# Suicide prevention for physicians: identification, intervention and mitigation of risk

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## Abstract

General physicians and general practitioners are at the front line of suicide prevention, and patients are commonly assessed or admitted to emergency department and medical wards following self-harm. The rate of suicide is low, making it hard to determine who is at risk. Traditional suicide risk assessment tools relied mainly on demographic risk factors, despite decades of research failing to find clinically meaningful associations. Reliance upon risk factor identification fails both clinicians and patients. Prediction studies offer no clinical usefulness for individual patients, as even risk factors associated with the highest odds ratio and a significant statistical correlation may not be clinically useful when assessing individuals. Self-harm and suicidal thoughts should be taken seriously and always met with empathy and understanding. Instead of focusing on quantifying and characterising suicide risk so it can be 'managed', the emphasis is on identifying individual risk factors, needs and strengths, instilling hope and empowering individuals to seek and accept support. Suicide is preventable; we need a new narrative away from 'characterising, quantifying and managing risk' and greater focus on 'compassion, safeguarding and safety planning'. We provide an overview of current research and offer clinically useful suggestions and resources to support clinical encounters.

**Keywords** Compassion; safety plans; self-harm; suicide; suicide mitigation; suicide prevention

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## Key points

- Do not be scared to ask about self-harm or suicidal thoughts — this is the first step in reducing the likelihood your patient will die by suicide. All patients who self-harm or experience suicidal thoughts, however 'minor', require a co-produced safety plan
- We strongly advise all physicians to undertake suicide awareness and intervention training
- Document the date, time and important factors in the history and examination. 'If you did not document it, then you did not ask it'

## Why is this important?

In the UK in 2014 (the latest date for which data are available) >6100 people died by suicide, of whom three-quarters were men. This total is >3 times higher than the number of deaths from road traffic accident deaths. Suicide is the biggest killer of men <50 years in the UK, accounting for one in four deaths in men <35 years of age. Non-fatal self-harm (with or without suicidal intent) is one of the most common reasons for presentation to an emergency department (ED) and acute hospital admission. There are >200,000 hospital attendances following self-harm in England every year.

## Suicidal thoughts and suicidal acts

Suicide is not the inevitable outcome of suicidal thoughts. Suicidal thoughts occur in response to emotional and physical pain. The vast majority of suicidal people are highly ambivalent about living and dying, but the degree of their emotional pain sometimes prevents them considering alternative options to suicide. They do not necessarily wish to end their life; they are just unable to see any other way to deal with the situation.

## Importance of assessment following self-harm or a suicide attempt

Although most people who self-harm do not intend to end their life, self-harm increases the risk of future suicide (Table 1), which is why every episode of self-harm needs to be taken seriously. Guidelines from the National Institute of Health and Care Excellence recommend that all patients should be given a psychosocial assessment following self-harm; this in itself can reduce repetition of the behaviour. In general hospitals, staff can minimise the risk of early self-discharge through compassionate engagement with patients who attend following self-harm.

## Assessing a patient at risk of suicide

A recent *British Medical Journal* review of suicide risk assessment and intervention in people with mental illness illustrates that risk assessment tools placing particular emphasis on demographic factors are unable to predict suicide risk accurately and should not be relied on.[1] The current approach to risk

### Assessment of suicidal thoughts

- Suicide intent lies on a continuum from fairly common vague, passive suicidal thoughts to rarer high suicide intent/high lethality suicidal acts.
- All aspects of suicidal thoughts need to be identified:
  - Perception of the future as persistently negative and hopeless
  - Nature of the suicidal thoughts i.e. frequency, intensity, persistence, etc.
  - Degree of suicide intent: planning and preparation for suicide attempt
  - Putting affairs in order
  - Ability to resist acting on their thoughts of suicide or self-harm

Source: Based on the CK Continuum & CK Classification Cole-King 2010. Included with kind permission from Connecting with People.

**Table 1**

assessment and responding only to individuals identified as 'high risk' is fundamentally flawed. Furthermore, we suggest that the use of terms such as 'low risk' or 'high risk' is unreliable, open to misinterpretation and unsafe.

Demographic risk factors increase the suicide risk of a whole population across its lifetime, but do not predict suicide in an individual at a single time point. The absence of risk factors does not mean an absence of risk of suicide.[2] For a variety of reasons (e.g. stigma, shame, fear, embarrassment) people may conceal or minimise their suicidal thoughts.

Assessing a patient at risk of suicide requires a bio-psychosocial assessment, including details of their suicidal thoughts, intent and plans, personal and demographic information, and a mental state examination. Every contact made by a suicidal individual represents an opportunity to intervene and prevent the individual going on to die by suicide. Although up to 90% of suicide deaths are likely to have occurred in conjunction with a mental illness or substance misuse,[3] less than a third of people who die by suicide in the UK have had contact with specialist mental health services in the 12 months before their death (National Confidential Inquiry 2010, see further reading). A large proportion of those who have not had such contact will, however, have been seen in primary care or at a general hospital. *As long as suicide is seen as the preserve of specialist mental health services, opportunities for intervention will be missed.*

## The importance of compassion and suicide mitigation

The pervasive expectation that risk must be controlled, and preferably eliminated, might paradoxically increase rather than reduce 'suicide risk'. This is because it can drive risk 'underground' and make practitioners reluctant to identify patients at risk of suicide for fear that they will be unable to 'manage suicide risk'. 'Suicide mitigation' is a more helpful approach than 'suicide risk management'.[4] Suicide mitigation starts from the assumption that the expression of suicidal thoughts always needs to be taken seriously and met with empathy and understanding. Increasing hopefulness, resilience and reasons for living have been shown to reduce suicide risk.

Having a discussion about suicide is potentially lifesaving, but the clinical encounter is heavily dependent on what the patient chooses to reveal or keep hidden. In the assessment process we rely on our patient to trust us with often painful and difficult disclosure of their suicidal thoughts. The establishment of a therapeutic alliance and trusting relationship between professional and patient is essential if the latter is to disclose suicidal thoughts and permit the clinician to make a sound psychosocial assessment; it can also be a protective factor against suicide.[2,4] For a variety of reasons (e.g. stigma, shame, fear or embarrassment) people may conceal or minimise their suicidal thoughts. Healthcare professionals who are empathetic and compassionate encourage increased disclosure by patients about their concerns, symptoms and behaviour, and are ultimately more effective at delivering care.[5]

## How to ask about suicidal thoughts

- Encourage the individual's engagement through application of a non-judgemental, empathic and confident approach.
- Be aware of body language (both yours and the patient's).
- Start with open questions, followed by closed specific questions about suicide intent (Tables 2 and 3).

Clinicians can gain useful and important information from third parties, such as family, friends or first responders, in addition to any objective evidence, particularly if someone has self-harmed or attempted suicide. Examples of objective evidence include making plans or preparations for suicide, choice of method (if there has been a suicide attempt or self-harm), attempts to avoid discovery, and a written note or will.

## Risk factors and 'red flag' warning signs

The clinician should be familiar with established risk factors and risk groups (Table 4) for suicide at a population level, but should not rely wholly on this knowledge when assessing risk in specific individuals. Thus, a person may be at risk of suicide even though not a member of a high-risk group.

Conversely, not all members of high-risk groups are equally at risk of suicide. Moreover, suicidal thoughts (and risk) can vary across a relatively short time period. The assessment of suicide risk by the clinician needs to be individually focused and carried out regularly. The strongest risk factor for acting on suicidal thoughts in high-income countries is a mood disorder, particularly if accompanied by substance abuse and/or stressful life

### Importance of asking about a plan

- In the World Health Organisation World Mental Health Survey Initiative ($n = 84{,}850$), 29% of people with suicidal thoughts went on to make a suicide attempt, usually within a year of onset of the thoughts
- There was a 56% probability of a suicide attempt if the individual also had a suicide plan
- There was a 15.4% probability of a suicide attempt if they did not have a suicide plan

Source: Nock, M, Borges, G, Bromet, EJ et al. 2008 Cross-national prevalence and risk factors for suicidal ideation, plans and attempts. The British Journal of Psychiatry Jan 2008, 192 (2) 98–105; **DOI:** http://dx.doi.org/10.1192/bjp.bp.107.040113.

**Table 2**