Suicide Risk Assessment

See online here

Patients with chronic medical conditions: those with psychiatric disorders such as a major depressive disorder, veterans, and those with psychotic disorders are at an increased risk of suicidal ideation, attempt, or death. The assessment of suicide risk in the patient is very important as it can help in preventing a serious suicide attempt that might cause death. Therefore, the main purpose of suicidal risk assessment tools is to direct and guide specific suicide prevention interventions.

Suicide Risk Assessment

This refers to the process of making close observations, evaluations, as well as estimations of the probability of an individual committing suicide. This process provides a systematic approach to ensure that key information, that could be used to prevent the suicide from occurring, is not missed.

Suicidal ideation (suicidal thoughts)

Suicidal ideation refers to the thoughts of hurting one's own self. The thoughts can range from a detailed plan to a fleeting consideration and does not necessarily include the final act of killing oneself. Many suicidal risk assessment tools are concerned with the determination and exploration of suicidal ideation. Previous observational studies have shown evidence that the risk of suicide clearly increases when the patient has expressed suicidal ideation before.

The issue when discussing with the patient whether he or she might commit suicide is that one might actually implant that idea in the patient's mind. This concern is invalid because **research has shown that patients appreciate the specific inquiry about suicidal ideation in most cases** and do not consider it as some form of intrusion; therefore, specific inquiry about suicidal ideation in a patient who belongs to a high-risk population, such as one diagnosed with a major depressive disorder, is recommended.

Facts about suicide thoughts:

1. People with a family history of mental health are more likely to have suicidal thoughts.
2. People who own guns are more likely to complete suicide.
3. The thoughts are preventable and there is plenty of help available.
4. The causes of suicidal thoughts include depression, anorexia, as well as the abuse of drugs.

Suicide plan

A suicide plan is a proposed method of carrying out a design that will lead to a potentially self-injurious outcome.

The second most important definition to use is a suicide plan. If the idea of ending one's own life, i.e. suicidal ideation, is present, further exploration of any suicidal plans is highly recommended.

Note: Specific questions about the plan one has made to end his or her life can differentiate those who have thought this through from those who did not really think it through.
It can determine the risk of truly committing suicide in the future, and can also determine whether the patient might also threaten the safety of others surrounding him, i.e. setting a shared house on fire.

Sample question to assess suicidal planning:

- Do you have a plan, or have you been planning to end your life?
- If so, how would you do it? Where would you do it?
- Do you have a timeline in mind for ending your life? Is there something that would trigger the plan?

Methods of suicide

Firearms	Poisoning	Hanging / Suffocation	Self-inflicted trauma
• Most common method of completed suicide • More common among males	• More common among females • Prescription drugs more common than illicit substances		

The readiness of the patient to commit

Whenever you inquire about the suicidal plan, you should also inquire about the readiness of the patient to commit such a plan. For instance, if the plan involves using a gun, then specific questioning about whether the patient has purchased a gun is mandatory. **If the patient provides very specific details about the plan, he is apparently ready to commit the plan** and has a very strong suicidal ideation. He or she should be admitted for inpatient care and urgent intervention might be needed.

Also, explore the patient’s reasons to die vs. reasons to live. Inquire about aborted attempts, rehearsals (such as tying a noose or loading a gun), and non-suicidal self-injurious actions, as these are indicators of the patient’s intent to act on the plan. Consider the patient’s judgment and level of impulse control. Administer a mental status exam if in doubt about mental status.

Suicidal Ideation, Suicide Plans, and Suicidal Attempts

In a recent study in the United States, researchers wanted to know the number of those who have thought about committing suicide within the last year. Unfortunately, **9.4 million Americans have answered that they thought about killing themselves**, i.e. suicidal ideation was positive.

To understand how serious the issue is, the researchers asked a follow-up question to those who had positive suicidal ideation. The follow-up question was whether they have put some plans in place to end their lives. Surprisingly, up to 29% of those who had positive suicidal ideation have also had a suicidal plan.

Approx. 12% of those who had positive suicidal ideation have gone through with the idea of suicide, and have made a non-fatal suicidal attempt! This number is very alarming as it indicates that, within 10 adults with significant suicidal ideation, 1 would commit suicide. To further understand the relationship between suicidal attempts and having a plan, a further analysis was performed to see how many of those who have committed suicide had a plan. 82% of those who committed suicide have reported that they had a plan before committing their suicidal attempt.

Based on this study, the 2 most important risk factors for a suicidal attempt are suicidal ideation and having a suicide plan.

Epidemiology

Age

The rate of suicide is highest in the middle-aged or the elderly; the number of suicides is the greatest in individuals aged between 15–29 years.

Sex

Men in their 50s are more likely to commit suicide compared to women.

Highest Rates:

- Elderly white men
- LGBT patients
- Rural area patients
- Access to firearms
- Military personnel
- Healthcare/veterinary professionals

Suicide Static

Modifiable risk factors	How to modify them
Mental illness – depression, anxiety, hopelessness	Modify this by adequately treating mental conditions
General medical conditions – chronic pain or end-stage conditions	Help patient access to medical care and primary care providers to address medical issues
Professional supports – access to psychiatric care and therapy	Refer to community psychiatry and therapy
Substance abuse	Educate about the dangers of substance use and its likelihood to cause disinhibition
Access to guns/weapons	Educate about removing firearms from the home
Employment/community supports	Refer to vocational training programs, disability, group housing, etc.
Anniversary of a loss	Explore patients feelings, anniversaries, and what they might have to look forward to with them

Why Commit Suicide?

One of the earliest, yet risky, interventions for preventing suicide is to understand why the patient wants to end his or her own life. If the patient has a clear reason that rationalizes their suicidal ideation, i.e. very strong feelings of guilt and responsibility for the loss of someone, then that person is at a very high risk of committing suicide. **Patients who want to commit suicide just to end their pain or suffering are easier to rationalize with** compared to those who want to commit suicide for psychotic or guilt purposes.

Is the Patient a Risk to the Safety of Others?

In many cases, the rational judgment of the depressed patient is cloudy, to say the least. A patient who wants to commit suicide might also pose a risk to the safety of others. In some cases, **suicidal ideation might be channeled into aggression and perhaps homicide ideation or even attempt**. Nowadays, it is mandatory to specifically and bluntly ask the suicidal patient whether they have plans or ideas about killing anyone else, i.e. homicide ideation.

In most cases of homicide-related suicide, the victims are the children or the partner of the suicidal individual. Suicidal adult men are more likely to commit homicide compared to adult women.

When making this assessment, ask the following questions:

1. Has the patient harmed anyone else?
2. What is the person’s rationale for harming another person?
3. Is there evidence of postnatal depression?

Family History of Suicide

Another important aspect of your assessment for the risk of suicide in the interviewed individual is to inquire about a family history of suicide or homicide.

Note: Inquiry about previous suicidal attempts in the family, family history of depressive disorder, psychosis, or substance abuse can shed light on the seriousness of the individual's suicidal risk. Inquiry about a recent family loss, i.e. the loss of a partner, a child, or a parent, can also provide more information about the risk of suicide.

When to Provide an Urgent Intervention in a Suicidal Patient?

There are certain signs that should alert the psychiatrist that the risk of suicide in the interviewed patient is significantly high and urgent intervention is warranted.

The patients who have created a clear plan for suicide are at a very high risk of committing suicide.

The patients who started writing their will, writing a suicide note, developing a funeral plan, and saying goodbye to friends and family are very likely to go through with their suicidal plan and should receive an urgent intervention.

Additionally, patients with a family history of suicide are more likely to commit suicide and should receive an intervention. The presence of a gun in the patient's house also raises a red flag. Substance abuse increases the risk of suicide significantly in someone who has a suicidal plan.

The patients with severe and acute immediate stress, i.e. the loss of a beloved person, are at an exquisitely increased risk of committing suicide, especially if they show positive suicidal ideation. Patients who are diagnosed with a major depressive disorder and have positive suicidal ideation are more likely to commit suicide than the general population, even if they do not have a suicidal plan.

Patients with psychotic disorders who have strong auditory hallucinations to commit suicide or homicide should be admitted to urgent inpatient care even maybe against their will.

Finally, in many cases, the assessment of suicidal risk in the patient can be very subjective. If you, as the treating physician, have a feeling that the risk is high even if you cannot explain why then urgent intervention for the prevention of suicide in that patient is needed.

Disposition of suicidal patients

Admission to a psychiatric hospital	Involuntary or emergency commitment	Discharge

Debatable efficacy: • Close outpatient follow-up may have better or similar outcomes	• Variation of the laws by state • Time between 72 hours and 15 days	• Ensure close follow-up with a mental health professional within 72 hours • Provide resources and patient education • Discuss the temporary removal of guns with the patient and his/her family

National Suicide Prevention Lifeline

Call 1-800-273-8255

Available 24 hours every day

References

Assessing Suicide Risk via emedicine.medscape.com

Legal Note: Unless otherwise stated, all rights reserved by Lecturio GmbH. For further legal regulations see our legal information page.

Notes