24 hours a day. Many psychiatrists are traumatised by the dangers and demands involved in dealing with highly suicidal patients and by the occurrence of completed suicides due to 'malignant sadness', while understanding the inevitable rate of fatalities associated with physical malignancies unresponsive

to best therapies. No professional can be available 24 hours a day, but suicide is not restricted to office hours, representing about 20% of the week. Predicting suicide is like predicting the weather; we can be more accurate a day or two in advance than a week in advance (Horgan, 1996).

Overt support

Supplementing daily consultations by requesting a text update during another part of the day, every day, reinforces the life-saving therapeutic bond of joint effort and presumably puts another hurdle between thoughts of suicide and acting on such thoughts. Paradoxically, one of the risks in providing such intensive therapy to a suicidal patient, particularly as a secondary or tertiary referral, is that the pre-existing therapeutic team will back off, feeling redundant or not wanting to complicate treatment. This provokes feelings of abandonment in the patient, often accompanied by a fear the therapist providing intensive care is also going to abandon them once treatment has been successful.

Extra contact and overt caring at times of suffering and crisis are particularly appreciated by patients and families. In return, just as soldiers fight battles to a large extent because of loyalty, many patients report fighting off suicidal and self-harm ideas, spurred on by the knowledge they are intensely cared for by their doctor and are not alone. The classical highly controlled relationships of advanced psychotherapy need to be altered in the case of moribund patients, whose illness tells them they are simply another anonymous case for an overburdened doctor. Doctor and patient negotiate a temporarily closer relationship in the face of danger, ranging from humour to self-disclosure, emphasising the protectiveness of a human bond rather than a perceived dispassionately calculating professional. It is useful to monitor the

closeness of the relationship as assessed by the patient. Decisive intrusive actions and reassurances are essential skills of experienced doctors in the middle of a critical operation.

As with any very ill patient, dependency of some degree is inevitable. In depression, this usually subsides once the illness and associated risk have been controlled. Downward titration of contact is inevitable and necessary, due either to patient improvement, or due to non-improvement despite a trial of this modality of treatment. Personality disordered patients craving emotional input present a double bind, being more prone to inappropriate attachment, but simultaneously having increased rates of depression, self-harm and suicide. This type of therapy, varying so much from the distant therapist traditional model, requires therefore that all parties understand that calls and texts are noted appropriately in the patient records, similar to any other treatment modality. Non-suicidal self-harm complicates patient selection for intensive suicide prevention, a very time-limited and stress-limited resource from any psychiatrist, especially when dealing with multiple such patients simultaneously, each of whom requires a different bond.

Dual acting psychotropics

In life-threatening general medical situations, the simultaneous use of two relevant medications is not controversial. Why do we not routinely begin treatment immediately with two antidepressants in life-threatening severe depression? We cannot predict which single antidepressant will work, with the delay endangering life, so presumably, the use of two antidepressants increases the statistical chances of response and survival. In a double-blind randomised study of 105 patients, Blier et al. (2010) 'suggest that use of antidepressant combinations from treatment initiation may double the likelihood of remission compared with use of a single medication'.

The number of patients severely affected by serotonin syndrome is extremely low, possibly described as negligible relative to our escalating and now 60 completed suicides (and our estimated 2000 plus attempted suicides) a week. Given the research that those with a failed suicide attempt are at 100 times the risk of completed suicide subsequently, especially in the 12 months following a suicide attempt, should these patients, in particular, not be given double the protection biochemically?

In a survey conducted over 10 years ago (Horgan et al., 2007), 79% of Australian consultant psychiatrists had already trialled a combination of antidepressants. Combining agomelatine or mirtazapine with selective serotonin reuptake inhibitors (SSRIs) or serotonin–norepinephrine reuptake inhibitors (SNRIs) is considered to be safe practice without significant risk. The combination of venlafaxine with mirtazapine, so-called ‘California rocket fuel’, was used in the US government–approved STAR*D trial, and worldwide since. Agomelatine, for example, can be safely combined with nearly all psychotropics (although use with fluvoxamine is not recommended). Mirtazapine is described in the literature as a supplement to other antidepressants, reflecting its safety. Bupropion has been combined with SSRIs and SNRIs for decades overseas, including in the STAR*D trial. However, it should not be combined with vortioxetine. Reboxetine can also be safely combined with SSRIs (Horgan, 2011). A number of SSRIs do not inhibit the metabolism of tricyclic antidepressants, but most psychiatrists would be hesitant to provide powerful but cardiotoxic medication to suicidal patients. Of course, adding to antidepressants

atypical antipsychotics, lithium and other supplements that are currently being trialled is useful at times (Malhi et al., 2015). Side-effects from combination antidepressants generally are no more than the side-effects of the individual drugs.

As part of symptom control and crisis management, sedative antipsychotics and benzodiazepines may have an important role as emotional analgesics in the suicidal, ranging from alleviating dangerous insomnia and anxiety to providing ‘non-fatal oblivion’ when suicidal ideas threaten to become irresistible.

Cost considerations

Wide application of the above techniques by psychiatrists and by general practitioners (GPs) is likely to save the healthcare system significant amounts of money in hospitalisation costs and reduce the economic costs of suicide and attempted suicide. Such savings may allow funding to reimburse this model of healthcare for identified high-risk patients over a specified period of time. Currently, phone contact is not reimbursable, nor is telepsychiatry in large cities. As nearly all psychiatric illnesses are fuelled by stress, this model provides wide opportunities for researchers, as we struggle to minimise morbidity and mortality, and the burden on taxpayers. The patients described here, like many of their contemporaries, are contributing to our society, and this approach has saved our economy probably millions of dollars in medical care, ongoing hospitalisation and suicide costs.

Conclusion

Psychiatrists trying to stem the commonest cause of death and injury in

Australians under 45 years of age can operate with the skill levels of our intensive care unit (ICU) colleagues. We can all adroitly combine multimodal medications, cognitive behavioural therapy (CBT) and the psychotherapies. Since our dying patients are conscious, should we not call or text them frequently as part of our unique form of intensive care?

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