

Depressed Patients: Potential Risk for Suicide

Information for Primary Health Care Professionals

The contents of this document are for informational and educational purposes only. It is not a complete guide for the care of patients with depression who are at risk of suicide. This document is not intended to be a substitute for professional medical advice, diagnosis, or treatment.

This guidebook is specifically designed for physicians who treat patients with depression. It provides information about patients who may be at risk for suicide, how you may assess the potential for suicide, and some potential interventions for treating these patients.

Suicide—an International Dilemma

According to a report on violence and health issued by the World Health Organization in 2002, as many as 815,000 people worldwide killed themselves in 2000. That approximates one person committing suicide every 40 seconds.¹ Clearly, suicide is a major public health problem worldwide.²

In the United States alone, suicide is estimated to account for 30,000 deaths per year. Suicide ranks as the eighth leading cause of death with approximately 75 suicides per day.³

You're in a Unique Position to Intervene

Patients with thoughts of suicide are not uncommon in a primary care setting. In fact, on average, 45% of suicide victims have contact with primary care providers within one month of suicide.⁴

As a primary care physician, you probably know your patients medically better than anyone else, and most likely, you have already earned their trust. If there are changes in mood or appearance, or simply in the way they present, you may be most likely to see it. If you determine there is a risk of suicide, you're the best person to help this patient until other resources can be identified and a complete psychiatric assessment can be performed. Whenever you encounter a patient you feel is at risk for suicide, remember—this is an opportunity to intervene, to help save a life.

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Factors Associated With Risk for Suicide

There are many factors that play an important role in suicide. As you might suspect, the presence of a mental illness is the primary predictor of suicide. In a retrospective analysis using a psychological autopsy approach, investigators found that up to 87% of suicide victims suffered from a depressive disorder, confirming major depression as a primary risk factor for suicide in men and women.^{5,6}

Most of the information we have about suicide and the risk factors associated with it is obtained through interviews with people who attempted suicide, but, for one reason or another, failed.

The following are the most important suicide risk factors to watch for^{3,7}:

- **Age:** Suicide rates increase with age.
- **Gender:** Men are more likely to commit suicide than women. (Although suicide attempts are higher among women, men complete the suicide more often.)³
- **Previous suicide attempts:** Approximately 40% of attempters have made a previous suicide attempt.³
- **Alcohol dependence:** The suicide rate among people with alcohol dependence is much higher than that of people without alcohol dependence.³
- **Organized plan:** The more definite and detailed the plan and the easier the access to the means to accomplish the suicide, the greater the risk.⁷
- **Illness:** Patients with serious physical illness, such as breast cancer, multiple sclerosis, or AIDS, are at increased risk.³
- **Lack of social support:** People who are divorced or have had a marital separation, are widowed or single, live alone, are unemployed or retired, or experienced a recent bereavement are at increased risk.³
- **Family history** of suicide increases the risk.³
- **Coexisting personality disorders**, such as borderline and antisocial personality disorders, increase the risk.³
- **Impulsiveness, aggression, or violent behavior**, particularly in those with access to a weapon, increases the risk.³

Suicide results in over 800,000 fatalities every year.

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Asking Questions About Suicide

Physicians may feel uncomfortable asking about suicidal thoughts because they feel unprepared to respond to the patient's answer. Don't worry that asking a patient about their suicidal intentions will put the idea in their head. Discussing ideas or plans for suicide may help relieve the anxiety a patient may be feeling and establish a safe environment for a full assessment. Asking the patient to talk about his or her plan or thoughts may help you determine if the patient has the intent and the means to commit suicide.

Ask Questions at Each and Every Patient Encounter

More often than not, evaluating a patient for suicide depends on your subjective clinical judgment. However, familiarity with the risk factors will allow you to better recognize patients at increased risk for suicide. Sometimes patients may give nonverbal and/or verbal cues that can trigger more in-depth questioning.

Nonverbal cues may include

- Downcast eyes.
- Psychomotor retardation of speech or movement.
- Less attention to appearance.

Verbal cues may include comments like

- "I don't think I can take this much longer."
- "The world would be better off without me."

You might begin a discussion with something as simple as, "I notice you seem sad today" or "You don't seem yourself today. Is something troubling you?" Asking about family life, school, work, or relationships may give patients the opportunity to express suicidal thoughts. It's important to ask questions at each and every patient encounter.

Here are a few more probing questions that may help you begin assessing the likelihood of suicide in a particular patient:

- "Other people with similar problems sometimes lose hope. Have you?"
- "With this much stress, have you thought of hurting yourself?"
- "Have you ever thought of killing yourself? How would you do it?"
- "What has kept you from acting on these thoughts?"

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Common Methods and Means of Suicide

According to the *Diagnostic and Statistical Manual of Mental Disorders*, up to 15% of individuals with severe major depressive disorder die by suicide.⁸

Some of the more common methods of suicide include⁹

- Drug overdose.
- Firearms.
- Gas poisoning, such as motor vehicle exhaust.
- Hanging, strangulation, suffocation.
- Jumping from a height, such as a building or a bridge.
- Poison.
- Wrist cutting.

Existence of a plan and a method for committing suicide is considered a significant indicator of a high risk of suicide.

Many people have a preference for a given means based on the following factors¹⁰:

- Availability.
- Certainty of death.
- Discovery of the body (eg, by loved ones or strangers).
- Dramatic impact.
- Familiarity with the method.
- How much planning is required (eg, buy a gun, hoard pills).
- Likely pain involved.
- Scope of concealing or publicizing death (ie, insurance or shame).
- Technical skills needed (eg, how to shoot a gun).
- The time it takes to die while conscious.

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Potential Interventions

If you determine your patient is at risk for suicide, the patient's safety should be the primary focus. Depending on the severity of the risk, psychiatric hospitalization should be considered. Determine what crisis support is available on a local basis—the emergency department of a local hospital or a mental health crisis center—and make sure phone numbers are readily available to the patient, family, and/or caregivers.

Care of a patient at risk for suicide should be undertaken only by a physician with the appropriate training and experience. The following are some practical interventions that may be beneficial in helping your patients.

1. Establish and maintain a therapeutic alliance.

A cooperative doctor-patient relationship is important. Treatment management is a dynamic process, shaped by and communicated between the patient and the involved caregivers to explore changing information or behaviors, adherence to treatment, and progress. Increase the number of office visits, and make sure the patient's condition can be reassessed on a frequent basis, even if it's through a phone contact.

2. Begin a thorough and organized treatment plan that targets the underlying psychiatric illness.

Chronic thoughts of suicide must be considered part of a serious psychiatric illness, like depression, and appropriate treatment for the illness should be initiated as clinically warranted. Treatment may include psychotherapy, medication, patient education, and/or self-help techniques.

3. Help the patient establish a support network.

If you determine that the risk of suicide is not imminent and feel that the patient can be treated on an outpatient basis, it is a good idea to make sure a support network is in place. This could be a family member, a friend, a caregiver, or even a social worker—someone who can check in on the patient between office visits and make sure the treatment plan is strictly followed. Make sure the patient and support network know what to do if suicidal thoughts occur and if there is access to a crisis prevention help line.

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Potential Interventions (con't.)

4. Identify and remove the potential means to commit suicide.

Family members and friends can be extremely helpful in identifying and removing possible vehicles for committing suicide, such as poison or guns, and prevent access by the patient. A common method of suicide is drug overdose. Medication can be stockpiled and used to accomplish the suicide act. Therefore, consider the following:

- Get a list of all the medications the patient is taking.
- Ask the patient to bring in all medications, including over-the-counter medications.
- Write prescriptions for the smallest quantity consistent with good patient management.

5. Prepare a Suicide Prevention Contract.

The Suicide Prevention Contract, also known as a no-harm contract, a no-suicide contract, or a safety contract, is simply an agreement in which patients promise not to harm or kill themselves. Contracts may be verbal or written. They can be renewed as needed.

Generally, they contain an explicit statement not to harm oneself, a specific duration of time, and a contingency plan should suicidal ideation occur. The most effective contract is the one the person writes and signs. Some clinicians ask their patients to read the contract out loud and then repeat it back in their own words to make sure the patients truly understand what they are committing to.¹¹

A Suicide Prevention Contract should never be considered a substitute for a comprehensive suicidal risk assessment or clinical vigilance. Although Suicide Prevention Contracts are commonly used in clinical practice, there are no studies to substantiate their effectiveness in reducing suicide.

6. Help patients learn about their illness and what they can do to help themselves.

Provide educational materials, self-help materials, and other resources, such as Web sites, where patients can learn about their illness.

***Write prescriptions for the smallest quantity
consistent with good patient management***

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American Foundation for Suicide Prevention (AFSP)

120 Wall Street, 22nd Floor
New York, NY 10005
Toll-Free Phone: 1-888-333-2377
www.afsp.org

Families for Depression Awareness

395 Totten Pond Road, Suite 404
Waltham, MA 02451
Phone: 1-781-890-0220
www.familyaware.org

National Institute of Mental Health (NIMH)

Public Information and Communications Branch
6001 Executive Boulevard,
Room 8184, MSC 9663
Bethesda, MD 20892-9663
Toll-Free Phone: 1-866-615-6464
www.nimh.nih.gov

Mental Health America

2000 N. Beauregard Street, 6th Floor
Alexandria, VA 22311
Toll-Free Phone: 1-800-969-6642
www.mentalhealthamerica.net

American Psychological Association

750 First Street, NE
Washington, DC 20002-4242
Toll-Free Phone: 1-800-374-2721
www.apa.org

National Alliance on Mental Illness (NAMI)

Colonial Place Three
2107 Wilson Boulevard, Suite 300
Arlington, VA 22201-3042
Toll-Free Phone: 1-800-950-6264
www.nami.org

American Counseling Association (ACA)

5999 Stevenson Avenue
Alexandria, VA 22304
Toll-Free Phone: 1-800-347-6647
www.counseling.org

American Mental Health Counselors Association (AMHCA)

801 North Fairfax Street, Suite 304
Alexandria, VA 22314
Toll-Free Phone: 1-800-326-2642
www.amhca.org

Association for Behavioral and Cognitive Therapies (ABCT)

305 Seventh Avenue, 16th Floor
New York, NY 10001-6008
Phone: 1-212-647-1890
www.abct.org

American Psychiatric Association

1000 Wilson Boulevard, Suite 1825
Arlington, VA 22209-3901
Phone: 1-703-907-7300
www.psych.org

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References

1. World Health Organization. World Report on Violence and Health: Summary. Geneva, Switzerland; 2002:19-20.
2. Kumar CT, Mohan R, Ranjith G, et al. Characteristics of high intent suicide attempters admitted to a general hospital. *J Affect Disord.* 2006; 91:77-81.
3. Roy A. Psychiatric emergencies. In: Sadock BJ, Sadock VA, eds. *Comprehensive Textbook of Psychiatry.* Vol I. 7th ed. Philadelphia, PA: Lippincott Williams & Wilkins; 2000:2031-2040.
4. Luoma JB, Martin CE, Pearson JL. Contact with mental health and primary care providers before suicide: a review of the evidence. *Am J Psychiatry.* 2002;159(6):909-916.
5. Schneider B, Wetterling T, Sargk D, et al. Axis I disorders and personality disorders as risk factors for suicide. *Eur Arch Psychiatry Clin Neurosci.* 2006;256:17-27.
6. Cheng AT. Mental illness and suicide. A case-control study in east Taiwan. *Arch Gen Psychiatry.* 1995;52:594-603.
7. Hirschfeld RM, Russell JM. Assessment and treatment of suicidal patients. *N Engl J Med.* 1997;337(13):910-915.
8. Mood disorders. In: *Diagnostic and Statistical Manual of Mental Disorders-Text Revision.* 4th ed. Washington, DC: American Psychiatric Association; 2000:345-376.
9. American Psychiatric Association. *Assessing and treating suicidal behaviors. A quick reference guide.* 2003.
10. Daigle MS. Suicide prevention through means restriction: assessing the risk of substitution. A critical review and synthesis. *Accid Anal Prev.* 2005;37:625-632.
11. Goin M. The "Suicide-Prevention Contract": A Dangerous Myth. *Psych News.* 2003;38(14):3.