Assessment of Suicide Risk : Practical Issues

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INTRODUCTION

Suicide is a major public health problem worldwide with complex multifactorial origins. More than 800,000 lives worldwide are lost to suicide every year, and Asia accounts for more than 60% of such deaths. India has seen a steady increase in the incidence of suicidal deaths in the last five decades.¹ The estimated suicide-related death rate in India is 21/100,000, which is nearly twice the global average (11.4/100,000) and translates into more than 230,000 lives lost annually.² Assessment of suicide risk is of utmost importance and is considered one of the key area and responsibilities of a consultant psychiatrist.

CHALLENGE

Suicidal ideation and behaviours, akin to the symptoms of an acute coronary syndrome or stroke, require immediate attention. Unlike their vascular emergency counterparts, however, no evidence-based algorithms exist to reliably assess, manage, and prevent suicide. The low frequency of suicide is partly responsible for this difficulty. The World Health Organization's (WHO's) suicide prevention multisite intervention study on suicidal behaviours (SUPRE-MISS), an intervention study, has revealed that it is possible to reduce suicide mortality through brief, low-cost intervention in developing countries.³

MANAGEMENT GOALS

Management of suicide includes screening for suicidal ideation or behaviours, performing an assessment of the individual's current risk of imminent harm, and creating a treatment plan in collaboration with the patient and any involved supports. This process needs to be individualized, collaborative, and

completed using a calm, cooperative, and curious interview style.⁴

SCREENING GOALS

The goal of suicide screening is to determine if an actionable risk is present. In a primary care setting, this screen should be efficient, easily completed by a front-office staff, and have high sensitivity (or low false negative rate).

HOW TO SCREEN

The Patient Health Questionnaire-9 (PHQ-9) is a quick, subjective reporting scale that can be incorporated into the medical record. Affirmative responses to item 9 regarding thoughts of death or self-harm have a hazard ratios of 10 and 8.5 for attempts and deaths in a community setting, respectively.⁵ While many clinics refer to the PHQ-2 for depression screening, the cut-off for further depression assessment is typically three and can miss 50–60% of patients who would otherwise endorse suicidal ideation on item 9 of the extended version.⁶

The Columbia Suicide Severity Rating Scale (C-SSRS) is a public forum questionnaire that can help screen for suicide and form a detailed account of an individual's suicidal ideations or behaviours. It is easy to administer with minimal training, available in multiple languages, and easily included in an electronic medical record. In studies, it has reported sensitivity of 67%, specifically of 76%, positive predictive values of 14%, and negative predictive values of 98%.⁷

WHO TO SCREEN

There is no current consensus on who should be screened for suicidal ideation or plans. The World

Health Organization (WHO) currently recommends that all individuals over the age of 10 with any mental health disorder, epilepsy, interpersonal conflict, recent severe life event, or other risk factor for suicide should be asked about thoughts or plans to self-harm or attempt suicide.⁸

In addition to the above guidelines, specific complaints or patient characteristics may warrant suicide screening. These include :

- o Changes in mood, including any depressive symptoms, emotional distress, anger, irritability, or aggression
- Anxiety or agitation
- Sleep complaints
- Evidence of unpredictable or impulsive behavior
- Sudden change in life circumstances
- Increase in alcohol or other drug use
- Increasing healthcare utilization, including hospitalizations, office visits, and emergency room visits
- Therapy non-adherence, including medications, physical therapy, and psychotherapy
- Presentation because of family/friend – more than 50% of individuals who presented to primary care providers before suicide were convinced to do so by family or friends.⁹

ASSESSMENT GOALS

After screening has identified an individual at risk, a formal suicide risk assessment should occur with the following goals: identify modifiable and fixed risk factors, identify protective factors, clarify the current level of suicidal intent and planning, and estimate.

HOW TO ASSESS

Interviews between care providers and suicidal patients need to maintain or enhance the therapeutic alliance. All assessments should be conducted with

curiosity, concern, calmness, and acceptance of the individual's current emotional and cognitive state. Patients with suicidal ideation may feel hopeless, desperate, or cognitively overwhelmed, interfering with their ability to comprehend and convey these thoughts to others. Clinicians should stay attuned to their own reactions that may be non-therapeutic, such as hostility, avoidance of negative feelings, or the blurring of professional roles, possibly as a way to take on a savior role.¹⁰

In *adolescent populations*, the HEADSS assessment (Home, Education and employment, Activities, Drugs, Sexuality, and Suicide and safety) was developed in the Australian primary care setting to assess the psychosocial needs of younger populations and guide decision-making. The primary goal of any adolescent patient interview is to understand the developmental perspective of the patient while empowering them to participate in their healthcare, discuss sensitive topics with minimal discomfort, and to ultimately take any signs or symptoms of distress seriously.

RISK FACTORS

One challenge with suicide risk factor assessment is that many risk factors are static, not modifiable, and are limited in helping determine who needs higher level of care.

In contrast, some risk factors may be more acute or sub-acute in nature, indicating a heightened risk for suicide in the near term.¹² Some of these more acute risk factors, referred to as “warning signs,” were identified by a consensus panel formed by the American Association of Suicidology (AAS) to help clinicians appreciate what the patient is doing or saying in the present moment that may acutely increase their risk.¹³ There is concern that even in the setting of significant protective factors, acute risk factors can significantly elevate an individual's risk for suicide.

- **Prior suicide attempt** remains the strongest predictor of future attempts and completions. There is increasing correlation between suicidal

ideation and behaviors, especially for those presenting in an emergency room setting. Although most individuals who self-harm do not go on to commit suicide, repeated self-harm even without intention to end life is a predictor of suicide and is typically present within the 12 months preceding suicide in young people. It should be noted, though, that over 90% of suicides are completed on the first or second attempt.¹⁴

- ❑ **Suicidal ideation**, in contrast to a history of suicide attempts, may represent an increase in suicide risk, especially if this ideation has developed into the seeking of means to perform the action, increasing discussion about death, and rehearsal behaviors. There is no documented difference between passive or active suicidal ideation in suicide course or outcome; as such, both should hold weight in suicide assessment.
- ❑ **Stressful life events** must be considered within the circumstance and age of the patient. Common adolescent events include bullying (either as victim or perpetrator), disciplinary actions, legal issues, school difficulties, romantic break-ups, assaults, or problems relating to home-life. For adults, financial difficulties, relationship losses, unemployment, and intimate partner violence all increase the risk for suicide attempts. These events may ultimately resolve with time and action, but during a visit with a primary care provider, they are unlikely to be modifiable.¹⁵
- ❑ All **psychiatric disorders**, with the exception of intellectual disability and later course dementias, are associated with an increased risk of suicidal ideation, attempts, and completions. This risk is significantly greater during active periods of illness and correlates with severity of illness. Hopelessness in the setting of depression increases the risk for suicide and is typically modifiable with treatment of the mental health disorder.
- ❑ **Physical illnesses** such as pulmonary disease, cancer, stroke, diabetes, ischemic heart disease,

and spine disorders are all independently associated with suicide completion. Suicide decedents tend to spend more time in the hospital for both medical and psychiatric reasons in the months prior to their death, endorse lower global quality of life assessment scores, and suffer from more physical impairment. Similar risk for depression and suicide is also found in adolescent populations with chronic physical illnesses. While some illnesses cannot be cured, the amount of disability or functioning may be modifiable with therapy.¹⁶

- ❑ **High-risk substance use** or use disorders, including alcohol, prescription, and illicit drugs, are associated with increased suicide risk, both in adult and adolescent populations. Twenty percent of suicides occur while individuals are intoxicated. Increasing substance use despite worsening mood symptoms, associated dysfunction, and increasing suicidal ideation may lead to a more acute suicide risk compared to a previous baseline level of use.

PROTECTIVE FACTORS

Similar to risk factors, most individuals have both modifiable and non-modifiable protective factors that may be enhanced during periods of acute distress to help prevent against suicide.¹⁷ Following questions can help elicit these factors:

- ❑ What keeps you going during difficult times?
- ❑ What are your reasons for living?
- ❑ What has kept you from acting on those thoughts?
- ❑ What or who do you rely on for support during times like these?

SUICIDAL EVALUATION

Part of a suicide risk assessment is gaining a very clear understanding of the individual's desire to complete suicide, their capability to do so, and their current suicidal intent. Some questions that can help elicit this information are included below.¹⁸

- ❑ Why do you want to die?
- ❑ Have you done anything in preparation for your death?
- ❑ On a scale of 1–10, where would you rate your seriousness or wish to die?
- ❑ Have you tried out any particular method or taken steps in rehearsal for suicide?

DETERMINING LEVEL OF RISK

The overall goal at this point is that the primary care provider has been able to adequately identify key risk factors, both modifiable and acute, and protective factors in order to rate the individuals current risk of suicide. This acute, current risk may differ from the patient's chronic level of suicide risk, the latter of which is typically based on static demographic factors that are not modifiable. There can be ambiguity around risk factors and what may define a chronic and hard to manage risk versus an acute risk that must be dealt with immediately, necessitating clinical judgement. As many assessment and screening tools do, we propose that overall risk be defined as a manageable three levels (low, medium, or high). Individuals at the lowest and highest risk may be easiest to identify and those at more moderate levels of risk may require greater assessment to discern the most appropriate management strategy.¹⁹

CURRENT ASSESSMENT GUIDELINES

- *Suicide Assessment Five-step Evaluation and Triage (SAFE-T)* : Most important and used guidelines by mental health professional.²⁰
- *Zero Suicide Model* : National Action Alliance for Suicide Prevention²¹
- International Association for Suicide Prevention (IASP) Guidelines for Suicide²²
- Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors : APA²³

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