

### ASSESSING SUICIDE RISK

All depressed patients should be assessed for the risk of suicide by direct questioning about suicidal thinking, impulses, plans and personal history of suicide attempts. Patients are reassured by questions about suicidal thoughts and by education that suicidal thinking is a common symptom of the depression itself and not a sign that the patient “crazy.” Possible questions to ask the patient are:

- ?? *Have you had any thoughts about harming yourself?*
- ?? *Do you feel life isn't worth living anymore?*

Distinguish between just thought and actual intentions, actual plans and previous attempts:

- ?? If the patient has no ideas, intentions, plans or previous attempts, then treat depression.
- ?? If the patient has ideas and vaguely phrased intentions but no definite plans or history, treat depression, consult specialist if unsure, and involve family or caregiver in monitoring if possible.
- ?? If the patient has thought plus definite intentions, actual plans or previous history, CONSULT PSYCHIATRY.

### DETERMINING SUICIDE RISK

Use “*S-U-I-C-I-D-A-L*” to help you decide actual risk for suicide:

#### **S--Sex of the patient**

- ?? More men commit suicide.
- ?? More women than men attempt suicide
- Availability of significant others: Married patients are less likely to commit suicide than single ones, and divorced patients are at higher risk than married ones.
- Quality of personal relationships: A patient's feelings of loneliness or isolation from important people in his or her life may lead to suicidal thinking.

#### **U--Unsuccessful previous attempts**

- ?? More likely that an additional attempt will end in death. An accurate history about previous attempts is crucial. It should include the means previously used (to assess their lethality), the presence or absence of other people at the time(s) of the attempt(s), the patient's distance from medical help at the time(s), the presence or absence of loss of consciousness, and the length of stay(s) in the hospital following the attempt(s).

**I--Identification** with family members who have committed suicide in the past may make suicide a more acceptable option to some patients.

#### **CI--Chronic Illness**

- ?? Psychological or medical, and/or recent onset of severe illness is an increased risk factor for completed suicide.
- ?? Patients with depression, psychosis, and panic disorder are definitely at higher risk.

**D--Depression** significantly increases the risk of suicide as does drug abuse.

#### **A--Age of the patient.**

- ?? Older men are at greater risk for suicide.
- ?? Young schizophrenic males are at high risk.

**A--Alcohol use** is also common in successful suicide.

- ?? A patient acutely intoxicated with alcohol or other substance will be more impulsive and more likely to kill himself. Chronic alcoholism is also a risk factor.

**A--Alliance** or therapeutic relationship

- ?? of the patient with the provider evaluating his suicidal potential should be considered.

**L--Lethality** of suicidal method is an important factor in the assessment.

- ?? The use of guns, hanging, and jumping from high places are the most lethal means.
- ?? Drug overdose and wrist cutting are generally less lethal.
- ?? Recent losses (death, divorce, loss of job) are also critical factors in assessing potentially suicidal patients.