SUI

Risk factors cannot predict suicide, but evaluating risk helps you determine the next appropriate action

CIDE INTERVENTION

How to recognize risk, focus on patient safety

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More than 50% of psychiatrists have experienced the death of a patient by suicide.[1] For many of us, suicide represents the most feared outcome of a patient's mental illness and makes managing suicide risk critical to everyday practice.

Unfortunately, we have little ability to predict suicide. Research into risk factors and the use of suicide rating scales have produced no consistently definitive methods to determine who will and who will not attempt or complete suicide.[2] The purpose of suicide assessment, then, is not to predict suicide but to help us understand the sources of a patient's suicidality and develop an informed intervention.

This article describes a practical, commonly accepted approach to suicide risk assessment and intervention, based on the B-SAFE model (Basic Suicide Assessment Five-step Evaluation) proposed by Jacobs et al (***Figure, page 32***).[3] Using this method to assess suicide risk can help you answer questions such as:

- Which factors are most important to consider when evaluating suicide risk in my patient?
- What questions should I ask my patient to find out if he or she is suicidal?
- How do I know if a patient is at risk for suicide?
- What emergent interventions are called for when managing the acutely suicidal patient?
- How should I document a suicide risk assessment?

continued

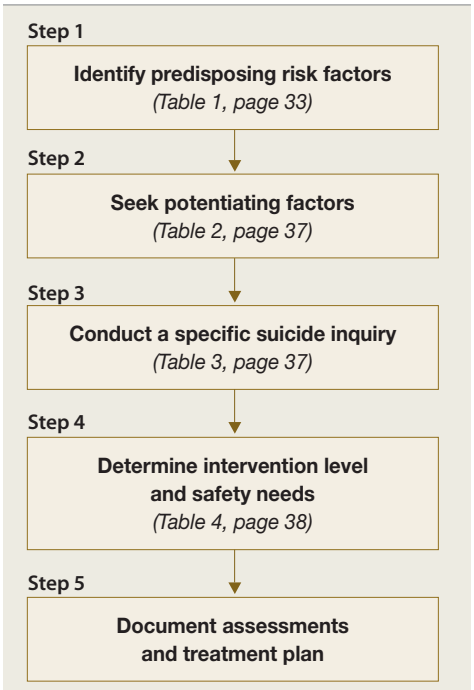
Suicide intervention

Clinical Point

Talking to patients may help you understand their suffering, perhaps the most important clue to heightened suicide risk

Figure

Basic Suicide Assessment Five-step Evaluation (B-SAFE)



Source: Created from information in references 2,11

Why ask about suicide?

No single risk factor or combination of risk factors can predict or preclude suicide. Even so, attempting to evaluate an individual's risk by asking about suicidal thinking, reviewing risk factors, or using clinical rating scales helps you determine the next appropriate action (discharge, medication, psychiatric referral, consultation, or hospitalization).

While talking to patients and evaluating their risk for suicide, you may begin to understand their suffering—described as the most common denominator in suicide[2] and perhaps the most important clue to heightened suicide risk. Such an exploration allows you to identify potential:

- risk factors that can be modified
- preventative factors to promote.

Don't be afraid to ask. Asking about suicidal thoughts is necessary—but not enough—to understand an individual's potential for suicide. Never be afraid to ask patients about suicide, believing that doing so will "put ideas into their heads." By the same token, a patient who denies thoughts or plans for suicide may still be at risk.

Identifying at-risk patients is much more difficult than just asking if they are considering suicide. Opening a concerned dialogue can provide a sense of relief to the patient while allowing you to explore:

- the extent and seriousness of the suicidal thoughts
- associated risk factors or conditions, such as depression.

Stepwise risk assessment

The first 3 steps of Jacobs' B-SAFE model focus on identifying predisposing and protective factors for suicide.[3] For an in-depth discussion, consult the American Psychiatric Association practice guideline for the assessment and treatment of patients with suicidal behaviors.[4]

STEP 1 **Risk factors.** Use the patient interview, medical records, and collateral information to uncover potential suicide risk factors (***Table 1***).[2]

Psychopathology. Focus on depression, bipolar disorder, schizophrenia, substance abuse, and personality disorders, which are strongly associated with suicide. These disorders are considered modifiable risk factors—diagnosis and appropriate treatment can diminish suicide risk.

Suicidality has been associated with early depression or bipolar disorder, often before patients receive a diagnosis or effective treatment. Recovery and immediate post-discharge periods also are thought to be times of heightened suicide risk.

Psychosocial variables. Demographic and psychosocial variables may influence suicide risk estimation. A retrospective study of 100 patients who attempted suicide suggests that the most predictive factors for suicide are:

- living alone
- being aged 17 to 35 (although in other studies, more advanced age also has been linked to increased suicide risk[3])
- complaints of severe hopelessness, anhedonia, and insomnia.[5]

Physical illness may potentiate suicide risk. Medical illnesses that produce great

Table 1

Factors associated with potential for increased suicide risk

Variable	Risk factors
Demographic	Male gender, Caucasian race, rural residence, possibly age (varies among studies)
	Imprisoned; widowed, divorced, or separated; living alone; no children or no children living in the home
Psychosocial	Lack or loss of social supports, recent loss of employment, decrease in socioeconomic status or poverty, hopelessness
	History of victimization (physical or sexual abuse), psychological turmoil, severe relationship conflict, aggressive or impulsive traits
	Writing suicide notes; family history of suicide, previous attempts, 'imitation' suicide, gun ownership
	Occupational risk (physicians, dentists, nurses, pharmacists, veterinarians, farmers)
Psychiatric	Psychiatric diagnosis of recent onset
	Mood disorder, particularly major depression and bipolar disorder
	Schizophrenia; alcohol or other substance abuse or addiction; personality disorder; panic attacks or severe psychic anxiety
	Insomnia; poor concentration or confusion; anhedonia
Medical	Huntington's disease, stroke, multiple sclerosis, head injury, spinal cord injury, systemic lupus erythematosus, AIDS
	Epilepsy, pain, malignant neoplasms, peptic ulcer disease, renal disease

Source: Adapted with permission from reference 3

pain, disfigurement, limited function, or fear of dependence may reduce a person's will to live and increase suicide risk.[6] Epilepsy has been associated with a 4- to 5-fold increase in suicide risk[7] and is the only medical diagnosis to carry a documented increase in suicide among children and adolescents.[8] Often these medical disorders coexist with psychiatric disorders, complicating the task of determining independent risk.

Severity of attempts or self-mutilation. When evaluating self-injurious or suicidal behavior in the emergency setting, consider the severity of the attempt as part of overall suicide assessment. Self-injurious behavior (cutting or burning) or impulsive suicide attempts (planned for <3 hours, committed in the presence others, or where discovery is very probable) appear to carry less severity or intent to die than do carefully planned and/or hidden suicide attempts.[9] However, consider at high risk for suicide any patient with self-mutilating or suicidal behavior who expresses persistent intent to die; acute stabilization on an inpatient unit may be necessary.

STEP 2 'Protective' factors. Discover and discuss internal and external factors that might help prevent the individual with suicidal thoughts from converting those thoughts into action (*Table 2 page 37*).[2] When discussing these potentially protective effects, emphasize the patient's:

- resilience during past personal crises
- family responsibilities
- religious or spiritual beliefs.

'No-harm contracts.' Suicide (or "no-harm") contracts with patients might help open communication about factors that promote or mitigate suicide risk. Such contacts do not prevent suicide or lessen medicolegal risk in the event of a patient suicide, however.[10]

STEP 3 Suicide plans. Ask about suicide thoughts, plans, and behaviors (*Table 3, page 37*).[11] Probe gently to allow the individual to discuss his or her feelings and to explore the next appropriate avenue of care.

In my experience, patients who reveal passive suicidal ideation (such as, "I sometimes wish I would just die in my sleep") and strong deterrents to acting on thoughts

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Clinical Point

Consider at high risk any patient with self-mutilating or suicidal behavior who expresses persistent intent to die

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of suicide (such as, "My children need me," or "It's against my religion") should continue outpatient treatment. Those without deterrents or who discuss active and imminent thoughts and recent actions—writing suicide notes, buying a weapon, stockpiling pills—require emergent evaluation for psychiatric admission. Ask about thoughts of self-injury or mutilation (such as cutting or burning), as well as homicidal ideation.

Recognizing that patients with suicidal thoughts are almost always ambivalent about suicide to some extent—conflicted by simultaneous desires to live and to die—gives you the opportunity to intervene by allying with the part of the patient that wants to live. Creating a therapeutic connection also will help you determine the level of intervention required.

STEP 4 Intervention. Understanding why a patient feels suicidal—gathered in Steps 1 to 3—can help you choose the appropriate intervention. Among the 5 steps, Step 4 relies most heavily on clinical judgment:

- Is the suicidality acute or chronic?
- How great is the risk for suicide?
- To keep the patient safe, how urgent is the required intervention?

Acute risk. Suicidality related to Axis I psychiatric disorders tends to be acute, with prominent pain, anguish, and a desire to escape. Patients may describe a driven quality to the suicidality, which commands a treatment plan that maintains patient safety until suicidal feelings remit.

Hospitalization is often needed, plus focused treatments such as medication, psychotherapy, or electroconvulsive therapy. Intensive outpatient follow-up or partial hospitalization programs might be considered for patients:

- with whom you have a strong therapeutic alliance
- who have sturdy psychosocial support
- whose precipitating factors for suicidality have resolved.

Chronic risk. Suicide risk tends to be more chronic and has an impulsive quality for patients with suicidality related to personality disorders and environmental factors. Personality disordered patients may report feelings of anger, rage, or vengeance connected with their suicidal thoughts.

Hospitalization might become necessary, although multiple hospitalizations can be counter-therapeutic. Attempting in therapy to teach the patient to cope with

Table 2

Potentially protective factors against suicide

Internal
Successful past responses to stress
Positive coping skills
Spirituality
Capacity for reality testing
Frustration tolerance/optimism
Overall individual resiliency
External
Children or pets in the home
Religious prohibition or beliefs
Positive therapeutic relationships
Sense of responsibility to family
Social supports and connections
Financial incentives or deterrents

Source: Adapted from reference 11

Table 3

Evaluating suicide risk: Questions to ask patients

Have you felt so sad or depressed that you thought life is not worth living?
Have you thought about hurting yourself or taking your own life?
Have you thought about a way or plan to kill yourself?
Do you have the means to complete the plan? (such as, do you have access to weapons or pills?)
Have you practiced or rehearsed this plan to end your own life?
Do you have a location picked out?
What has stopped you from following through with the plan?
Have you ever attempted suicide?
Has anyone in your family ever attempted or committed suicide?

Source: Adapted with permission from reference 3

Clinical Point

Suicidality related to Axis I disorders tends to be acute, with a driven quality; patients often feel pain, anguish, and a desire to escape

Suicide intervention

Clinical Point

Patients with personality disorders may report feelings of anger, rage, or vengeance connected with their suicidal thoughts

Box

Sample: How to document a suicide risk assessment

This 46-year-old, recently divorced man is experiencing his second episode of major depression associated with clear-cut panic attacks and suspected psychotic features. Although he denies current suicidal ideation, the treatment team believes he is at moderate to high risk for suicide because of known past history of serious suicide attempt with first depression, the presence of panic/anxiety, and possibly psychotic features. Additional risk is posed by loss of marital support and his inability to verbalize meaningful protective factors.

The plan is to convert from observation status on the inpatient unit to full admission, as the suicide risk precludes discharge at present. Further medication management and consideration for electroconvulsive therapy will take place, with daily reassessments. Suicide precautions ordered.

Table 4

Safety measures to protect the suicidal patient

Hospitalize—voluntarily or involuntarily—on a locked psychiatric unit
Provide constant 1-to-1 observation by staff
Transport the patient, accompanied by adequate personnel
Use physical restraints or seclusion while maintaining continuous observation
Employ metal detector to remove dangerous, hidden objects
Remove and secure patient's belongings (bags, coats, purses may contain pills or weapons)
Search visitors' belongings before allowing access to unit
Ensure that inpatient unit meets all coded safety regulations

suicidal thoughts and feelings might be a more effective intervention.

Malingering. Use your best judgment when patients make suicide threats that could represent malingering to achieve hospitalization.

STEP 5 **Documentation.** Document your assessment of the suicidal patient and decision making to:

- clarify the treatment plan
- communicate to other caregivers
- manage medicolegal risk.

Include a brief summary (***Box***) that is timely, legible, and communicates the estimated degree of risk, known data, diagnosis, and planned interventions such as medications, tests, consultations, and follow-up reassessments.

Interventions for suicidal patients

Physical protection. Take decisive action when you determine that suicide risk is elevated and imminent. Pursue urgent psychiatric hospitalization, with or without patient consent, in accordance with local probate and involuntary commitment statutes.

The logistics of protective action can be challenging; transportation is often required, and the patient is not always cooperative with admission. ***Table 4*** lists measures and precautions that can help keep the suicidal patient safe.

Disease-specific interventions. Because suicidal ideation is often symptomatic of a primary psychiatric disorder, rapidly identifying major depression, bipolar disorder, or a psychotic illness is crucial to reducing suicidal thoughts and behaviors. Prescribe appropriate antidepressants, mood stabilizers, and antipsychotics at adequate doses and for sufficient duration.

Be vigilant for distressing symptoms that may be elevating the patient's suicide risk, such as anxiety, panic, agitation, insomnia, or pain. Pharmacotherapies—such as anxiolytics, sedative-hypnotics, antipsychotics, or analgesics—may rapidly reduce suffering.

Impulsivity associated with substance use disorders—particularly during intoxication and withdrawal syndromes—requires aggressive attempts by the treatment team to engage the patient in detoxification and rehabilitation.

Direct antisuicide therapy. Clozapine carries an FDA-approved indication for preventing suicide in patients with

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Related Resources

- National Suicide Prevention Lifeline, sponsored by the Substance Abuse & Mental Health Services Administration: 1-800-SUICIDE or 1-800-273-TALK (8255); www.suicidepreventionlifeline.org.
- American Foundation for Suicide Prevention (AFSP) 1-888-333-AFSP; www.afsp.org.
- Simon RI, Hales RE. *Textbook of suicide assessment and management.* Washington, DC: American Psychiatric Publishing; 2006.

Drug Brand Names

Clozapine • Clozaril
Lithium • Eskalith, Lithobid, others

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schizophrenia or schizoaffective disorder. The mechanism by which clozapine helps prevent suicide is not known, but its antisuicidal effects appear to be independent of its antipsychotic effects.[12]

Lithium has been reported to reduce risk of suicide and suicide attempts in patients with bipolar disorder, perhaps by as much as 80%.[13] Such benefit has not been observed with other mood stabilizers, suggesting that lithium confers protective effects against suicide beyond its mood-stabilizing effects. Suicide risk is known to increase after lithium is discontinued.[14]

Lithium's antisuicidal effects may arise from its ability to enhance serotonin. This theory, although unproven, is consistent with observations associating central serotonergic deficiency with suicidal and aggressive behaviors.

Psychosocial measures. Address psychosocial variables that may increase suicide risk (***Table 1, page 33***). Recruit and involve the patient's support system, augmented with a close follow-up plan. Case management to explore housing and job opportunities can help. Work with the patient's family or others to remove guns from the patient's access. Individual, marital, and family therapies can reduce conflicts and strengthen coping skills.

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Suicide intervention

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Clinical Point

Clozapine's antisuicidal effects in schizophrenia or schizoaffective disorder appear independent of its antipsychotic effects

Bottom Line

The purpose of suicide assessment is not to predict suicide but to help you understand the sources of a patient's suffering and develop an informed intervention. The 5-step 'B-SAFE' model can help you protect patients from imminent risk while needed therapies are started. Address psychiatric and medical comorbidities, and document the process for medicolegal purposes.