

Clinical Guide

Assessment of suicide risk in people with depression

The guide was developed by the University of Oxford's Centre for Suicide Research to assist clinical staff in talking about suicide and assessing suicide risk with people who are depressed.

Introduction

This guide is intended for a range of healthcare professionals, including:

General practitioners and other primary care staff

Mental health workers

Counsellors

IAPT (Increasing Access to Psychological Therapies) therapists

Accident and Emergency Department staff

Support workers

This guide is primarily about assessing risk in adults. However, the principles can be applied to younger people (although the issues relating to consent may differ).

The guide may also be useful for reviewing the care of people, including through Significant Event Analyses.

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About this guide

How was this guide produced?

This guide was informed by the findings of a systematic review of risk factors for suicide in people with depression¹. It was also developed with input from experts in primary and secondary care.

Why is this guide needed?

Suicide is a major health issue and suicide prevention is a government priority. In the UK there are over 5000 suicide deaths per year², and nearly 500 further suicides in Ireland³. Approximately three-quarters of these occur in men, in whom suicide is the second most frequent cause of death in those under 35 years of age. The most common method of suicide is hanging, followed by self-poisoning.

Approximately 90% of people dying by suicide have a psychiatric disorder⁴, although this may not have been recognised or treated. Depression is the most common disorder, found in at least 60% of cases. This may be complicated by other mental health issues, especially alcohol misuse and personality disorders.

Clinicians working in a range of settings will encounter depressed people who may be at risk. For example, approximately 50% of those who take their own lives will have seen a general practitioner in the three months before death; 40% in the month beforehand; and around 20% in the week before death⁵. Primary care staff are therefore in a particularly important position in the detection and management of those at risk of suicide. Also, approximately a quarter will have been in contact with mental health services in the year before death⁶.

While most clinicians outside of psychiatric specialties will only experience a few suicides during their career, it is crucial that they are vigilant for people who may be at risk. It is important to recognise that the effects of suicide on families can be devastating.

The suicide of a patient can also have a profound effect on professionals involved in their care. Following a suicide they may be helping support the people bereaved by the death, dealing with official requirements (e.g. response to the coroner and other agencies), and at the same time trying to cope with their own emotional responses.

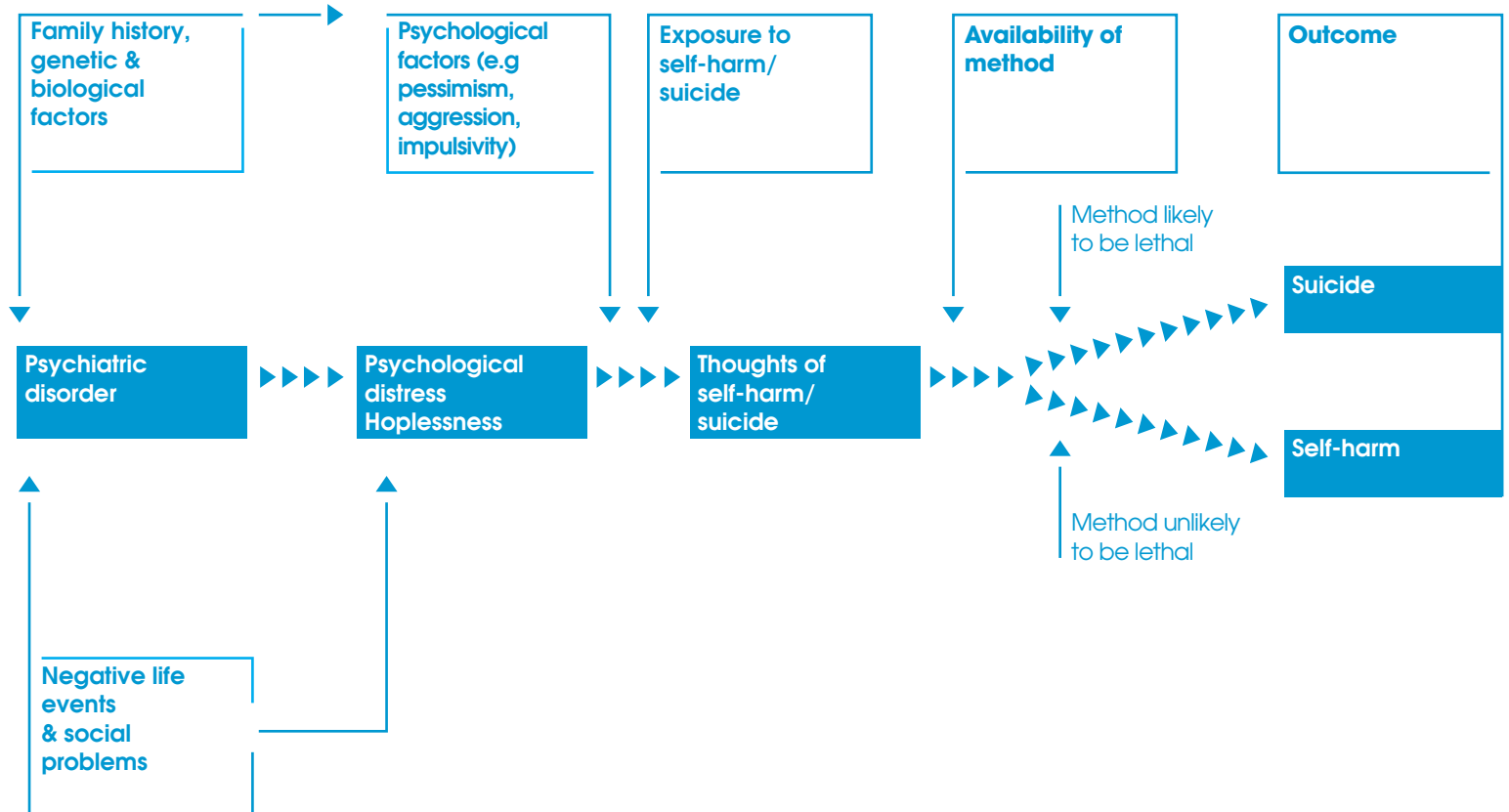
Approximately 90% of people dying by suicide have a psychiatric disorder.

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Explaining suicide

Suicide can result from a range of factors, including, for example, psychiatric disorder, negative life events, psychological factors, alcohol and drug misuse, family history of suicide, physical illness, exposure to suicidal behaviour of others, and access to methods of self-harm. In any individual case multiple factors are usually involved.

Suicide pathway model⁷



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Risk factors

No one is immune to suicide. People with depression are at particular risk for suicide, especially when factors shown in the table are present¹. Previous self-harm (i.e. intentional self-poisoning or self-injury, regardless of degree of suicidal intent) is a particularly strong risk factor. Also, a number of other risk factors for suicide have been identified and should be considered when assessing depressed individuals. It should be noted that family history of suicide or self-harm is particularly important. There are also some factors which may offer some degree of protection against suicide.

Risk factors specific to depression	Other risk factors for consideration	Possible protective factors
<ul style="list-style-type: none"> - Family history of mental disorder. - History of previous suicide attempts (this includes self-harm). - Severe depression. - Anxiety. - Feelings of hopelessness. - Personality disorder. - Alcohol abuse and/or drug abuse. - Male gender. 	<ul style="list-style-type: none"> - Family history of suicide or self-harm. - Physical illness (especially when this is recently diagnosed, chronic and/or painful). - Exposure to suicidal behaviour of others, either directly or via the media. - Recent discharge from psychiatric inpatient care. - Access to potentially lethal means of self-harm/suicide. 	<ul style="list-style-type: none"> - Social support. - Religious belief. - Being responsible for children (especially young children).

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How to assess someone who may be at risk

The interview setting

Assessment should take place in a quiet room where the chances of being disturbed are minimised. Ideally you should meet with the patient alone but also see their family/carers/friends, together or alone, as appropriate. In general, open questioning is advisable although it may become necessary to use more closed questions as the consultation progresses and for purposes of clarification. There is no definitive way to approach enquiring about suicide but it is essential that this is assessed in anyone who is depressed.

There may be circumstances under which assessment is conducted by telephone. This will clearly place limitations on the assessment procedure (e.g. access to non-verbal communication). However the principles of assessment are the same. Where feasible, a face-to-face assessment is recommended.

Asking about suicidal ideas

Some patients will introduce the topic without prompting, while others may be too embarrassed to admit they may have been having thoughts of suicide. However the topic is raised, careful and sensitive questioning is essential. It should be possible to broach suicidal thoughts in the context of other questions about mood symptoms or link this into exploration of negative thoughts (e.g. "It must be difficult to feel that way – is there ever a time when it feels so difficult that you've thought about death or even that you might be better off dead?"). Another approach is to reflect back to the patient your observations of their non-verbal communication (e.g. "You seem very down to me". "Sometimes when people are very low in mood they have thoughts that life is not worth living: have you been troubled by thoughts like this?").

There is no definitive way to approach enquiring about suicide but it is essential that this is assessed in anyone who is depressed.

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How to assess someone who may be at risk

You may want to ask about a number of topics, starting with more general questions and gradually focusing on more direct ones, depending on the patient's answers. This must be done with respect, sympathy and sensitivity. It may be possible to raise the topic when the patient talks about negative feelings or depressive symptoms. It is important not to overreact even if there is reason for concern. Areas that you may want to explore include:

- Are they feeling hopeless, or that life is not worth living?
- Have they made plans to end their life?
- Have they told anyone about it?
- Have they carried out any acts in anticipation of death (e.g. putting their affairs in order).

- Do they have the means for a suicidal act (do they have access to pills, insecticide, firearms...)?
- Is there any available support (family, friends, carers...)?

There is increasing evidence that visual imagery can strongly influence behaviour. Therefore it is worth asking whether a person has any images about suicide (e.g. "If you think about suicide, do you have a particular mental picture of what this might involve?"). While assessment of risk factors for suicide in people with depression and more generally (see sections 6 and 7) can inform evaluation of risk, it is also important for the clinicians to pay heed to non-verbal clues and their intuitive feelings about a person's level of risk.

Sometimes patients with few risk factors may nevertheless make the clinician feel uneasy about their safety. The clinician should not ignore these feelings when assessing risk, even though they may not be quantifiable.

5 Involvement of others

Where practical, and with consent, it is recommended that clinicians inform and involve family, friends or other identified people in the patient's support network. This is particularly important where risk is thought to be high.

Family and social cohesion can help protect against suicide. It is often useful to share your concerns about suicide risk, since family, friends and carers may be unaware of the danger and can frequently offer support and observation. They can also help by reducing access to lethal means, for example by holding supplies of medication and hence lowering the risk of overdose.

If the person is not competent to give consent⁸, the clinician should act in the patient's best interests. This is likely to involve consultation with family, friends or carers⁹.

6 Managing risk

When a patient is at risk of suicide this information should be recorded clearly in the patient's notes. Where the clinician is working as part of a team it is important to share awareness of risk with other team members. Out-of-hours emergency services need to be able to access information about risk easily.

It is advisable to be open and honest with patients about your concerns regarding the risk of suicide and to arrange timely follow-up contact in order to monitor their mental state and current circumstances.

Patients should be informed how best to contact you in between appointments should an emergency arise. You should encourage them to let you know if they feel worse or the urge to act upon their suicidal thoughts increases. Patients should also be given details of who to contact out of hours when you are not available. Where appropriate, reception or administrative staff may need to be alerted that a patient should be prioritized if they make contact.

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Managing risk

It is important to assess whether patients have the potential means for a suicide attempt and, if necessary, to act on this: for example, only prescribing limited supplies of medication that might be taken in overdose and encouraging family members, friends or carers to dispose of stockpiled medication. Medicines that are particularly dangerous in overdosage include tricyclic antidepressants, especially dosulepin, paracetamol and opiate analgesics. Restricting access to other lethal means (e.g. shotguns) should also be considered.

Some internet sites can be a helpful source of support for patients, but there are also pro-suicide websites and those which advise about lethal means. Patients should be asked if they have been accessing internet sites and, if so, which ones.

Suicide and self-harm can be contagious. It is worth enquiring about exposure to such behaviours, including in family, friends and in the media, and the patient's reactions to this.

Active treatment of any underlying depressive illness is a key feature in the management of a suicidal patient and should be instigated as soon as possible.

If the risk of suicide in a patient seen in primary care is high, particularly where depression is complicated by other mental health problems, referral to secondary psychiatric services should be considered. In many areas there are crisis teams which can respond quickly and flexibly to patients' needs and can arrange appropriate psychiatric support and treatment.

Many clinicians will make informal agreements with patients about what they should do if they feel unsafe or things deteriorate. More formal signed agreements are not recommended as there is a lack of evidence regarding their efficacy, and their legal status in the event of a suicide is unclear.

Regular and pro-active follow-up is highly recommended.

Clinicians seeing suicidal patients should consider access to peer support and supervision. When a clinician experiences the death of a patient by suicide they should seek support and advice to help cope with this.

Active treatment of any underlying depressive illness is a key feature in the management of a suicidal patient.

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Frequently asked questions & common myths

Does enquiry about suicidal thoughts increase a patient's risk?

No. There is no evidence that patients are suggestible in this way. In reality many patients are relieved to be able to talk about suicidal thoughts.

Do antidepressants increase the risk of suicide?

The risk of increasing suicidal thoughts and gestures following commencement of an antidepressant has received considerable media coverage. The current consensus is that there may be a slightly increased risk among those under the age of 25, where closer monitoring is required. However, the active treatment of depression is associated with an overall decrease in risk. The most successful way of reducing suicide risk is to treat the underlying depressive illness, and to monitor patients carefully, especially during the early phase of treatment.

Are there any rating scales I can use to quantify risk?

There are many rating scales which attempt to quantify risk but none are particularly useful in an individual context. They tend not to take account of the circumstances in which a person may be experiencing suicidal ideation and are reliant upon self-report.

They should therefore be used with caution and only as an adjunct to a clinical assessment. Some measures of level of depression are useful (e.g. PHQ-9, Beck Depression Inventory), some of which include items on hopelessness and suicidality. Such a measure is best used at each patient visit in order to help monitor progress (the patient might be asked to complete this in advance or in the waiting room).

When should I ask about suicide?

All patients with depression should be asked about possible thoughts of self-harm or suicide. As already noted, there is no evidence to suggest that asking someone about their suicidal thoughts will give them "ideas", or that it will provoke suicidal behaviour. When this is best asked will vary from patient to patient (see section 4: Asking about suicidal ideas).

There is no evidence that enquiry about suicidal thoughts increases a person's risk.

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Frequently asked questions & common myths

The patient doesn't want me to inform their family, friends or carers that they have had suicidal thoughts. What should I do?

This is a difficult situation as family, friends and carers play an important role in helping to support depressed individuals and in keeping them safe. It is always worth exploring why the patient is reluctant for others to be informed as you may be able to address some of their concerns. Offering to be present when they inform close ones can be helpful. Unless there is imminent risk you cannot breach patient confidentiality so ultimately you may have to respect their wishes.

The patient is always expressing suicidal ideation. When should I worry?

Chronic suicidal ideation most commonly occurs in people with personality disorders. However, this group of people is at higher risk of suicide in the long term. While it can be difficult to distinguish circumstances when ideation may transform into action it is important to try to identify any factors that may significantly destabilise the situation - for example, a relationship breakdown, loss of a key attachment figure, alcohol and/or drug misuse, or physical illness.

Should I tell the patient that I am concerned they are at risk?

In general a collaborative approach is advisable. Sharing your concerns with the patient in an empathic manner will allow them to feel listened to and allow you to both agree a plan to try and keep them safe. If psychosis is a prominent feature of the presentation this may be more difficult and may require urgent psychiatric care.

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Resources

Sources of help for patients, family, friends and carers

General

Samaritans Tel: 08457 90 90 90
<http://www.samaritans.org>

NHS 111 Tel: 111
<http://www.nhs.uk/111>

NHS Choices: depression
<http://www.nhs.uk/conditions/depression>

NHS Choices: suicide
<http://www.nhs.uk/conditions/suicide>

Royal College of Psychiatrists: Depression
<http://www.rcpsych.ac.uk/mentalhealthinfoforall/problems/depression.aspx>

Therapeutic

Mind: how to cope with suicidal feelings
http://www.mind.org.uk/help/diagnoses_and_conditions/suicidal_feelings

Beyond Blue: depression
http://www.beyondblue.org.au/index.aspx?link_id=89

Healthtalkonline: depression
 A website which explored themes around depression, with illustrative interviews
http://www.healthtalkonline.org/mental_health/Depression

CALM (Campaign Against Living Miserably)
 A website which offers support for distressed people, especially young men
<http://www.thecalmzone.net/what-is-calm/>

Papyrus
 Support for young people with suicidal thoughts
<http://www.papyrus-uk.org/support/for-you>

For relatives, friends and carers

Mind: how to support someone who is suicidal
http://www.mind.org.uk/help/medical_and_alternative_care/how_to_help_someone_who_is_suicidal

Papyrus
 Support for parents
<http://www.papyrus-uk.org/support/for-parents>

Bereavement by suicide

Help is at hand
 A resource for people bereaved by suicide and other sudden, traumatic death. Can be downloaded from:
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_116064.pdf

Healthtalkonline: bereavement due to suicide
 A website which explores themes around bereavement, with illustrative interviews with bereaved people
http://www.healthtalkonline.org/Dying_and_bereavement/Bereavement_due_to_suicide

Self-help books

Gilbert, P. (2009). *Overcoming depression: A guide to recovery with a complete self-help programme*. London: Robinson.

Veale, D., & Willson, R. (2007). *Manage your mood: How to use behavioural activation techniques to overcome depression*. London: Robinson.

Westbrook, D. (2005). *Managing depression*. Oxford: OCTC Warneford Hospital.

Williams, J. M. G. (2007). *The mindful way through depression: Freeing yourself from chronic unhappiness*. New York: Guilford Press.

Butler, G., & Hope, R. A. (1995). *Managing your mind: The mental fitness guide*. Oxford: Oxford University Press.

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Resources

Information for professionals

NICE guidance on management of depression

Depression: the NICE guideline on the treatment and management of depression in adults (updated edition)

<http://www.nice.org.uk/CG90>

Depression in children and young people: identification and management in primary, community and secondary care

<http://www.nice.org.uk/CG28>

Practical guidance for professionals

Mind: Supporting people with depression and anxiety.

A guide for practice nurses

http://www.mind.org.uk/assets/0001/4765/MIND_ProCEED_Training_Pack.pdf

National suicide prevention strategies

Preventing suicide in England: a cross-government outcomes strategy to save lives (2012)

http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_128065

Talk to me: A national action plan to reduce suicide and self harm in Wales 2008-2013

<http://www.wales.gov.uk/splash?orig=/consultations/healthsocialcare/talktome>

Choose life: National strategy and action plan to prevent suicide in Scotland

<http://www.chooselife.net/>

Protect Life: a shared vision. The Northern Ireland Suicide Prevention Strategy and Action Plan (2012- March 2014)

http://www.dhsspsni.gov.uk/phnisuicidepreventionstrategy_action_plan-3.pdf

Reach out: Irish National Strategy for Action on Suicide Prevention 2005-2014

http://www.nosp.ie/reach_out.pdf

NICE guidance on management of self-harm

Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care

<http://www.nice.org.uk/CG16>

Self-harm: The NICE guideline on longer-term management

<http://www.nice.org.uk/CG133>

Further reading

Kutcher, S. P., & Chehil, S. (2007). Suicide risk management: A manual for health professionals. Malden, Mass: Blackwell.

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Risk assessment summary of key points

All patients with depression should be assessed for possible risk of self-harm or suicide.

Risk factors for suicide identified through research studies are:

Risk factors specific to depression	Other risk factors for consideration	Possible protective factors	In assessing patients' current suicide potential, the following questions can be explored:
<ul style="list-style-type: none"> – Family history of mental disorder. – History of previous suicide attempts (this includes self-harm). – Severe depression. – Anxiety. – Feelings of hopelessness. – Personality disorder. – Alcohol abuse and/or drug abuse. – Male gender. 	<ul style="list-style-type: none"> – Family history of suicide or self-harm. – Physical illness (especially when this is recently diagnosed, chronic and/or painful). – Exposure to suicidal behaviour of others, either directly or via the media. – Recent discharge from psychiatric inpatient care. – Access to potentially lethal means of self-harm/suicide. 	<ul style="list-style-type: none"> – Social support. – Religious belief. – Being responsible for children (especially young children). 	<ul style="list-style-type: none"> – Are they feeling hopeless, or that life is not worth living? – Have they made plans to end their life? – Have they told anyone about it? – Have they carried out any acts in anticipation of death (e.g. putting their affairs in order)? – Do they have the means for a suicidal act (do they have access to pills, insecticide, firearms...)? – Is there any available support (family, friends, carers...)? – Where practical, and with consent, it is generally a good idea to inform and involve family members and close friends or carers. This is particularly important where risk is thought to be high. – When a patient is at risk of suicide this information should be recorded in the patient's notes. Where the clinician is working as part of a team it is important to share awareness of risk with other team members. – Regular and pro-active follow-up is highly recommended.

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Useful contacts

This page can be printed and given to your patient. You may wish to add any relevant local telephone numbers.

NHS 111

Website: <http://www.nhs.uk/NHSEngland/AboutNHSservices/Emergencyandurgentcareservices/Pages/NHS-111.aspx>

Telephone: 111.

Available 24 hours a day, 365 days a year.
Calls are free from landlines and mobile phones.

SAMARITANS

Website: <http://www.samaritans.org>

Email: jo@samaritans.org

Telephone: 08457 90 90 90.

Available 24 hours a day.

PAPYRUS

Website: <http://www.papyrus-uk.org/support/for-you>

Telephone: 0800 068 41 41.

The helpline is open every day of the year;
on weekdays from 10am - 5pm
and 7pm - 10pm and during the
weekends from 2pm - 5pm.

Advice for young people who may have suicidal thoughts, and parents and carers.

MIND

Website: <http://www.mind.org.uk/>

Email: info@mind.org.uk

Telephone: 0300 123 3393.

Mind helplines are open Monday to Friday,
9.00am to 6.00pm.

Local numbers/notes

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References

- ¹ Hawton, K., Casañas i Comabella, C., Haw, C. and Saunders, K. (submitted for publication). Risk factors for suicide in individuals with depression: A systematic review. This is a review of 19 studies worldwide in which risk factors have been examined.
- ² Office for National Statistics: Suicide rates in the United Kingdom, 2006 to 2010: <http://www.ons.gov.uk/ons/rel/subnational-health4/suicides-in-the-united-kingdom/2010/stb-statistical-bulletin.html#tab-Suicide-rates---Tables>, and General Register Office for Scotland: Probable Suicides: Deaths which are the Result of Intentional Self-harm or Events of Undetermined Intent (1974-2010) <http://www.gro-scotland.gov.uk/statistics/theme/vital-events/deaths/suicides/tables-and-chart.html>.
- ³ National Office for Suicide Prevention, Ireland <http://www.nosp.ie/>
- ⁴ Lönnqvist, J. (2000). Psychiatric aspects of suicidal behavior: depression. In: Hawton, K., and van Heeringen, K. (2000). *The International Handbook of Suicide and Attempted Suicide*. New York: Wiley.
- ⁵ Pirkis, J. Burgess, P. (1998). Suicide and recency of health care contacts. A systematic review. *British Journal of Psychiatry*, 173, 462-474.
- ⁶ Five-year report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2006) <http://www.medicine.manchester.ac.uk/mentalhealth/research/suicide/prevention/nci/reports/avoidabledeathsfullreport.pdf>
- ⁷ Adapted with permission from: Hawton, K., Saunders, K. E. A. and O'Connor, R. C. (2012). Self-harm and suicide in adolescents. *Lancet*, 379, 2373-2382.
- ⁸ General Medical Council confidentiality guidance (2009) http://www.gmc-uk.org/guidance/ethical_guidance/confidentiality.asp
- ⁹ Mental Capacity Act 2005 <http://www.legislation.gov.uk/ukpga/2005/9/contents>

This guide was developed at the Centre for Suicide Research at the University of Oxford by Professor Keith Hawton, Carolina Casañas i Comabella, Dr Kate Saunders and Dr Camilla Haw, with the following general practitioners: Dr Kate Smith, Dr Deborah Waller and Dr Ruth Wilson, and with the assistance of several other clinicians with a range of professional backgrounds. It has been funded by the Judi Meadows Memorial Fund and Maudsley Charity.

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