Psychiatric Emergencies

Assessing and Managing Suicidal Ideation

Andrea N. Weber, MD, MME[a,b], Maria Michail, PhD[c],
Alex Thompson, MD, MBA, MPH[b],
Jess G. Fiedorowicz, MD, PhD[a,b,d,e,*]

KEYWORDS

• Depression • Mental health • Prevention • Primary health care • Risk assessment • Suicide

KEY POINTS

- Screening tools, including but not limited to the Patient Health Questionnaire 9 and the Columbia Suicide Severity Rating Scale, may identify individuals at risk and in need of further assessment.
- The suicide risk assessment involves a clinical judgment based on an individualized evaluation of various risk and protective factors for suicide.
- There exist a variety of interventions to modify suicide risk and that should be tailored to the individual's risk profile.

INTRODUCTION

Suicide is a complex personal and sociologic phenomenon accounting for 1.6% of all deaths in the United States. According to the Centers for Disease Control and Prevention (CDC), there were 42,773 suicides reported in the United States in 2014 (a rate of 13.4 per 100,000), which represents a 24% increase since 1999. Suicide is the 10th leading cause of death in all age groups, with approximately 50% of those deaths involving firearms. Firearms account for 55% of suicides in men, whereas poisoning is the most common means of suicide in women. For people aged 10 to 34 years,

[a] Department of Internal Medicine, The University of Iowa, 200 Hawkins Drive, Iowa City, IA 52242, USA; [b] Department of Psychiatry, Carver College of Medicine, The University of Iowa, 200 Hawkins Drive, Iowa City, IA 52242, USA; [c] School of Health Sciences, University of Nottingham, D17 Institute of Mental Health, Innovation Park, Triumph Road, Nottingham, NG7 2TU, UK; [d] Department of Epidemiology, College of Public Health, The University of Iowa, 145 North Riverside Drive, 100 CPH, Iowa City, IA 52242, USA; [e] Abboud Cardiovascular Research Center, Carver College of Medicine, The University of Iowa, 2269 Carver Biomedical Research Building, Iowa City, IA 52242, USA
* Corresponding author. Department of Psychiatry, The University of Iowa, 200 Hawkins Drive, Iowa City, IA 52242.
E-mail address: jess-fiedorowicz@uiowa.edu

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suicide remains the second leading cause of death behind unintentional injury. For those aged 35 to 54 years, it is the fourth leading cause of death in the United States, killing more people than liver disease, diabetes, stroke, or infection.[1]

Although suicidal ideation remains the most common psychiatric emergency encountered by mental health providers, its management and risk factors are more commonly treated by primary care providers. More than 90% of individuals who complete suicide present to their primary care provider within weeks to months of their death.[2–5] Primary care providers with practices of approximately 2000 patients, on average, lose a patient to suicide every 3 years.[6] Growing requirements for depression screening in primary care render screening, assessing, and managing suicidal ideation and behaviors a more common element of practice. However, most providers fail to screen for suicidal ideation and consider themselves unprepared to do so. When evaluating standardized patients presenting with depressive symptoms, only 36% of providers screened for suicidal ideation, with many potential barriers identified.[7] More than 40% of patients who present to primary care are hesitant to discuss their depressive symptoms, noting stigma, belief that depression is not a primary care problem, and belief that they should be able to control their own symptoms.[8] Many providers lack the time, space, access to subspecialty care, and mental health training to appropriately assess and manage suicidal patients.[9,10] In a study of 50 primary care providers who lost a patient to suicide, 88% of these patients endorsed suicidal ideation at their last visit, but such comments were at times thought to be attention seeking or not significantly different from baseline. Providers also struggled with limited access to mental health services for their patients.[5] This challenge is also described when working with adolescent populations in which risk factors are often interpreted as attention seeking or part of normal development. In younger populations, open communication can be difficult and involving a support system can be more challenging.[11]

The aforementioned challenges make the process of assessing for suicide risk a daunting task for busy practitioners. This article summarizes the latest evidence and guidelines for suicide risk assessment and management with a focus for application in busy outpatient settings.

CHALLENGE

Suicidal ideation and behaviors, akin to the symptoms of an acute coronary syndrome or stroke, require immediate attention. However, unlike their vascular emergency counterparts, no evidence-based algorithms exist to reliably assess, manage, and prevent suicide.[12] The low frequency of suicide is partly responsible for this difficulty. Suicides accounted for 1.6% of all deaths in the United States in 2014. Even in a high-risk demographic, such as older men, the overall prevalence of suicide is very low, particularly within a narrow time frame. Even when protocols have been applied to an inpatient psychiatric population with a high baseline risk for suicide, positive predictive values remain less than 11%.[13] Adding to the complexity, the impact of many of the variables associated with suicide at a population level may vary at the level of the individual. For instance, marriage is generally protective of suicide,[14] but for a given patient it may be a key stressor driving suicidal thoughts, the primary reason to not act on suicidal thoughts, and everything in between. This possibility necessitates a contextual model of clinical decision making in what has been called the quintessential clinical judgment.[15]

Although the ability to predict suicide may seem grim, there has been increasing evidence that education of primary care providers, population-based suicide prevention strategies (such as media desensationalization and gun reform), and collaborative