

Suicide Risk Assessment

Interviewing Basics

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Epidemiology

Suicide is common.

According to Statistics Canada, in 2009 there were 3,890 suicides in Canada, a rate of 11.5 per 100,000 people.

In 2009, suicide ranked as the ninth leading cause of death in Canada. Among those aged 15 to 34, suicide was the second leading cause of death.

Epidemiology

Suicide risk is highest in mid-life.

Across age groups, individuals aged 40-59 have the highest suicide rates. In Canada in 2009, 45% of completed suicides were in this age group.

Single people have a higher suicide rate.

For both genders, single individuals are the most likely to die by suicide, followed by widowed and divorced, then by married individuals.

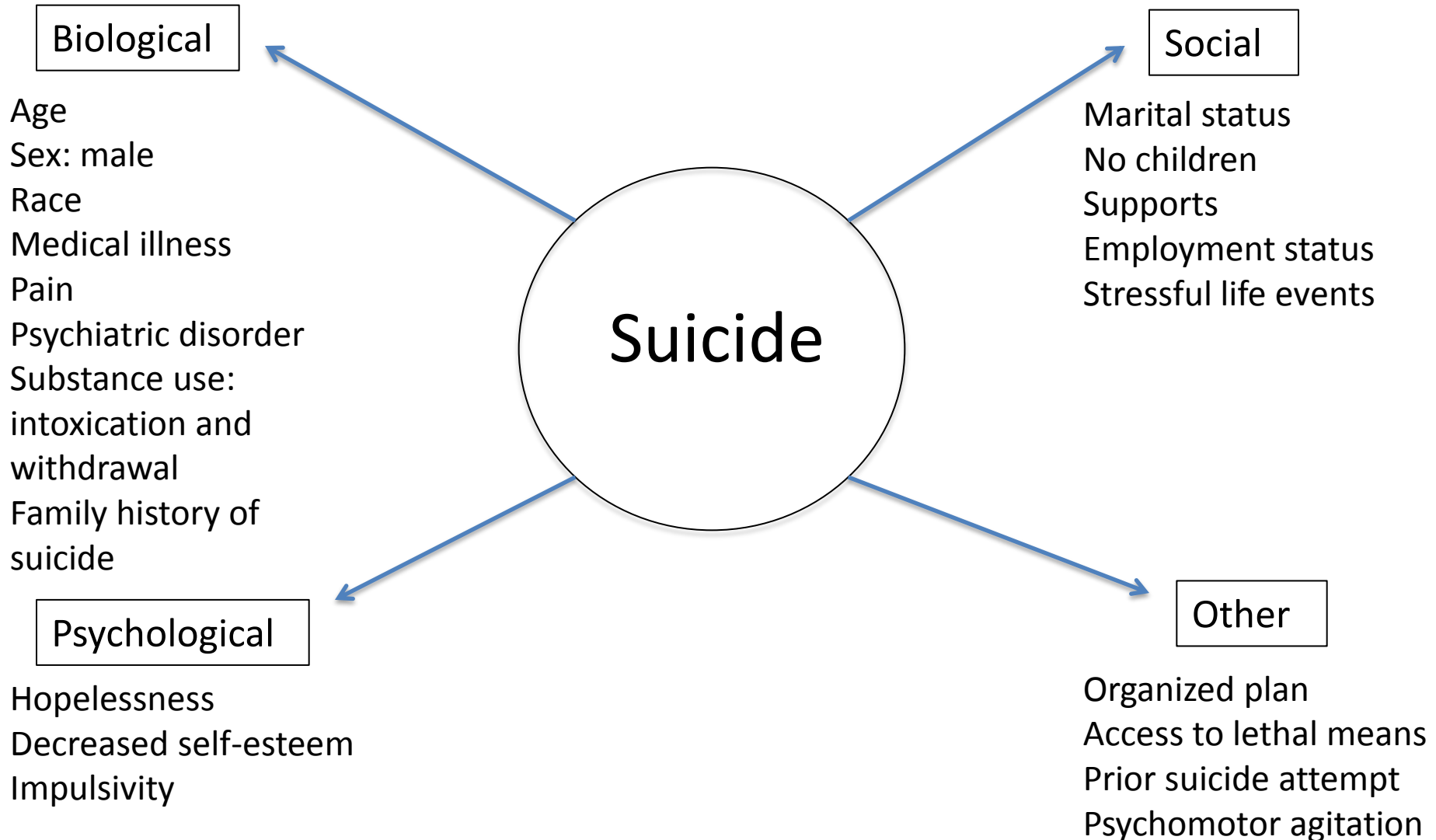
Epidemiology

There are gender differences.

Although females are three to four times more likely to attempt suicide, males are more likely to die by suicide. The suicide rate for males is three times higher than the rate for females.

The discrepancy may be due to less fatal methods used in females. Males are most likely to die by hanging, and females by poisoning.

Suicide Risk Factors



A Mnemonic

Sex (male)

Age

Depression

Previous attempts

EtOH use

Rational thinking loss (psychosis)

Suicide in family

Organized plan

No spouse (no supports)

Serious illness, pain

Protective Factors

Responsibility to **others** - partner, children, pets

Religious beliefs – belief that suicide is “wrong”

Positive **coping skills** and social **supports**

Hope for the future

Fear of acting

Positive **therapeutic relationship**

The Patient Interview

Try to form a **positive alliance** with the patient during your interview, by communicating in an **empathic** and **non-judgmental** manner.

Wait until you feel there is **trust** before you delve into their suicidal thoughts and plans.

Eliciting Suicidal Ideation

Ask in a **frank and calm** manner. Patients may be hesitant to talk about suicide for many reasons – your communication style should **signal to the patient that talking to you about suicide is okay.**

“Sometimes, people with depression feel so terrible that they’re not sure if they want to go on living. Have you had any thoughts about ending your life?”

“It sounds like you’ve been in a rough spot. Has it brought you to the point where you wonder if it’s worthwhile to live?”

Eliciting Suicidal Ideation

Assess **frequency and intensity**:

“How often do you have those thoughts?” “How long do they last?”

Ask about **control**:

“Can you push the thoughts away, or call someone for help?”

Eliciting a Plan

When asking about a plan, assess if it is a **feasible plan** with **available means**. Ask about time and place.

Ask about **practiced or aborted attempts**.

Be specific.

“Have you thought of a way of ending your life?”

“Have you picked a date? A place?”

“Which pills will you take? How will you get them?” “Which bridge do you think you would go to? Where is it?”

“Have you held the pills in your hand?” “Have you stood at the edge of the balcony / bridge?”

Eliciting Intent

As clinicians, and for our patients, it is important to recognize that **thoughts and actions are not always congruent.**

“It sounds like you’ve thought quite a bit about jumping off a bridge. Do you think it is something you would actually do?”

“You talk about wanting to end your life – are you planning to do this?”

Eliciting Intent

Ask if they have made **final arrangements**.

“Have you written a suicide note?”

“Have you made arrangements for your children / your pet?”

“Have you prepared a will?”

Assess Protective Factors

Ask about **hope**. Elicit **ambivalence towards dying**.

“It sounds like things have been really hard. Do you have some hope that things will get better for you?”

“I can see you’ve been thinking a lot about dying. I wonder if there’s a part of you that wants to live.”

“What’s kept you going?” “What stops you from acting on these thoughts?”

Validate and Elicit Hope

“You’re in a lot of pain.”

“Things have been rough.”

“You’ve been really strong talking about some very difficult stuff.”

“I think we can get you some help.”

“I’m glad you came in.”

“I’m hoping we can help you deal with this better.”

What Not to Do

Do not worry that you might “give patients the idea” to kill themselves by talking about it.

Do not ask questions with a negative – “You haven’t thought of killing yourself, have you?”

Do not imply there is a “correct” answer by replying with something like “good,” or “great,” when a patient denies suicidal ideation.

Do not use vague or indirect language – ask patients in a calm and direct manner. This is not a time to risk misunderstanding.

Other Important Steps

Document your findings, assessment of suicide risk, and rationale for management plan.

As appropriate, try to get **collateral** information from significant individuals in your patient's life.

Use the **Mental Health Act** Forms (or discuss use of these forms with your supervisors) as appropriate if there is sufficient level of risk.

Discuss these cases with your supervisors, and with colleagues going forward.

Quiz #1

Which of the following psychiatric disorders increases the risk of suicide?

- a. Substance use disorder
- b. Depression
- c. Bipolar disorder
- d. Schizophrenia
- e. Personality disorder
- f. All of the above

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Quiz #2

True or False:

A family history of completed suicide is a protective factor – the patient would not want to put his / her family through it again.

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True or False:

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FALSE

A family history of suicidal acts is an important biological risk factor. Genetic and neurobiological factors in suicide have been identified.

Always be sure to ask about family history in your interview.

Resources

911 or local Emergency Department

Toronto Distress Centres (416) 408-4357 or 408-HELP

Gerstein Centre 416-929-5200, 24 hrs/7 days

Telecare (Mandarin & Cantonese), 416-920-0497

Contact Centre Telecare Peel 905-459-7777, 24 hrs/day; Languages: English, Punjabi, Hindi, Urdu, Spanish, Portuguese

Warm Line, Progress Place 416-960-9276 or 416-960-WARM, Monday to Sunday, 8pm to 12 midnight

Distress Centre Peel 905-278-7208, 24 hrs/7 days

Durham Crisis Line 905-666-0483, 24 hrs/7 days

Assaulted Women's Helpline 416-863-0511, 24 hrs/7 days Toll-free: 1-866-863-0511

Oakville Distress Centre - 905-849-4541, more info available at www.distresscentreoakville.com