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Suicide risk assessment and threats of suicide

Suicide can be described as a fatal act of self-harm initiated with the intention of ending one's own life. Although often seen as impulsive, it may be associated with years of suicidal behaviour including suicidal ideation or acts of deliberate self-harm. Self-harm is defined as any act of self poisoning or self injury irrespective of motivation, and is associated with an increased risk of suicide [1] [2].

Epidemiology [3]

- In 2017, there were 5,821 suicides registered in the UK. This equates to 10.1 deaths per 100,000 of the population. This has been declining from a rate of 14.7 per 100,000 population in 1981.
- Male suicides account for three quarters of suicides. This has been the case since the mid-1990s, although rates of male suicides are declining, whereas female suicide rates have been consistent over the past ten years. In 2017 in the UK there were 15.5 male deaths per 100,000 population (the lowest since the recording series began in 1981), and 4.9 female deaths per 100,000.
- The highest suicide rate in 2017 was in men aged 45-49. In this group there were 24.8 deaths per 100,000 population.
- In women in 2017 the age group with the highest suicide rate was those aged 50-54 with a rate of 6.8 deaths per 100,000.
- The most common methods of suicide are hanging, strangulation and suffocation, followed by poisoning.
- In the UK, a quarter of people who die from suicide have been in contact with a health professional in the previous week, and most within the last month [4].

- The UK government has strategy policies in place to continue to reduce suicide rates, and the National Institute for Health and Care Excellence (NICE) has published guidance for local implementation by various organisations [1] [5]. These policies cover those in custodial settings as well as in the community. There are also strategies for those working with university students; in 2016-17 at least 95 university students died by suicide [6].
- One survey in England suggested as many as 20% of people reported suicidal thoughts in their lifetime, and 6.7% reported having made a suicidal attempt [7].
- A World Health Organization (WHO) report in 2014 estimated that every 40 seconds, somebody in the world dies from suicide and that over 800,000 people die from this cause each year worldwide.

Aetiology

Risk factors for suicide [8] [9]

- Previous suicide attempt or previous self-harm. Self-harm is associated with a significantly higher risk of death and much of this is from suicide [2] [10]. A history of self-harm is present in up to three quarters of women who die from suicide, and more than that in those under the age of 25.
- Male gender.
- Unemployment.
- Physical health problems such as disabling or painful illness, including chronic pain. People with chronic pain are at least twice as likely to attempt suicide as those without [11].
- Living alone.
- Being unmarried.
- Alcohol and/or drug dependence.
- Active mental illness (specifically affective disorder, schizophrenia, personality disorder. See 'Mental disorders and risk of suicide', below).

- Risk factors for suicide are more common in the prison population; therefore this group of people are at higher risk [12]. The Five Year Forward View for Mental Health document states that up to 9 out of 10 of those in prison have mental health, drug or alcohol problems [4].

Protective factors [8]

Evidence is weak but protective factors *may* include:

- A strong religious faith.
- Family support to find alternative solutions to their problems.
- Having children at home.
- A sense of responsibility for others.
- Problem-solving skills.

It may sometimes be that a change in protective factors triggers a higher risk situation. Some risk factors are static/stable and not subject to change (such as gender or past history of self-harm) whereas others are dynamic and are subject to change (such as level of alcohol intake, relationships, social situation, level of depression). It may be possible to alter the dynamic factors, and this may be relevant to the management plan.

Mental disorders and risk of suicide [4] [13]

The risk of suicide in patients with mental disorders is 5-15 times higher than that for patients without co-existent mental disorders. Around 90% of individuals who die by suicide have mental illness, although this varies globally. Around 25% in the UK have been in contact with mental health services prior to death. Risk is thought to be greatly increased following discharge from inpatient mental health wards, although inpatient suicides have reduced significantly over a period of 20 years.

In the UK the most common diagnoses among those dying from suicide are as follows (percentage is prevalence in those who died by suicide between 2004-2014) [8]:

- Affective disorders (45%) particularly depression.

- Schizophrenia (17%). Studies suggest that patients with schizophrenia have an 8.5-fold greater risk of suicide than the general population [14].
- Personality disorder (8% where it is the primary diagnosis).
- History of alcohol misuse (45%).
- History of drug misuse (33%).

Assessment [2] [8]

Assessing the risk of suicide in a person expressing suicidal thoughts, or presenting with self-harm or a suicide attempt, is crucial in attempting to prevent deaths. Asking questions about suicidal thoughts does not increase the risk of suicide [8] [15]. There are a number of risk-predicting score systems for determining suicidal intent. However, none has good predictive ability, and NICE guidelines advise these should NOT be used [15] [16]. Instead a comprehensive clinical interview should be used for assessment as follows:

General

- Establish rapport, develop a trusting relationship.
- Use open questions.
- Establish current anxieties or problems.
- Observe behaviour and be alert to any mismatch between words and behaviour. Clinician instinct can be important, as suicidal thoughts may be denied.

Assess risk factors

- Assessment of mental health:
    - Past psychiatric history.
    - Depressive and other psychiatric symptoms.
    - Medication.
    - History of alcohol and illicit drug use.
    - Observe verbal and non-verbal indicators of mental state (eye contact, apparent mood, hallucinations and unusual beliefs, agitation, speed of speech).
- Previous self-harm or suicide attempts.
- Age, gender, social situation.
- Relationships which may be supportive/protective, or which may pose a threat (abuse or neglect). Recent changes to relationships or social situation may be significant.
- Access to lethal methods.

Assess current intent and plans

- Wish to be dead.
- Feelings of hopelessness.
- Regret/remorse over current/previous attempt.
- Expectation about outcome of self-harming behaviour or suicide attempt/threat.
- Specific plans.
- Lethality and frequency of plans or attempts.
- Other self-harming behaviour.
- Assess current suicidal intent/wishes.
- Length of time suicidal feelings have been present.
- Mental state at time of self-harm or suicide attempt or threat (alcohol or drug intake, social situation, relationship changes, bereavements).

- Plans for others after death: suicide notes, changes to will, consequences.

'Red flags' to consider may include a sense of hopelessness, a feeling of entrapment, well-formed plans, perception of no social support, distressing psychotic phenomena and significant pain/physical chronic illness [17].

Assess needs [16]

- Social problems.
- Untreated mental health disorders.
- Physical symptoms and disorders.
- Coping strategies.
- Skills, strengths and assets.
- Psychosocial and occupational functioning.
- Personal and financial difficulties.
- Needs of dependants.

Management [2] [8] [16]

General

- Following assessment as above, form a summary and a risk assessment. There will be a balance of risk and protective factors, which will vary between individuals and which may further vary between situations in any one individual (for example, after consumption of alcohol, with fluctuating moods in mental disorders, or with changing life events). It is inevitably not entirely precise or predictable. However, accurate assessment followed by appropriate support and treatment may save lives.
- Subsequent action will depend on the level of risk believed to be present. It will also be guided by specific risk factors identified.
- Aim to be supportive, empathetic and reassuring in developing a relationship.
- Remove access to preferred means of suicide where possible.

In the short term an immediate judgement is needed, depending on whether:

- The patient is willing to engage with a management plan.
- The assessing clinician feels the patient is safe to go home.
- The clinician feels urgent referral to psychiatry/mental health team is needed (if agreed by patient).
- The clinician feels a Mental Health Act assessment is appropriate, in discussion with mental health services, where it seems there is high risk but the patient does not agree to referral.

Care plans

Form and agree a care plan. Aims may include:

- Prevent self-harm or suicide attempts, or escalation of either behaviour.
- Reduce level of injury from self-harming behaviour.
- Improve quality of life.
- Improve social or occupational functioning.
- Improve mental health conditions.
- Improve physical symptoms.

Care plans should:

- Be multidisciplinary (and be shared with the person's GP if not involved).
- Be developed collaboratively with the person who has self-harming or suicidal behaviour.
- Identify short- and long-term goals, steps to achieve them, and professionals responsible for helping achieve them.

- Include a risk management plan:
    - Address specific identified risk factors where these can be modified.
    - Include information about support available, including local services and charity help-lines such as the Samaritans.
    - Include a crisis plan (self-management strategies, and how to access services in a crisis).

Specific treatment options may include:

- Medication. Antidepressant use can be controversial as potentially some may increase suicidal thoughts, particularly in the younger population, and risk from overdose must be mitigated. Mood stablising treatment such as lithium and certain antiepileptics can reduce suicidal thoughts, and ketamine is under research as an option for future [15].
- Counselling.
- Cognitive behavioural therapy (CBT).
- Dialectical behaviour therapy (DBT) - a specific type of CBT which has the largest evidence base, although more studies are needed to establish the most effective psychological therapy [18]. DBT focuses on acceptance techniques, and change techniques, helping people change damaging patterns of behaviour.

Provide follow-up at regular intervals, depending on assessed level of risk, but probably within 24 hours. There is a period of potentially higher risk after starting an antidepressant and close follow-up is required in the early stages.

Management of high-risk individuals

If high level of risk is established, ensure safety with 24-hour support through the crisis team of the local mental health service. Consider grounds for psychiatric evaluation and detention under the Mental Health Act if the person refuses. See the separate Compulsory Hospitalisation and Consent To Treatment (Mental Capacity and Mental Health Legislation) articles for further details. Involuntary detention cannot be used in the UK if the mental state is due to alcohol or drug intoxication alone.

Further reading

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