Suicide prevention

Targeting the patient at risk

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BACKGROUND

Suicide is a major cause of death from adolescence upward. While there has been a concentrated effort to educate families and health workers to be aware of warning signs of pending suicide, there has been limited information or practical strategies available for people at risk of suicide or for those who have suicidal thoughts. Recent acknowledgment of the role of impulsivity in suicide highlights the need for such information.

OBJECTIVE

This article identifies those at risk of suicide and outlines strategies for suicide prevention.

DISCUSSION

Patients with suicidal thoughts are not an infrequent component of presentations in general practice and present a considerable challenge to the general practitioner because it is very difficult to predict who will make a suicide attempt. There has been much published to assist the GP to identify those at risk, but little to suggest how to assist the patient in such a crisis. Research into the role of impulsivity in suicide would suggest that unless the patient has strategies to confront the suicidal thoughts themselves, they remain at significant risk.

I have spent many years counselling people who have struggled with suicidal ideation. I became aware of certain commonalities in their experiences of suicidal thoughts, and how by adopting simple strategies they could stay safe. My own experience with bipolar disorder became a 'nightmare' when I had to take regular high dose steroids to treat another condition. This lead to extended dark days and my own experience of suicidal thoughts.

From these experiences I produced, 'Toughin' it out. Strategies for dealing with suicidal thoughts', which is highly applicable to the general practice context (see *Resource*). As well as a clinical tool, the pamphlet is being used increasingly as a suicide prevention strategy for those at risk.

The extent of the problem

In Australia there are more deaths from suicide than motor vehicle accidents. According to the Australian Bureau of Statistics, in 2003 there were 2213 deaths from suicide and 1811 from motor vehicle accidents. In Australia, on average, six people suicide per day. According to international figures, 80% of all suicides are men, and men aged 25–55 years are the largest group in suicide statistics.[1] Suicide is the commonest cause of death between the ages of 25–55 years and the second commonest cause of death in adolescents[1] (*Figure 1*). Although there are a considerable number of suicides in the elderly, suicide forms a smaller proportion of deaths at this age due to the frequency of other causes of death.[2] Contrary to international trends, male youth suicide rates have been falling in Australia since 1997 (*Figure 2*). The reasons for this decline are uncertain.

Who is at risk?

There is variation in the characteristics of those who suicide. However, overall, the feature most common is the number of risk factors that come together at a particular point in time. This applies to both suicides and suicide attempters. About 90% will have 2–7 major risk factors[3] (*Figure 3*). Main risk factors include:

- social and economic disadvantage, including low educational achievement and unemployment
- childhood and family adversity
- individual characteristics (eg. impulsivity, aggression, low self esteem and hopelessness, cognitive rigidity, poor locus of control, social disengagement)
- mental disorders and drug addiction
- stress and adverse circumstances, especially loss of

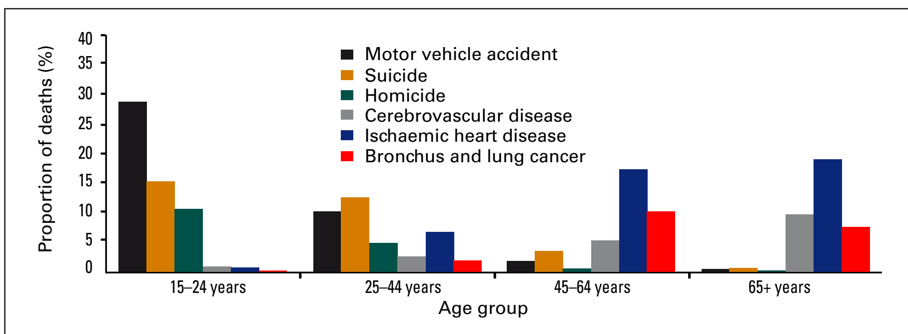

Figure 1. Selected causes of death among males globally, 1999
The Australian statistics follow the same pattern. The statistics for females is almost identical

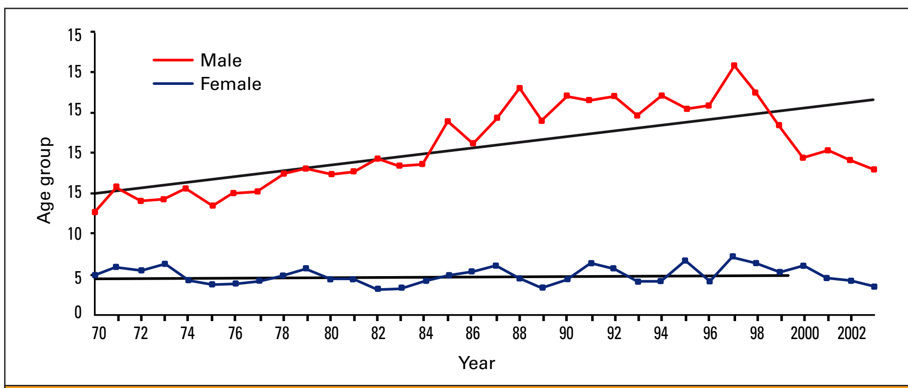

Figure 2. Youth suicides in Australia 1968–2003

physical health and loss of employment, marital breakdown, loss of custody of children, and other interpersonal loss

- deliberate self harm or attempted suicide in the previous year (especially the first few months)
- indigenous ethnicity
- rural and remote setting
- knowledge of others who have suicided or family history of suicide
- ease of access to guns or other means of suicide.[1,3]

Suicide and mental health

People with mental health disorders are at a significantly increased risk of suicide. Forty-one percent of people who die from suicide have been discharged from psychiatric inpatient care in the past 12 months and 9% are inpatients at the time of death or die on the day of discharge.[4] At the time of discharge, patients have a risk about 100 times that of the general population.[5] In Queensland, between 1990 and 1995, almost twice as many suicides occurred in hospital compared to those in custody.[6] Discrimination and stigma are thought to contribute to suicidal risk as they contribute to isolation, loneliness, unemployment and homelessness.[7]

Suicide and substance abuse

Substance abuse policies have had a greater impact on suicide rates than suicide prevention strategies and mental health policies.[1] Alcohol abuse is the most significant contributor overall, especially binge drinking.[1] Opiate users have 14 times the suicidal risk of the general population and chronic cannabis users four times the risk.[1]

Suicide and men

Although more women attempt suicide, 80% of completed suicides are male. Men have more conduct and drug and alcohol problems than women, and a lower incidence of anxiety and depression. Men generally have poorer social support networks, less often ask for professional help, are less inclined to talk about feelings, and often believe they should be 'in control' of their lives. They are often action oriented, and use more lethal suicide methods.

Impulsivity

Recent research suggests that impulsivity may play a far greater role in suicide than previously thought.[8] Of those who attempted suicide:

- 75% take <1 hour to make the decision
- 25% <5 minutes
- 24% <10 minutes
- only 7% thought for >24 hours
- 93% of drunken attempts thought for <30 minutes; 75% for <10 minutes, and
- 75% lost the urge to suicide in 24 hours.[8]

The impact of removing the availability of the means to suicide has a considerable impact on suicide rates due to its association with impulsivity.

Presentation in general practice

Case study

The patient mentions that they are having suicidal thoughts or responds in the affirmative when you ask directly about such thoughts. You decide that, according to your assessment, the patient does not need to be hospitalised, even though you know that research shows that such risk assessments are probably not worth the paper they are written on when trying to predict who will suicide. You are keen to give the patient strategies to keep them alive until the danger passes, but you are aware that the only resources available are for families, carers, and health workers to assist in picking up warning signs.

This scenario is a general practitioner's 'nightmare'; confronted on a regular basis. The patient may be reacting to a life crisis, or often, in combination with a mental health disorder such as depression or anxiety.

The patient may mention the presence of such thoughts, but it is more likely that, because of guilt or shame, they only admit to such thinking on direct questioning. Men in particular find it difficult to confess to such thoughts because it may be seen as 'giving up' or a sign of being 'mental'. For this reason, and for fear of consequences such as being sent to a mental health service, patients will often deny

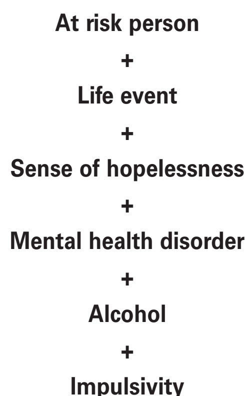

Figure 3. The lethal combination

the presence of such thoughts, even on direct questioning.

We know that suicidal ideation is very common under such circumstances and that the majority of people will not act on such thoughts – the difficulty is identifying who will.

Strategies for dealing with suicidal thoughts

Knowing the thoughts and outsmarting them

Suicidal thoughts seem to come in waves. Thoughts often reach a peak and then subside over a few hours. Recognising this wave-like presentation allows the person to resist doing anything 'silly' knowing that the thoughts will subside. The thoughts are often worse at night, especially if the person is on their own. The thoughts try to shame the person into keeping them to themselves, and in this way they isolate the person. The thoughts try and convince the person that there is no future. Worst of all, the thoughts try and trick the person into the idea that their family would be better off without them and their problems. This is never the case. The destructive legacy of suicide stays with the surviving family and friends for life.

Beating the thoughts and staying alive

People rarely suicide in company. If the person feels they are not in control of the thoughts they can ensure their safety by being with someone. They should be encouraged to break their silence and talk about what is happening to them. If they are on their own, they should be encouraged to ring a friend, a family member, or counselling service. They should be given such contacts including 24 hour national helpline numbers.

Setting up a context to be safe

Alcohol and illicit drugs should be avoided as they often increase disinhibition and therefore increase impulsivity. They often feed negative thoughts and make a person feel sad or bad. Any means of suicide should be removed from the home.

Staying positive and hopeful

Suicide is much more likely to occur when the situation appears hopeless. Depression often gives a false sense that things can never improve, that there is no way out. Adolescents lack the life experience to realise that you do get through tough situations and that eventually the most pessimistic of situations moves on. It is worth reminding patients that at some stage they will get out of the hole they are in and wonder however the suicidal thoughts ever got such a grip on them.

The 'good samaritan'

I encourage patients to nominate a 'good samaritan' who will stay with them for the next 24–48 hours until the crisis has settled to some degree. This person can also help the patient liaise with support services such as mental health services and other nongovernment organisations.

Reducing the means of suicide

In the United Kingdom, a drop in suicide rates was achieved by reducing the number of paracetamol in a packet. Clearly, if you were steadfastly going about a suicide attempt, you can easily shop around for more. However, if the tablets are not in the home at the time of the impulse to self harm, then the person takes fewer tablets.

The same applies with the alteration of the type of gas used in heating or the alteration of car exhausts to be less lethal. Fencing constraints at popular leaping places also has a significant impact. The introduction of tighter gun laws has also had a significant effect.[1]

Each of these examples highlights the contribution of 'impulsivity' to the likelihood of suicide.

Road to recovery

So far the aim has been to counter the degree of impulsivity and sense of hopelessness that occurs when there is a major life event combined with depression. The aim has been to keep the person alive so that at a future time they can begin to work on the underlying issues that caused them to be in such a vulnerable position. This may involve treating any underlying mental illness or substance abuse appropriately, counselling, improving lifestyle (including exercise), and resolving stressful situations. It may involve the person having a stronger sense of being in charge of their life, improved self esteem, and a greater sense of self control. It should also involve expanding their social network so that they feel more connected and supported by their community.

Postsuicide intervention

Postsuicide intervention is beyond the scope of this article, however, one relevant aspect links the role of impulsivity in the act of suicide.

My own anecdotal experience has been of many parents giving themselves a tough time for years following a suicide of a family member. They often learn of the tendency of people to give out 'signs of intent' before the act – which they must have missed. Often this does not fit with their experience. This is especially the case in indigenous health: from their perspective, their child had appeared to be 'okay' beforehand and the suicide took them by surprise.

Knowing just how impulsive suicide can be, which limits the opportunity for intervention and knowing the difficulties that health professionals have in predicting the likelihood of suicide, can significantly reduce the burden of guilt for family survivors.

Suicide prevention

National suicide prevention concentrates on several strategies:

- building up community resilience and connectedness
- building up individual resilience and self esteem
- increasing awareness of the association between mental health and suicide
- increasing awareness of families, carers and service providers of the warning signs

of suicidal intention
- reducing the means to suicide
- encouraging the media to report about suicide responsibly, and
- alcohol awareness.

Social factors such as socioeconomic status, unemployment, and community all have a major impact on suicide rates. The obvious gap in activity and resources is that little is directed toward people with current suicidal thoughts or those at risk of suicide.

Targeting those at risk

Currently, there is no risk assessment tool that has any efficacy at predicting who will suicide. However, research does inform policy makers who is at risk. Prevention should be targeted to such groups by way of strategies to survive suicidal ideation. Because of the role of impulsivity, those at risk require strategies before they are exposed to such thoughts. Target groups for suicide prevention strategies include:
- youth (eg. programs such as 'Mindmatters' which introduces mental health education to secondary school students)
- mental health patients (standard education for clients, especially standard discharge planning)
- drug and alcohol patients, and
- family court participants.

Conclusion

The patient who presents with suicidal thoughts should be given simple strategies for staying alive. Support, and especially company, should be mobilised, especially in the short term. The GP has a significant role in identifying those at risk and making sure that these patients have knowledge of survival strategies in case they are required in the future.

Resource

'Toughin' it out. Survival skills for dealing with suicidal thoughts': available at www.toughinitout.com

Conflict of interest: none declared.

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Poetry

Ultrasound poem #2

Call them Mum
and Dad:
this unsteady couple
whose knocked-up shack broke
building codes
leaning to the smoky screen.

Plastic gloves and sonic finger
pixel-plunge to grip
the after-image of
their passionate conflagration,
fed an angry timber

that forged this ashen child,
fist waving
from the dying fire
of its creation.

Tim Metcalf

The opening lines are broken and uncomfortable, and the first stanza is disjointed like the relationship it portrays. The ultrasound examination shows these parents the fist of their child, which is already raised in defiance at the desolate landscape of their lives, but which, phoenix like, represents resilience and hope.