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SUICIDE: RISK ASSESSMENT and SAFETY ISSUES

One of the most difficult issues in the treatment of mental illness and substance abuse is suicidal ideation. Part of the difficulty resides in the fact that, even after 50 years of research and clinical study, we have few tools and markers to predict suicide, who will attempt it and who will become a victim of suicide. In order to address a vital clinical need in the face of very little in the way of evidence-based practice, Douglas Jacobs, a Cambridge, MA psychiatrist, developed the B-SAFE[1] model, a 5-step evaluation process that gives some guidelines and helpful interventions. This tool guides the practitioner toward the questions to ask and the factors to consider when evaluating suicidal risk; it assists in pegging the appropriate interventions and documenting the risk assessment.

1. Identify predisposing risk factors.
2. Seek potentiating factors.
3. Conduct a specific suicide inquiry.
4. Determine intervention level and safety needs.
5. Document assessments and Treatment Plan.

Some of our dilemma is that no single risk factor or combination can actually predict who will or won't commit suicide, nor help us specifically to determine which patients will be safe. However, we have learned that one clue, albeit subjective and impressionistic, is the level of the patient's ***suffering***. One way in is to explore the issue, as one would inquire about pain: 'what's the level from 1 to 10?' "Is this the worst you ever experienced?" This inquiry also opens up the identification of preventive factors that may be strengthened and supported as well as the risk factors that may be modified.

Because suicidality may be frightening in any treatment setting, or even a taboo, often clinicians may be afraid to talk about it or even ask some basic questions. They may have the mistaken belief that if they raise the question, the patient may start to think about something that never entered their minds before. This could not be further from the truth. In fact, the most common response from a suicidal person is relief that finally there is someone who is willing to talk with them about their pain. On the other hand, the prudent clinician is alert to certain risk factors that alert their danger signals in the face of reassurance and denial on the part of the patient.

I. General Risk Factors[2]

A. Psychopathology: depression, bipolar disorder, schizophrenia, substance abuse, and personality disorders have been strongly connected with completed suicide. Proper diagnosis and appropriate treatment can diminish these risk factors.

The immediate post-discharge period after hospitalization for any of these conditions is a time of heightened risk, as are the early weeks of starting on anti-depressant medication; also, include early recovery from drug and alcohol addiction.

B. Psychosocial factors:

1. Living alone with no social supports
2. Ages 17 to 35; also, the geriatric population
3. Insomnia
4. Hopelessness
5. Anhedonia – no joy, no interests

C. Medical or physical illness:

1. Pain
2. Disfigurement
3. Limitation of function, as in stroke or accident
4. Fear of or actual dependence
5. Epilepsy carries a 4-5-fold increase in suicidal risk among children and teens.

D. Severity of the failed suicidal attempt or self-mutilation (decreased severity associated):

1. Impulsive suicide (or self-injury) attempt planned for less than 3 hours
2. Committed in the presence of others
3. Committed so that discovery was likely

II. Specific Risk Factors

A. Demographic:

1. Male, Caucasian, rural
2. Imprisoned, widowed or divorced, living alone, no children or empty nest

B. Psychosocial:

1. Lack of social supports, recent loss of employment, decrease in socioeconomic status
2. History of abuse (physical, sexual, emotional), severe relationship turmoil, aggressive or impulsive traits
3. Family history of suicide, prior suicide attempts, writing suicide notes or rehearsing suicide, owns gun
4. Occupation: physicians, dentists, nurses, pharmacists, veterinarians, farmers

C. Psychiatric:

1. Recent psychiatric diagnosis

2. Mood disorder, especially major depression, bipolar disorder
3. Schizophrenia, addiction (drugs or alcohol), personality disorder, severe anxiety disorder, panic attacks
4. Insomnia
5. Poor concentration
6. Anhedronia

D. Medical:
1. Multiple sclerosis
2. Stroke
3. Spinal cord injury; head injury
4. Huntington's chorea
5. Lupus
6. AIDS
7. Epilepsy*
8. Pain
9. Cancer (malignant), peptic ulcer, kidney disease

*N.B. Epilepsy is the only medical diagnosis that carries a documented increase in suicide rates in children including teenagers. Also, in the general population, it increases risk of suicide 4 to 5 times.

III. What are Some of the Factors that Lessen the Likelihood of Suicide?

A. Internal:
1. Successful handling of stressors in the past
2. An array of positive cooping skills
3. Spirituality, religious affiliation
4. Good reality testing
5. Optimism and high frustration tolerance
6. Resiliency

B. External:
1. Children or pets at home
2. Religious beliefs and prohibitions
3. Sense of responsibility to family
4. Social supports
5. Financial incentives

IV. What are Some of the Key Questions to Ask?

A. Have you been suicidal? Attempted suicide?
B. Have you ever thought about hurting yourself or killing yourself?
C. (If #B is positive) Did you ever have a plan or a way to kill yourself?
D. If currently suicidal, do you have access to pills, a weapon or other means?
E. Have you been rehearsing this plan to end your life?
F. Do you have the location picked out?
G. What has stopped you from following through with the plan?
H. Is there a family history of suicide or attempted suicide?

V. Intervention[3]

The level and intensity of intervention relies primarily on the clinical assessment and your clinical setting. Patient safety is the key factor. It is important to take decisive action when your assessment determines that suicide risk is elevated and imminent. If the patient is being treated in an outpatient setting, hospitalization, voluntary or involuntary, may be necessary.

VI. Documentation

There are multiple reasons for good documentation, among them being other clinicians may soon become involved with your patient's care and benefit from your assessments.

A. Clarify the treatment plan. Provide a summary that is legible and gives the estimated level of risk, any known history and key positive, as well as negative data, i.e., no family history of suicide.
B. Communicate with other caregivers
C. Manage the medical-legal risk

Summary:

The purpose of suicide assessment is not to predict suicide but help you to maximize patient safety and understand the patient's suffering. The 5-step Assessment and Intervention model helps to protect patients from impulsive and driven risk while the proper level of intervention is instituted. Psychiatric, substance abuse and medical co-morbidities need to be addressed. Once the suicidal alarm bell goes off, documentation of the process is necessary for medical-legal purposes.

References:

1. Jacobs, DG et al. Suicide assessment: an overview and recommended protocol in: "The Harvard Medical School guide to suicide assessment and intervention." San Francisco, CA: Jossey-Bass Publishers; 1999: 3-39.

2. Lewis, LM. No-harm contracts: a review of what we know. "Suicide Life Threat Behav" 2007, 37(1): 50-57.

3. Baldessarini RJ et al. Decreased risk of suicides and attempts during long-term lithium treatment. "Bipolar Disord" 2006; 8: 625-39.

3