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How to Assess and Ensure the Safety of Your Suicidal Patients

Every year, more than 30,000 people in the United States and approximately one million people worldwide die by suicide (Nock, et al., 2008), making it one of the leading causes of death. In the time leading up to suicide, contact with primary care providers is common: Approximately 45% of suicide victims are known to have had contact with a primary care provider in the month prior to their suicide (Luoma, Martin, & Pearson, 2002). Therefore, it is crucial for family physicians to be aware of the risk factors and warning signs of suicide. Many of the risk factors have been identified, and we will review the most important ones here. As part of the assessment process, protective factors (resources) must also be explored. We will outline a method of assessment, organized around exploring these risk and protective factors that involves an interview of the patient with the goal of obtaining an empathic understanding of the patient's circumstances and state of mind. We will then describe the decision-making process that goes into determining whether a particular patient needs to be hospitalized to avoid self- harm or can safely be referred to a mental health professional for outpatient treatment. If the latter decision is made, the physician and patient should then collaboratively develop a safety plan.

Risk Factors

Numerous research studies have established that people diagnosed with mood disorders have a greatly elevated risk of suicide. One study (Osby, Brandt, Correia, Ekbom, & Sparen, 2001) concluded that people diagnosed with depression are more than 20 times more likely to die by suicide. Other studies have established the predictive significance of hopelessness (Beck, Kovacs, & Weissman, 1975; Beck, Steer, Kovacs, & Garrison,1985), previous suicide attempts (Beautrais,A.L.,2003), andviewingoneself as a burden (Joiner, et al., 2002). Still other important risk factors include alcohol abuse (Adams & Overholser, 1992; Frances, Franklin, & Flavin, 2006); history of physical or sexual abuse (Andover, Zlotnick, & Miller, 2007; Joiner, et al., 2007); psychotic illness, including schizophrenia (Cohen, Test, & Brown, 1990); anxiety disorders (Sareen et al., 2005); medical illnesses, including chronic pain (Druss & Pincus, 2000); self-harming behavior, such as cutting (Hawton, Zahl, & Weatherall, 2003); a family history of suicide (Brent, et al., 2002); and insomnia and nightmares (Sjostrem, Hetta, & Waern, 2009). Given that the presence of suicidal thoughts and intent elevate the risk of suicide (Brown, Henriques, Sosdjan, & Beck, 2004), it makes sense that access to firearms does as well (Brent, 2001; Brent, et al., 1991).

Protective Factors (Resources)

The suicide assessment process has been described as an assessment of the internal struggle between the patient's wish to die and the wish to live (Brown, Steer, Henriques, & Beck, 2005). The wish to live—the critical importance of which is captured in Linehan, Goodstein, Nielsen, & Chiles' (1983) *Reasons for Living Inventory—is* strengthened by the presence of protective factors, including religious affiliation (Dervic, et al., 2004), connection with a social support system of family and friends (Robins & Fiske, 2009), a sense of purpose, and a sense of responsibility (Malone, et al., 2000) or social obligation. Effective pharmacologic treatment of mood disorders is also protective against suicide (Baldessarini, Tondo, & Henden, 2001; Isaacson, 2000).

The Assessment Process

There are several written instruments (e.g., rating scales or structured patient questionnaires) that have been developed and used to assess the degree of suicidality of individual patients (Range, 2005); however, according to the American Psychiatric Association (APA), no rating scale or instrument can replace the physician's clinical judgment in the assessment of suicide risk (Simon & Hales, 2006). The APA Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors (2003) states: "Although suicide assessment scales have been developed for research purposes, they lack the predictive validity necessary for use in routine clinical practice. Therefore, suicide assessment scales may be used as aids to suicide assessment but should not be used as predictive instruments or as substitutes for a thorough clinical evaluation." Clearly, a clinical interview is the gold standard.

Our assessment method (Flemons & Gralnik, in press) involves an in-depth clinical interview that is grounded in an empathic appreciation of the patient's experience and circumstances. As Coulehan and Block (1997) recognize, "Empathy is a type of understanding. It is not an emotional state of feeling sympathetic or sorry for someone. In medical interviewing, being empathic means listening to the total communication—words, feeling, and gestures—and letting the patient know that you are really hearing what he or she is saying. The empathic physician is also the scientific physician because understanding is at the core of objectivity" (as cited in Platt and Gordon, p.57). We empathically explore both the patient's risks *and* resources, focusing not only on the patient him- or herself, but also on the risks and resources contributed by his or her significant others. (Family physicians appreciate perhaps better than any other medical specialty that family members can be significant contributors to the exacerbation *or* amelioration of the patient's pain.) The clinical decision (or, what we term the *safety decision)* is made by developing an empathic sense of the patient's risks and resources and by attending carefully to his or her participation in the interview. Once the decision is made, action must be taken.

Taking Action

If the patient is in imminent danger of suicide, the physician must act to protect him or her from self-harm. In Florida, physicians and mental health professionals may hospitalize patients involuntarily under the provisions of Florida's mental health statutes (Baker Act). This is appropriate if the patient is unwilling or unable to consent to voluntary hospitalization, or if the physician feels that the patient's judgment is so impaired that consent is not valid. If the patient is not, in the physician's judgment, imminently suicidal, then an outpatient treatment plan, including a safety plan, should be initiated, and a referral to a psychiatrist and/or other mental health professional should be made.

Close outpatient follow-up is recommended, as this will allow the family physician to monitor the patient, assess if the safety plan is continuing to be workable, and determine if the patient has complied with follow-up appointments. Given the seriousness of the situation and the fact that the majority of suicidal patients suffer from a diagnosable mental illness (most commonly a mood or substance abuse disorder), it is wise for the family physician or staff to take a proactive role in scheduling appointments with a mental health professional. If an appointment with a psychiatrist or other provider cannot be obtained in a timely manner, this may sway the family physician to more strongly consider

hospitalization. Likewise, if during follow-up visits it is apparent that the patient is not improving or is not able to adhere to the safety plan, hospitalization should be reconsidered. Specialized treatment for chemical dependency will be appropriate for some patients as part of their overall treatment plan.

Safety Planning

In our approach (Flemons & Gralnik, in press), a safety plan is created in collaboration with the patient, with specific elements designed to respond to the current danger, address acute risks, and enhance safety. The plan should be comprehensive but not overly elaborate. It will almost always detail the involvement of the patient's significant others, including friends and/or family who constitute the support system for the patient. Some important elements of the safety plan include: preventing or restricting access to the means of suicide, including guns and other weapons; restricting involvement in dangerous behaviors, such as the abuse of alcohol or other substances; and accessing or creating a safe haven for the patient (for example staying with a family member or friend).

We always make sure to include emergency phone numbers the patient can call if needed prior to the next appointment, such as suicide hotlines (e.g., 1-800-SUICIDE), the evaluating physician's after-hours emergency number, local hospital emergency rooms, and 911. We also discuss with the patient and list on the plan the option of going to the hospital voluntarily for treatment, usually accompanied by a family member or friend, should the need arise (for example, if suicidal thoughts re-occur or intensify). Protecting time for rest, sleep, grieving, meditation/prayer, and exercise can all be discussed and added to the safety plan; if engaged in, they will serve to decrease the patient's level of stress and suffering, and therefore help to reduce the likelihood of a suicide attempt. A copy of the written safety plan should be filed in the patient's chart, and the original given to the patient.

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