

Does every allusion to possible suicide require the same response?

A structured method for assessing and managing risk

Practice recommendations

- Assess patients with major depression or substance abuse for suicide ideation, as they are at elevated risk for self-harm (B).
- Severity of suicide ideation is associated with suicide risk. Its assessment, therefore, should proceed sequentially from passive to active suicide ideation, to a specific detailed plan, including intention to harm oneself, reasons for living, and impulse control (B).
- Primary care patients at mild to moderate risk for suicide can be effectively treated in primary care settings (B); however, patients at high risk should be referred to mental health specialists given their need for intensive treatments and frequent monitoring (C).

I think I'd be better off—and my family would be—if I were dead.” This surprising announcement was just made in your office by a lady who is 74 years old and suffers with chronic pain. Are her words an exaggerated expression of frustration and anger, or do they convey a real intention to harm herself? How would you explore her thoughts and feelings? What kind of follow-up is needed?

Risk of suicide must not be thought of as being merely present or absent. The

significance of risk, if present, varies along a continuum. Specific elements in a patient's history can help determine the level of risk, as can the information you glean from a structured interview process that we review in this article.

■ You are uniquely positioned to assess suicide risk

As a primary care physician, you are often in a better position to assess suicide risk than is a mental health specialist. Any patient with major depression or a substance abuse problem can be at risk for suicide. Accurately identifying suicide ideation can be complex with primary care patients who have severe medical illness, somatic symptoms of depression, pain, disability, and social and environmental adversity.

How prevalent is suicidal ideation in primary care? While most primary care patients do not experience suicide ideation, the rate of such ideation in this population is high compared with general community samples. In a review of 10 studies, any level of suicide ideation among midlife and elderly primary care patients ranged from 1% to 10% depending on the assessment method used,⁵ with rates up to 54% obtained for patients with depressive disorders.⁶

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Of suicide victims aged 55 and older, 58% visited a general physician in the month before the suicide

Suicidal patients often come to your attention first. Eleven studies¹⁵ of completed suicides found that, on average, 23% of victims aged 35 and younger and 58% of victims aged 55 and older visited a general physician in the month preceding suicide. These rates substantially exceed those seen in specialty mental health services. Since older adults and women of all ages see physicians more often than others do, they may particularly benefit from primary care assessment and intervention efforts.¹⁵

No data exist on rates of physician contact for suicide victims among ethnic minorities, but their rate may be lower given that minorities use health services at lower levels.^{16,17}

Chart reviews revealed that 60% of patient visits by those who committed suicide included psychiatric components, such as depression or worry.^{18–20} However, suicidal patients explicitly informed their physician of suicide ideation or plans in only 19% to 54% of visits.^{18,21,22}

Distinct levels of risk. According to the *Diagnostic and Statistical Manual for Mental Health*, 4th edition (DSM-IV),¹ suicide ideation ranges from thoughts that life is not worth living or that one would be better off dead (passive suicide ideation), to thoughts about harming oneself (active suicide ideation), to specific plans for committing suicide. These distinctions are important. Pronounced suicide ideation not only increases the risk for self-harm among patients with major depression,^{2,3} it may also affect time to treatment response.⁴

As level of suicide risk increases, so does the need for your attention, to determine at regular intervals whether the level of risk has changed. Even a seemingly flip remark, as portrayed at the start of this article, may signal a desperate state of mind. At minimum, further psychiatric evaluation is warranted, as patients with suicide ideation often have a psychiatric disorder, such as major depression. Patients reporting a suicide plan or intention require immediate emergency room evaluation.

To ask or not to ask?

An older study²³ found limited evidence for reliable screening of suicide ideation in general practice. A recent study²⁴ found that physicians can be trained to accurately identify suicide ideation among their depressed patients.

Can asking about suicide provoke a suicide attempt? Some clinicians think so, but we know of no studies investigating this concern.

A patient's answer predicts outcomes. Another question is whether suicide ideation needs to be assessed over and above diagnosing psychiatric disorders such as major depression or alcohol abuse. A detailed analysis of the severity of suicide ideation is needed since it is the strongest predictor of successful suicide by patients with major depression.³ Furthermore, severe suicide ideation may affect time to treatment response⁴ and thus can influence decisions about duration of treatment.

Impact on mortality unknown. A important question regarding the impact of assessing suicide ideation is whether it reduces mortality. The US Preventive Services Task Force¹² identified no study directly examining this concern.

Will your assessment of risk improve a patient's outcome?

Evidence regarding the efficacy of antidepressant medications and psychotherapy in reducing risk for suicide is limited due to the methodologic and ethical difficulties associated with studying suicide. In a systematic review of intervention studies, Gaynes et al¹² reported inconsistent findings of whether treating at-risk individuals reduces the number of suicide attempts or completions.

Interventions do, however, reduce suicide ideation, depression severity, and hopelessness, and do improve functioning.^{12,25,26} In the only study specifically targeting elderly depressed primary care patients, management of depression combined with antidepressant medication or psychotherapy reduced suicide ideation

significantly more frequently than usual care.²⁷

SSRIs and suicide. A continuing controversy is the relationship between selective serotonin reuptake inhibitors (SSRIs) and suicide attempts; a relationship possibly due to these drugs' potential for agitation and akathisia. A review of randomized controlled trials documented a more than twofold increase in nonfatal suicide attempts among patients receiving SSRIs in comparison with placebo.²⁸ A similar risk level was detected when comparing SSRIs and tricyclic antidepressants.²⁸

Suicide attempts seem to increase during the first 1 to 9 days after treatment is started.²⁹ This suggests that SSRIs do not immediately resolve depression or suicide ideation and may possibly increase risk in the first weeks of treatment. Closely monitor patients who are started on SSRIs, for symptom severity and suicide ideation (SOR: C).

Patient contracts. Suicide prevention contracts are often used to ensure that patients inform a family member or a healthcare professional if they no longer feel able to resist their suicidal thoughts. However, studies of suicide victims and attempters have found that many such patients had such a contract in place before the suicidal act.^{30,31} Thus, the American Psychiatric Association's Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors³ cautions that suicide prevention contracts should not substitute for ongoing assessment of suicide ideation.

■ Targeting your assessment and management

Given the above knowledge base, physicians have been urged to help prevent suicide through targeted assessment and management.^{32,33} The Canadian Task Force on Preventive Health³⁴ and the US Preventive Services Task Force¹² recommend assessing suicide risk for primary care patients experiencing major depres-

FIGURE 1

Sequential questions to determine level of suicide risk

1. "In the past couple of weeks, were things ever so bad that you had thoughts that life is not worth living or that you'd be better off dead?" [Passive suicide ideation]

If Yes, continue with Question 2

2. "Have you had any thoughts about hurting yourself or suicide in the past couple of weeks?" [Active suicide ideation]

If Yes, continue with Questions 2a–2g

2a. "What have you been thinking of doing?" [Type of method]

2b. "How often do you have these thoughts? How long do they stay in your mind?" [Frequency and persistence]

2c. "What is going on in your life right now?" [Life stress (eg, loss, change in health status)]

2d. "Do you have a plan for doing this?" [Specific detailed suicide plan]

2e. "Do you intend to harm yourself?" [Suicide intention]

2f. "Is there anything preventing you from harming yourself? For example, how strong is your desire to live? Do you feel you have a purpose in life? Do you have hope for the future? Do you consider suicide morally wrong or against your religious beliefs? Do you want to avoid causing family and friends pain?" [Reason for living]

2g. "Do you feel you can resist these thoughts? Have you ever done anything to harm yourself? How often do you drink alcohol or use street drugs?" [Impulse control]

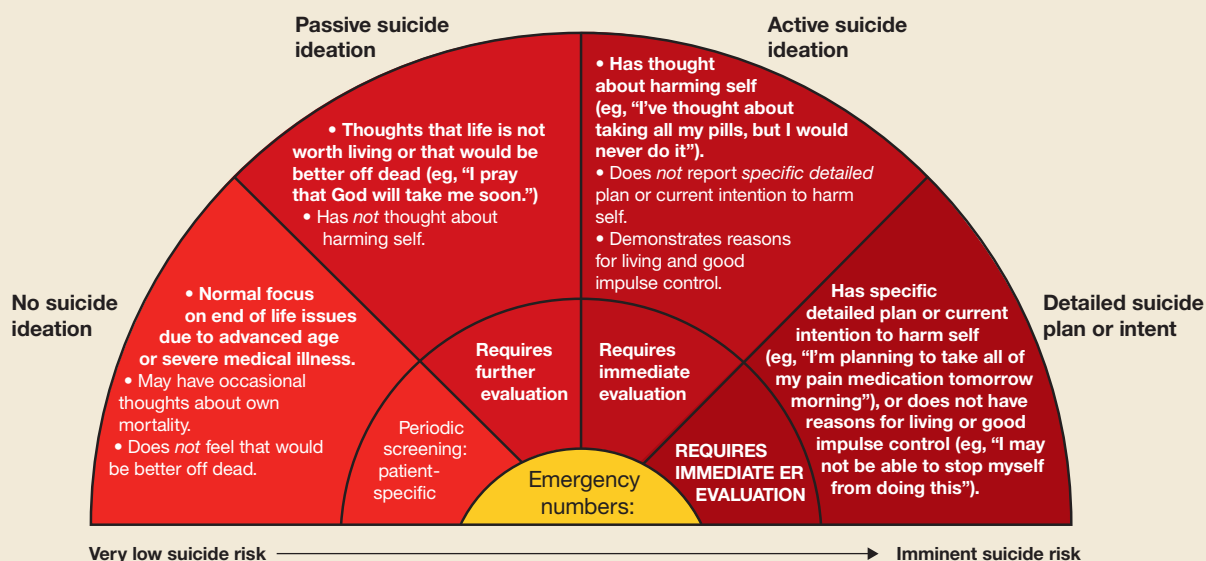
sion or substance abuse (SOR: B).

Assessment may also be appropriate for those with panic disorder or a past suicidal attempt, and for those facing life-threatening illnesses, other stressful situations, or transitional life changes (SOR: C).

In this next section, we offer a structured assessment that identifies successive levels of suicide risk and advise corresponding action steps (**FIGURE 1**).³⁵ The related visual tool (**FIGURE 2**), developed to improve depression detection by home care nurses,³⁶ is pertinent for primary care clinicians as well.

FIGURE 2

Suicide risk as a spectrum: Assessment and intervention strategies



From the educational videotape by Brown, Bruce, Raue, et al 2004.

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Asking about suicide is unlikely to provoke an attempt

Assessing suicide risk as a spectrum

Patient stigma, negative family and societal attitudes, and clinician discomfort can make depression and other emotional symptoms hard to talk about and impede appropriate screening.³⁷ This makes identifying suicide ideation all the more difficult. When should you screen, and how should you ask clinical questions?

Screening instruments can help.

Posing questions about suicide can be especially difficult during an initial visit. Therefore, you may administer a structured screening instrument such as the Patient Health Questionnaire (PHQ-9),³⁸ the Beck Depression Inventory – Primary Care version (BDI-PC),³⁹ or the Scale for Suicide Ideation (SSI).⁴⁰ Alternatively, you may use the brief clinical interview format proposed here (see also Hamilton⁴¹ and Frierson et al⁴²).

Spontaneous lines of questioning.

When a patient's particular circumstance

leads to a discussion of pain, the impact of disability, social history, or difficulties coping, it would seem only natural for you to proceed to an assessment of emotional symptoms. You may begin with questions about mood and other depressive symptoms, and then specifically inquire about suicide ideation.

Older adults and patients whose ethnic and cultural backgrounds are different than yours may be particularly challenging. Recognize a particular group's attitudes about suicide and revealing suicide ideation, and adapt assessment strategies accordingly. With older patients, for example, end-of-life discussions may serve as a way to elicit thoughts about death and dying.⁴³

Using normalizing statements. Such statements can counteract the stigma experienced by patients with suicidal thoughts. For example, you may say "It is common for people who have medical

CASE Questions to determine level of suicide risk*

Background: Mrs. Lee is a 74 year old, married, Caucasian woman with the following medical conditions: 1. severe osteoporosis, 2. fracture of vertebrae, with lower back pain, and 3. history of breast cancer, on Tamoxifen prophylactically. She reports depressed mood associated with her back pain.

Clinician: "In the past couple of weeks, were things ever so bad that you had thoughts that life is not worth living or that you'd be better off dead?"

Mrs. Lee #1: "Oh, no. I don't feel that way."

Patient denies passive suicide ideation.

Stop questioning here.

Mrs. Lee #2: "Yes, sometimes I do think that I'd be better off dead. It would be much easier for my family. I'm such a burden."

Patient endorses passive suicide ideation.

Continue questioning.

Clinician: "Have you had any thoughts about hurting yourself or suicide in the past couple of weeks?"

Mrs. Lee #2: "No. I would never hurt myself. But I sometimes wish I could just go to sleep and not wake up."

Patient denies active suicide ideation.

Stop questioning here.

Mrs. Lee #3: "The thought has crossed my mind."

Patient endorses active suicide ideation.

Continue with all remaining questions.

Clinician: "What have you been thinking of doing?"

Mrs. Lee #3: "I've thought of taking all my pills."

Clinician: "How often do you have these thoughts? How long do they stay on your mind?"

Mrs. Lee #3: "Every day or so, especially when the pain gets bad."

Clinician: "Besides dealing with the lower back pain, is there anything else going on in your life right now?"

Mrs. Lee #3: "Not really. I just can't seem to get any relief from my pain."

Clinician: "Do you have a plan to take all your pills?"

Mrs. Lee #3: "No."

Mrs. Lee #4: "No. I haven't worked up the courage yet."

Clinician: "Do you intend to harm yourself?"

Mrs. Lee #3: "No. I would never do that."

Mrs. Lee #4: "I might. I'm not sure."

Clinician: "Is anything preventing you from harming yourself?"

Mrs. Lee #3: "I guess my faith. Plus, I'd never do that to my family. It would be devastating to them."

Mrs. Lee #4: "Not really. I don't really have anything to live for."

Clinician: "Do you feel you can resist these thoughts?"

Mrs. Lee #3: "Yes. I told you I would never do that."

Patient reports active suicide ideation, but denies plan and intention.

Mrs. Lee #4: "I'm not sure. I don't know if I'll be able to stop myself from taking the pills." Patient reports active suicide ideation, and has uncertain intention, no reasons for living, and poor impulse control.

* From the educational videotape by Brown EL, Bruce ML, Raue PJ, et al. (2004): *Depression Recognition and Assessment in Older Homecare Patients*.

problems or who experience pain to have problems adjusting. Some people have emotional reactions like feeling depressed or hopeless, or even in some cases feeling like life is not worth living." Inquiring about suicidal thoughts generally won't increase a patient's distress, nor will it precipitate a suicide attempt. When performed by a concerned and sensitive clinician, this

assessment usually makes the patient feel more understood and cared for.⁵

How the process works. As shown in **FIGURE 1**, the clinician asks a series of questions to determine the patient's level of suicide risk. We suggest you ask about the prior 2 weeks, the same time frame covered in structured assessments like the PHQ-9.³⁸ Use follow-up probe questions, as necessary, to formulate a clinical judgment.

Patients endorsing question 1 are considered at minimum to experience passive suicide ideation. In this instance, you should ask question 2, which deals with active suicide ideation. If a patient endorses question 2, pose questions 2a through 2g to identify a specific detailed suicide plan and to gauge a patient's suicide intention, reasons for living, and impulse control. The **CASE** illustrates this process by presenting the same patient's alternative responses to a clinician's questions.

FIGURE 2 places the patient's responses on a spectrum of risk and assists in conveying assessment findings to mental health professionals. The horizontal axis shows the continuum of suicide risk from very low (left) to imminent (right), and the correspondingly increased attention required by health care professionals. (Printable copies of these figures are available from the authors at www.geri.u.org/suiciderisk)

The following descriptions assist in determining level of suicide risk and the associated intervention.

No suicide ideation

Presentation. Many primary care patients face end-of-life issues due to advanced age or severe illnesses. Indeed, older adults and the terminally ill are at the stage wherein occasional thoughts regarding death or mortality are normal and not pathological.⁴⁴ Suicide ideation is considered present only when patients state that life is not worth living, or that they would be better off dead. Few primary care patients report such suicide ideation.⁵

Recommendation. Psychiatric evaluation in the absence of other psychiatric symptoms is unnecessary.

Follow-up. Reassess minimal risk patients following deterioration in their medical, functional, or social-environmental situations, or when starting them on an antidepressant.⁴⁵

Passive suicide ideation

Presentation. Patients with passive suicide

ideation have frequent thoughts that life is not worth living, or that they would be better off dead—for example, praying nightly that God will take them soon. Patients at this risk level deny thoughts about harming themselves. However, as many as 10% of medical patients report such passive suicide ideation,⁵ which is a moderate risk factor for suicide.

Recommendation. Patients endorsing passive suicide ideation require further psychiatric evaluation to determine the presence of a depressive or other psychiatric disorder. You may choose to conduct this evaluation personally and, if appropriate, pursue treatment by prescribing recommended antidepressant medications.⁴⁶ Psychosocial interventions may seek to increase social contact, encourage hope, enhance ability to cope with stress and negative life events, and address meaning-of-life issues. Alternatively, you may refer such patients to psychiatrists, psychologists, social workers, or psychiatric nurses.

Follow-up. Schedule frequent visits with these patients, and assess their level of suicide risk at each office visit, particularly when the dosage of an antidepressant has been changed.⁴⁵

Active suicide ideation

Presentation. Patients with active suicide ideation have thoughts about harming themselves, with differing levels of severity whose boundaries can be imprecise. At the severity level's milder end, patients report active thoughts of self-harm but do not specify a particular method ("I feel like hurting myself, but I wouldn't know how").

Other patients may have specified a particular method for harming themselves, but lack a detailed plan or intention for doing so ("I've thought about taking all my pills, but I would never do that"). Ascertaining level of detail (for example, by asking "Which pills have you been thinking about? Have you thought about a particular time and place to take them? Have you made any preparations?") will clarify a patient's investment in harming him or herself. Insufficient

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With passive ideation, reassess level of risk often, particularly when you change antidepressant dosage

detail or specificity suggests lack of an organized plan or intent.

Patients with active suicide ideation but no detailed plan must articulate convincing reasons for living such as having a purpose in life, not wanting to cause family or friends pain, or deeming suicide morally wrong or contrary to religious beliefs so as not to be classified at the highest risk level. They must also demonstrate good impulse control, or the ability to resist acting on these thoughts. Factors such as current alcohol or substance abuse, or a history of suicide attempts may indicate poor impulse control. While only about 1% of primary care patients endorse any level of active suicide ideation,⁵ those who do are at increased risk even when reporting reasons for living and demonstrating good impulse control.

Recommendation. Patients endorsing active suicide ideation even when lacking a specific plan or intention require immediate, same-day evaluation by a mental health specialist given the clinical complexities in precisely defining level of active suicide ideation. With the patient's permission, a family member should be notified about his/her active suicide ideation. Medical ethics dictate that a family member be so informed without patient permission only when he or she is at a higher risk for suicide (see below). Primary care clinicians may directly treat patients with active suicide ideation,⁴⁶ or refer them to specialty mental health practitioners.

Follow-up. Schedule visits with patients who have active suicide ideation more frequently than visits for those with passive ideation. Assess their level of suicide risk at each office visit.

Specific detailed suicide plan or intent

Presentation. Patients who report active suicide ideation with a specific detailed plan, intention to harm themselves, no convincing reasons for living, or a lack of impulse control are classified at the highest risk level. The term "suicide plan" means a patient reports an adequately detailed

plan, as opposed to a more vaguely considered method. Given the association between suicide and firearms, especially in rural areas,⁴⁷ also be sure to assess home or workplace firearms whenever active suicide ideation is present.³ An example of this highest risk level is a patient who states, "I'm planning to take all of my pain medication tomorrow morning," or one who says, "I've been thinking about taking all of my pain medication, and I may not be able to stop myself from doing this." Very few primary care patients endorse a specific plan or intention to harm themselves,⁵ but those who do so constitute a clinical emergency.

Recommendation. Patients endorsing a specific plan or intention to harm themselves require immediate psychiatric evaluation for safety, and should be transported to an emergency department. A family member should be notified of the patient's suicide plan or intention.

Follow-up. Following emergency room evaluation and possible inpatient hospitalization, these patients should be referred to a mental health specialist for ongoing treatment and monitoring.

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Urgent psychiatric referral is needed for anyone expressing specific suicide plans

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When prescribing SSRIs, monitor suicide ideation closely in the first several days

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