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Determining suicide risk (Hint: A screen is not enough)

It takes more than an algorithm to accurately assess suicide risk. These tips will help you individualize your approach.

PRACTICE RECOMMENDATIONS

□ *An individualized assessment is essential to identifying relevant risk factors.* (C)

□ *Use direct questions, such as, "Have you had any thoughts about killing yourself?" to screen for suicidal ideation.* (B)

□ *Ask a family member or close friend to ensure that any guns or other lethal means of suicide are inaccessible to the patient at risk.* (C)

□ *Avoid the use of "no harm" contracts, which are controversial and lack demonstrated effectiveness.* (B)

Strength of recommendation (SOR)

- (A) Good-quality patient-oriented evidence
- (B) Inconsistent or limited-quality patient-oriented evidence
- (C) Consensus, usual practice, opinion, disease-oriented evidence, case series

CASE ▶ When Dr. A, a 68-year-old retired gastroenterologist with a history of hypertension and hypertriglyceridemia, sees his family physician (FP) for a routine check-up, his blood pressure, at 146/88 mm Hg, is uncharacteristically high. When the physician questions him about it, the patient reports taking his hydrochlorothiazide intermittently.

Dr. A, whom the FP treated for depression 5 years ago, appears downcast. In response to queries about his current mood, the patient describes a full depressive syndrome that has progressively worsened over the past month or so. The FP decides to assess his risk of suicide. But how best to proceed?

A ssessing suicide risk is an essential skill for a primary care physician. It is also a daunting task, complicated by the fact that, while mental illness often predisposes patients to suicide, large numbers of people who suffer from major depression or other mental disorders are at low risk for suicide. Yet FPs, who are often the first health care practitioners patients turn to for treatment of mental health problems¹ and who frequently care for the same patients for years, are well positioned to recognize when something is seriously amiss.

The difficulty comes in knowing what the next step should be. Many researchers have attempted to develop algorithms, questionnaires, and scales to facilitate rapid screening for suicide risk. But the validity and utility of such tools are questionable. Most have a low positive predictive value and generate large numbers of false-positive results.²⁻⁴ Thus, while a standard short screen or set of questions may be included in a suicide risk assessment, these measures alone are inadequate.^{2,3}

What's needed is an individualized approach that focuses on evaluating patients within the context of their health status, personal strengths, unique vulnerabilities, and specific circumstances. Here's what we recommend.

Identify patients in need

Consider an individualized suicide risk assessment for patients with any of the following:

- A presentation suggestive of a mental disorder or substance abuse⁵⁻⁸
- the onset of, change in, or worsening of a serious medical condition
- a recent (or anticipated) major loss or psychosocial stressor⁹
- an expression of hopelessness¹⁰
- an acknowledgement of suicidal ideation.

CASE ▶ Dr. A fits more than 1 of the criteria: In addition to the recurrence of his depressive symptoms, he expresses hopelessness—noting that he stopped taking his medication 2 weeks ago because “It just doesn’t matter.”

Dig deeper to assess risk

There are 4 key components of the assessment and documentation of suicide risk: (1) An overall assessment of risk, eg, low, moderate, or high; (2) a summary of the most salient risk factors and protective factors; (3) a plan to address modifiable risk factors; and (4) a rationale for the level of care and treatment provided. A thorough evaluation is the core element of the suicide risk assessment.^{2,11}

The depth of the evaluation depends on the apparent risk, with more effort required for those at moderate or higher risk. (For high-risk patients, severe symptoms may impede a lengthy interview, and the need for hospitalization may be obvious.)

Some of the information needed may be available from the patient’s prior history. The rest can be obtained from a current medical history, including a discussion of factors known to exacerbate—or mitigate—risk (TABLE 1). The most robust predictors of suicide include being male,¹² single, or living alone;¹³ inpatient psychiatric treatment;^{10,14} hopelessness;^{10,13} and a suicide plan or a prior suicide attempt (although most “successful” suicides are completed on the first try^{14,15}). In addition, suicide is often precipitated by a crisis, including financial, legal, or interpersonal difficulties, housing problems, educational failure, or job loss.

TABLE 1

Suicide assessment: Major risks vs protective factors

Risk factors
Suicidality (ideation, intent, plan)
Prior suicide attempts ^{2,13}
Hopelessness ^{10,13}
Mental illness* ⁵⁻⁷
Recent loss or crisis ⁹
Negativity, rigidity
Alcohol intoxication/abuse ^{8,17}
Elderly ¹²
Male ¹²
Single/living alone ¹³
Gay/bisexual orientation ^{13,25}
Psychiatric symptoms ^{† 10,14}
Impulsivity or violent/aggressive behavior
Family history of suicide ²⁶
Unemployment ²

Protective factors
Female
Marriage
Children ^{‡ 27,28}
Pregnancy ²⁹
Interpersonal support
Positive coping skills ^{30,31}
Religious activity ³²
Life satisfaction ³³

*Especially recent psychiatric hospitalization.

† Including, but not limited to, anxiety, agitation, and impulsivity.

‡ This includes any patient who feels responsible for children.

■ **Sex and age considerations.** For women, the incidence of suicide is highest for those in their late 40s. For men, who have a higher risk overall, the incidence increases dramatically in adolescence and remains elevated through adulthood, with a second large increase occurring after the age of 70.¹²

■ **Does the patient have a psychiatric diagnosis?** Mental illness has been found to be present in more than 90% of suicides,⁵⁻⁷ and a psychiatric diagnosis—or psychiatric symptoms such as agitation, aggression, or severe sleep disturbance^{2,10,16}—is a key risk factor. Substance abuse is another significant risk.^{8,17} The risk of suicide may be especially high after discharge from a psychiatric hospital.



Keep in mind that a situation that is protective for many—eg, marriage—may represent an added stressor and risk factor for a particular patient.

CONTINUED

Is there a lack of support? The absence of a support system is a significant risk factor; conversely, marriage and children are commonly reported protective factors. In questioning patients about family and social ties, however, keep in mind that a situation that is protective for many, or most, people—eg, marriage—may represent an added stressor and risk factor for a particular patient.¹⁸

Ask about suicidal ideation

The nature of suicidality, which may be the most relevant predictor of risk, can be assessed through a number of questions (TABLE 2).¹⁵ Not surprisingly, you are most likely to elicit information if you adopt an empathic, nonjudgmental, and direct communication style.

Whenever possible, begin with open-ended questions, and use follow-up questions or other cues to encourage elaboration. Ask patients whether they have thought about self-harm. If a patient acknowledges thoughts of suicide, ask additional questions to determine whether he or she has a plan and the means to carry it out. If so, what has prevented the patient from acting on it thus far?

Patients often require time to respond to such difficult questions, so resist the urge to rush through this portion of the suicide risk assessment. Simply waiting patiently may encourage a response.

CASE ▶ When directly questioned about suicidal ideation, Dr. A acknowledges that he has had thoughts of wanting to fall asleep and not wake up. Asked whether he has considered actually hurting himself, he pauses, looks away, sighs, and utters an unconvincing denial. When his FP observes, “You paused before answering that question and then looked away,” Dr. A re-establishes eye contact and admits that he has had thoughts of taking his life.

It is not uncommon for patients with suicidal ideation to initially deny it or simply fail to respond to questions, then later to open up in response to requests for clarification or further questions. This may be partly due to the patient’s own ambivalence. It may also have to do with the way the questions are presented. In order to get an accurate answer, avoid ques-

TABLE 2

Assessing suicidality: Sample questions

- Have you lost hope?
- Do you ever consider running away from your problems?
- Have you had any thoughts that life was not worth living?
- Have you had any thoughts about hurting yourself?
- Have you had any thoughts about killing yourself?
 - How might you do this?
 - Do you have any intentions of acting on these thoughts?
 - What has kept you from acting on these thoughts?
 - Do you have access to a gun or other means of killing yourself?

tions leading toward a negative response. Ask: “Have you thought about killing yourself?” not “You’re not thinking about killing yourself, are you?”

Does the patient have a plan?

Suicidal ideation is defined as passive (having thoughts of wanting to die) or active (having thoughts of actually killing oneself). It is crucial to assess the level of intent and the lethality of any plan. Too often, physicians fail to probe enough to find out whether the patient has access to a lethal means of suicide, including, but not limited to, firearms or large quantities of pills that could be used as a potentially fatal overdose.

CASE ▶ Dr. A admits that he has had suicidal thoughts for the past 2 weeks, and that these thoughts have become more frequent and intense. He also says that while drinking last weekend, he thought about shooting himself.

Although Dr. A occasionally hunts and has access to guns, he denies having any intent or plan to act on his thoughts. He adds that he would never kill himself because he doesn’t want his wife and adult children to suffer.

Follow up with family or friends

For patients like Dr. A, who appear to be at significant risk, an interview with a family mem-

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ber or close friend may be helpful—or even necessary—to adequately gauge the extent of the danger. Patients usually consent to a physician's request to obtain information from a loved one, particularly if the request is presented as routine or as an action taken on the patient's behalf. A patient's inability to name a close contact is a red flag, as individuals who are more isolated tend to be at higher risk than people with a supportive social network.¹⁹

A refusal to grant your request to contact a loved one is also worrisome, and it may still be appropriate to contact others for collateral information or notification if the patient appears to be at considerable risk.²⁰ In such cases, be aware of local laws, and document the rationale for gathering clinical information. Focus on obtaining information needed for risk assessment. Ethical guidelines state that when “the risk of danger is deemed to be significant,” confidential information may be revealed.²¹

CASE ▶ Dr. A is initially reluctant to allow you to call his wife, but consents after being told that this is a routine action and for his benefit. His wife confirms his history of depressive symptoms and recalls that he became more withdrawn than usual several months ago. She has been worried about him and is glad he is finally getting help. Although she is not concerned about her husband's safety, she agrees to remove the gun from their home—and to follow up with the FP to verify that she has done so. She accepts the FP's explanation of this as routine and is not overly alarmed by the request.

Further questioning of Dr. A and his wife, along with the FP's knowledge of the patient, makes it clear that he has previously demonstrated good coping skills. Dr. A cannot identify a recent stressor to explain his symptoms, but acknowledges that he has become more pessimistic about the future and intermittently feels hopeless.

Dr. A generally believes his depression will resolve, as it did in the past. He has no history of psychiatric hospitalizations or suicide attempts. Nor does he have a history of problem drinking, although he admits he has been drinking alcohol more frequently than usual in the past several weeks. He identifies his wife as

his primary support, although he's aware that he has been isolating more from her and his many other supports in the past month.

Estimate risk, decide on next steps

For experienced clinicians, a determination of whether an individual is at low, moderate, or high risk is often based on both an analytical assessment and an intuitive sense of risk. In some cases, it may be useful to distinguish between acute and chronic or baseline risk.³

Patients judged to be at the highest risk may warrant immediate transport to the emergency department.²² If a patient at this level of risk does not agree to go to the hospital, involuntary admission may be necessary, depending on the laws in your state. (For patients at moderate or moderate-to-high risk, especially if acutely elevated from baseline, hospitalization may still be offered or recommended—and the recommendation documented.)

■ **Pay particular attention to risk factors that can be modified.** Access to firearms can be restricted. Treatment of mental disorders, which can generally be considered modifiable risk factors, should be a primary focus. FPs may be able to successfully treat depression, for instance, with medication and close follow-up. Counseling or psychotherapy may also be helpful; provide a referral to an alcohol or drug treatment program, as needed.

■ **A psychiatric consultation or referral** is warranted if you do not feel comfortable managing a patient who has expressed any suicidal ideation.²³ Psychiatric referral should also be considered when the patient does not respond to treatment with close follow-up, when psychotic symptoms are present, when hospitalization may be warranted, or when the patient has a history of suicidal thoughts or an articulated suicide plan.

■ **Avoid suicide prevention contracts.**^{2,24} Asking a patient to sign a “no harm,” or suicide prevention, contract is not recommended. While such contracts may lower the anxiety of physicians, they have not been found to reduce patients' risk and are not an adequate substitute for a suicide risk assessment.

■ **Develop a crisis response plan.** Collaboratively developed safety or crisis response plans may be written on a card. Such



Suicide prevention contracts have not been shown to reduce the risk of suicide.

plans can provide steps for self-management (eg, a distracting activity) and steps for external intervention if needed, such as seeking the company of a loved one or accessing emergency services.

CASE ▶ Dr. A appears to be at moderate to high risk of suicide. Salient risk factors include his age, sex, occupation (health care providers and agriculture workers are at elevated risk^{12,13}), depression, increased use of alcohol, and suicidal ideation. He denies any intent of acting on these thoughts, however, and has a number of

protective factors, including the lack of a prior attempt, his expectation that the depression will resolve, demonstrated good coping skills, and a supportive marriage.

The patient declines an offer of hospitalization. He does, however, agree to quit drinking, and to begin a regimen of antidepressants with more frequent visits to his FP. His FP offers him a referral for psychotherapy, and he agrees to seek immediate help, should he feel unsafe. **JFP**

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Consider developing a crisis response plan that details steps for self-management and emergency outreach, if needed.

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