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Mental Health NHS Trust

NHS

Suicide Risk

A guide for Primary Care and Mental Health Staff

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Suicide Risk
A guide for Primary Care and Mental Health Staff

This booklet presents information on suicide, and offers guidance to primary care and mental health staff on suicide risk assessment and management.

The booklet is in easily accessible sections that can be used independently for reference, or together for an overall guide.

Contents

1. Introduction to Suicide Risk Assessment

Suicide isn't that rare

Suicide is not a rare occurrence. Suicide rates in young men have doubled in the past decade, and the recent Department of Health survey of suicide and homicide (Appleby, 2001) found that there were approximately 2000 deaths from suicide per year in England and Wales. Men are three times more likely than women to commit suicide.

Suicide and British health policy

- A target for British mental health policy in 1998 was to reduce suicide and death from undetermined injury by at least a further fifth by the year 2010 (Stationery Office, 1998)

- In response to this target, Standard seven in The National Service Framework for Mental Health (Department of Health, 1999) concerns suicide prevention and this includes:

  - Ensuring that primary care staff are able to assess and manage depression, including the risk of suicide.

  - Ensuring that mental heath staff are competent to assess the risk of suicide among people at the greatest risk.

  - Training in risk assessment and management is a priority for staff in mental health and primary care services, and should be updated every three years.

Suicide prevention in primary care and mental health services: needs and opportunities

- 1 in 4 people who subsequently committed suicide were found to have been in contact with mental health services in the year before their death.
- More than one in ten people with severe mental illness commit suicide.
- Suicide risk is also raised for people with depression or after a major loss.
- In-patient suicides in psychiatric wards are becoming more frequent.
- Recent discharge from psychiatric hospital is a high risk factor.
- In most of these cases staff perceived the immediate risk of suicide for these patients, prior to discharge, to be low.
- The number of visits to GPs usually increases significantly before committing suicide.

(Department of Health, 1999)

These facts mean that primary care and mental health staff have the potential to make a real contribution to suicide prevention.

The challenge for primary care and mental health staff

The challenge is to reduce suicide rates by:

- Assessing risk for an individual rather than the population (Men are three times more likely to commit suicide than women, but which men?)
- Improving the care provided to people identified as at high risk.

2. An Approach to Risk Assessment

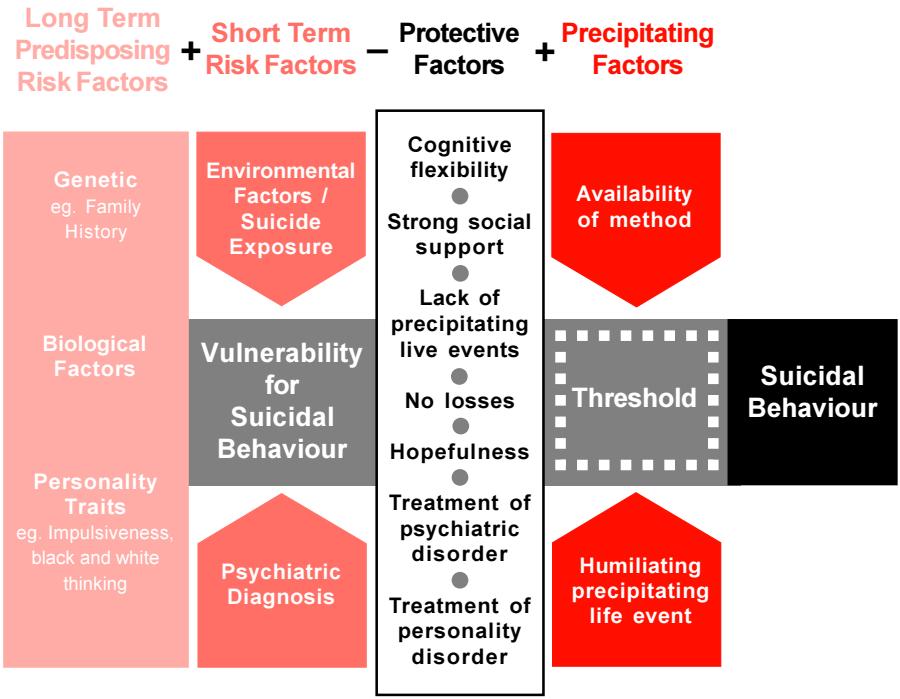
Risk factors are important because:

- They provide guidelines for clinical judgement and health care policy
- They allow early detection of symptoms and more accurate risk assessments, and thus aid prevention
- They allow intervention plans to be devised which address the individual's needs and circumstances

Pulling factors together: The Threshold Model

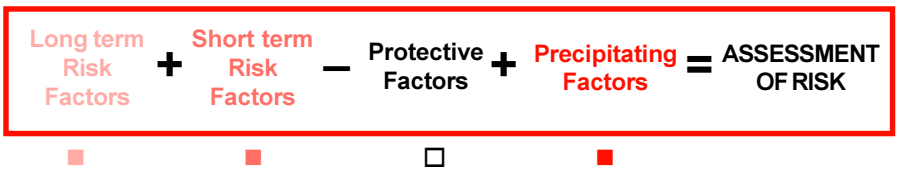
The Threshold Model shows how different types of risk and protective factors interact to produce a threshold for suicidal behaviour for the individual. The different types of factors are:

- **Long term predisposing risk factors** that can be present at birth or soon after birth → these identify people who are in risk groups
- **Short term risk factors** that can develop later in life → these may predict when someone is most likely to commit suicide
- **Precipitating risk factors** which occur due to a recent life event or access to a method of committing suicide → these allow a more immediate assessment of risk
- **Protective factors** that may be long or short term → these can offset risk



The model provides a framework for synthesising and evaluating the wide range of information needed to assess suicide risk for an individual.

The model can be summarised:



Risk, protective and precipitating factors

Long-term Risk Factors

Genetic or biological influences

- Family history of suicide or attempted suicide.
- Family history of depression.
- Family history of alcohol or other substance misuse.

Personality traits

- Black and white or all or nothing thinking.
- Rigid thinking, characterised by patterns of thought that are difficult to change.
- Excessive perfectionism, with high standards causing distress to the person or others.
- Hopelessness, with bleak and pessimistic views of the future.
- Impulsivity, tending to do things on the spur of the moment.
- Low self-esteem with feelings of worthlessness.
- Poor problem solving skills, with difficulty in thinking of alternative solutions.

Short-term Risk Factors

Environmental factors

- Divorced, separated or widowed.
- Being older and/or retired.
- Having few social supports.
- Being unemployed.

Psychiatric diagnosis

The three psychiatric disorders most strongly correlated with suicide are:

- Depression.
- Substance misuse (including alcohol).
- Schizophrenia.

Other psychiatric disorders that should be taken into account are:

- Personality disorders.
- Obsessive-compulsive disorder.
- Panic attacks or panic disorder.

Protective Factors

The absence of risk factors is protective. Additional protective factors are:

- Hopefulness.
- Receiving mental health care.
- Having responsibility for children.
- Having strong social supports and feeling supported.

Precipitating Factors

These are events that may tip the balance when a person is at risk. The include:

- Imprisonment or threat of imprisonment.
- Interpersonal problems, particularly humiliating social events.
- Recent job loss.
- Recent house move.
- Recent loss or separation.
- Recent reminders of past deaths or other significant losses.
- School or work problems.
- Unwanted pregnancy.

Suicide risk in depression

Depression is a strong short term risk factor for suicidal behaviour, particularly when it is unrecognised or untreated. Identifying and assessing depression and the associated risk is therefore vital.

Symptoms

What follows is a checklist of the most common symptoms of depression. If at least 3-5 of the symptoms below have been present for at least two weeks the person is likely to be suffering from clinical depression:

- ☐ depressed mood
- ☐ loss of interest and enjoyment
- ☐ increased fatigue or loss of energy
- ☐ appetite or weight disturbances
- ☐ disturbed sleep
- ☐ ideas of self harm or suicide
- ☐ reduced concentration and attention
- ☐ reduced self esteem and self confidence
- ☐ feelings of guilt, pessimism, no hope for the future

Factors that increase suicide risk in depressed people

- aged below 25 years
- aged over 65 years
- male
- misuse of alcohol
- manic-depression
- feelings of hopelessness
- self-neglect
- persistent insomnia
- severe depression
- impaired memory
- agitation
- anxiety
- panic attacks
- late onset of depression

World Health Organisation (2000)

3. The Process of Assessment

There are various scales to assess suicide risk that cover mental health state, symptoms and intent. However, they do not cover predisposing and precipitating factors.
A clinical interview should aim to gain a wide range of useful information in line with The Threshold Model.

Key stages in applying the Threshold Model to suicide risk assessment are:

1 Establish **rapport**; a trusting relationship is essential and can encourage disclosure of important information. Particularly important is listening with empathy, which in itself can reduce despair.

2 Enquire about **current mental health,** physical health and substance problems. Few social supports, recent loss and mental health problems, notably serious depression, can constitute important **short-term risk factors**.

3 Establish the **problem history** and previous methods of **coping** with similar problems. These factors contribute to assessing personality and are relevant to **long-term risk factors**. Poor problem solving, impulsiveness and rigid or black and white thinking are personality features that confer risk.

4 Seek information on **supports**, including the availability and the kind of help provided by family and friends, and any other services that are being accessed. It is very important to enquire about the person's current ways of coping with the difficulties. Also enquire about responsibilities for other people. All of this information helps to assess **protective factors**.

5 Ask about **current circumstances**, including other current and recent problems, life events and worries. Investigate available means for suicide. This information will help with assessing possible **precipitating factors**.

6 Assess the existence and specificity of any **plans** for suicide, including any nearby dates that have special significance for the person. Investigating the availability of means to commit suicide is very important at this stage. This information will help to assess **suicidal intent**.

Weighing up all of the information obtained through these stages will help you to judge how close the person is to his or her **threshold** for suicidal behaviour. This is your assessment of risk.

4. Managing Suicide Risk

Managing suicide risk is inseparable from risk assessment. Management techniques differ depending on the assessed level of risk. Key elements in order of ascending risk are:

Low risk

1. If risk is low, maintain **usual contact** arrangements.
2. A **counselling approach** is useful in promoting engagement and encouraging the patient to take shared responsibility for their future care and safety. The FRAMES approach to brief counselling is summarised bellow.
3. If you are concerned or anxious **seek advice from colleagues** or people in other nearby services. Difficult clinical judgements are unavoidable, and they can be greatly aided by discussion.
4. If your judgement is that additional help is not needed, use the person's current or **past coping methods** as the basis for advice on managing present difficulties.
5. Use the person's **existing support system** by planning with them how to engage family and friends, or with their permission, by contacting family or friends yourself.
6. Arrange **earlier contact** by telephone or an appointment if you think this would be helpful and would reduce your concerns.
7. If you feel more concerned **alert other involved professionals** and encourage the patient to make **other appropriate contacts** if necessary.
8. If you are still more concerned **refer** the person for more urgent or more specialist care as indicated. This could mean seeking an earlier appointment with a mental health professional who is already in contact, or making a referral to another service. Available services vary between localities.

High risk

9. If you are very concerned arrange **emergency help** in the form of an urgent mental health assessment or a 999 call.

In general:

- Always be aware of suicide risk
- Always keep good records
- Use the **FRAMES** approach as a counselling style to promote engagement and change:

  Feedback to the patient

  Responsibility for change lies with the patient

  Advice to change

  Menu of strategies for bringing about change

  Empathy as a counselling style

  Self-efficacy or optimism

5. Useful Information Sources

Further reading

Department of Health (2001).
Safety First: Five year report of the National Confidential Inquiry into suicide and homicide by people with mental illness

Gunnell, D., and Frankel, S. (1999).
Prevention of suicide: aspirations and evidence.
British Medical Journal, 308, 1227-1233.

Hawton, K., and Van Heeringen, K. (2000) (Eds).
The International Handbook of Suicidal Behaviour and Attempted Suicide.
Chichester: Wiley.

Milton, J., Ferguson, B., and Mills, T. (1999).
Risk assessment and suicide prevention in primary care.
Crisis, 20 (4), 171-177.

Resources

■ Useful Links

The Samaritans 08457 909090
www.samaritans.org *(e-mail address available here).*
Confidential telephone support for people in distress.

NHS Direct 0845 4647
A nurse-staffed telephone service for health advice and information.

Childline 0800 1111
Confidential telephone support for children

■ Websites

http://suicide-parasuicide.rumos.com – A good site offering helpful information for sufferers, relations of sufferers and health care professionals alike.

www.doh.gov.uk – This is the Department of Health's web site and contains statistics and information on suicide.

www.who.int – The World Health Organisation offers useful guides to suicide risk assessment for different members of mental health and primary care teams (these are also available in booklet form or can be downloaded from the internet)

www.save.org – This is a suicide awareness site including FAQs, general information on suicide, statistics, symptoms of suicide and depression, book lists and so on.

www.Depressionalliance.org – Information, advice and guidance, and support on depression.

6. Frequently Asked Questions

How do I quantify risk?

There are several published scales which can help to quantify suicide risk, but they:

- Rely on the assumption (often false) that people will disclose suicidal ideas.
- Give little attention to social, environmental and background risk factors.

A good clinical interview should gain wider and more useful information.

How do I begin to ask about suicide?

It is not easy to ask about suicide ideas; it is helpful to lead into the topic gradually with due attention to the patient, and using a counselling approach. For example:

1. do you feel unhappy and hopeless?

2. do you feel desperate?

3. do you feel unable to face each day?

4. do you feel life is a burden?

5. do you feel life is not worth living?

6. do you feel like committing suicide?

World Health Organisation (2000)

Won't talking about suicide put ideas into people's heads?

No, there is no evidence that discussing suicide is likely to precipitate suicidal behaviour. Discussing ideas openly can be one of the most helpful things to do.

When should I ask; is there a right time?

There will be a number of opportunities to begin to approach the topic of suicide and these include:

- Once a strong rapport has been established
- When the client feels comfortable about expressing their feelings
- When the client is in the process of expressing negative feelings

Should I discuss my assessment with the client?

Use a collaborative decision-making process. Interaction with the client is very important; for example the formulation of a contract showing what you both intend to do.

What about my role after my initial assessment?

Long-term management of the client's needs and continuous assessment is vital to prevent suicidal behaviour. Remember that risk factors can change over time and intervention plans should reflect this.

7. References

Appleby, L. (2001)
Safety First: Five year report of the National Confidential Inquiry into suicide and homicide by people with mental illness
London: Department of Health

Department of Health. (1999).
Our Healthier Nation: Modern Standards and Service Models
London: Department of Health

Stationery Office. (1998).
Saving Lives: Our Healthier Nation
London: The Stationery Office

World Health Organisation. (2000).
Preventing Suicide: A resource for General Physicians
Geneva: Department of Mental Health, World Health Organisation.

Local Contacts

Acknowledgements

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Jean Ruddick for help with typing.

What to look for

Symptoms of depression
Underlying psychiatric problems
I ndication of maladaptive personality features
Check life events
I ntent to commit suicide
Depression/suicide in family history
Environmental factors
Suicide attempt in the past

What to do

Avoid repeat prescribing
Counselling approach
Team discussion and supervision
I dentify risk on notes
Offer follow up or earlier appointment
Need to refer on?

P lan the next few days
L iaise with other professionals
Awareness of non-statutory services
Note informal supports
Specialist care