



Sinclair, L., & Leach, R. (2017). Exploring thoughts of self-harm and suicide. *BMJ*, 356, [j1128]. DOI: 10.1136/bmj.j1128

Publisher's PDF, also known as Version of record

License (if available):  
CC BY-NC

Link to published version (if available):  
[10.1136/bmj.j1128](https://doi.org/10.1136/bmj.j1128)

[Link to publication record in Explore Bristol Research](#)  
PDF-document

This is the final published version of the article (version of record). It first appeared online via BMJ at <http://www.bmj.com/content/356/bmj.j1128>. Please refer to any applicable terms of use of the publisher.

## University of Bristol - Explore Bristol Research

### General rights

This document is made available in accordance with publisher policies. Please cite only the published version using the reference above. Full terms of use are available:  
<http://www.bristol.ac.uk/pure/about/ebr-terms.html>



## PRACTICE POINTER

## Exploring thoughts of suicide

Lindsey Sinclair *ST6 liaison psychiatry*<sup>1</sup>, Richard Leach *general practitioner*<sup>2</sup>

<sup>1</sup>Royal United Hospital Bath, Avon, UK; <sup>2</sup>Northlands Surgery, Calne, Wiltshire, UK

A 50 year old man describes feeling low in mood. He has recently lost his job and his wife has left him. During the consultation he mentions that life is not worth living any more. Dr Smith is worried about how to follow up on this comment; the patient is making poor eye contact.

Many doctors worry about how best to assess suicide risk in individuals who present to them with thoughts of self harm.

The topic of suicide is difficult to research and consequently much of the evidence is of low quality. In a recent qualitative study, general practitioners in the UK reported that they found it difficult to identify who was “really” suicidal, to effectively assess risk, and to manage patients at risk of suicide.<sup>1</sup> Patients who repeatedly self harm can evoke powerful emotions in the healthcare provider, such as anger, fear, or a desire to save them.<sup>2</sup>

Clinicians should not fear asking about suicide; a review article failed to identify any studies in which asking about suicidal ideation increased the risk of a further attempt.<sup>3</sup> This article suggest how to assess someone who has thoughts of ending their life, perform a risk assessment, and decide who might benefit from additional input from a specialist mental health team.

### How common are suicidal thoughts and suicide attempts?

Suicide itself is a rare event. In 2014 there were 10.8 deaths by suicide per 100 000 of the population in the UK.<sup>4</sup> Between 3.5% and 5% of people reported suicidal thoughts in the last year, but only 0.5%-0.7% of individuals made an attempt to end their life, according to UK and US data.<sup>5 6</sup> The UK study found that over the course of a lifetime up to one fifth of the general population reported thoughts of ending their life.<sup>6</sup>

### How can doctors distinguish those at high risk of suicide?

A recent meta-analysis of studies that looked at risk factors for self harm as well as suicide found only four with strong evidence to support them:

- Previous episodes of self harm
- Male gender
- Being unemployed
- Having physical health problems.<sup>7</sup>

These factors are so common, however, that they are unlikely to help clinical decision making.

Possibly of more clinical use is the UK National Confidential Inquiry into suicides. This report, which covers 20 years of data in England, identified characteristics in individuals who died by suicide (table 1⇓).<sup>8</sup> The data confirm the four risk factors, but add

- living alone
- being unmarried
- drug/alcohol dependence
- active mental illness.

### Are there risk factors that you can change?

Most practising psychiatrists divide risk factors into dynamic and static or stable.<sup>12</sup> Static risk factors are not amenable to change and tend to be demographic (for example, gender or having a history of self harm). Dynamic risk factors, on the other hand, can vary and might be amenable to change. For example, someone would be at higher risk if their depression were untreated, compared with a person who had been adequately treated such that their mood had returned to normal. Other dynamic risk factors include access to methods of self harm (such as a weapon), disinhibition due to intoxication, substance misuse, living alone, unemployment, relationship problems, and difficulties with problem solving.<sup>2</sup> Considering which risk factors could be amenable to change can help with designing a management plan.<sup>13</sup> Weighing up all of these factors can be complex, however, and efforts to produce algorithms to predict risk based on risk factors have not been successful.

Correspondence to L Sinclair lindsey.sinclair@bristol.ac.uk

Data supplements on bmj.com (see <http://www.bmj.com/content/356/bmj.j1128?tab=related#datasupp>)

**Supplementary information:** Appendix files: Infographic

**What you need to know**

- Asking about suicide will not make patients more likely to harm themselves
- Identify risk factors for suicide, but also ask about protective factors
- Asking about suicide enables clinicians to gauge risk and formulate a treatment plan

**Are there protective factors?**

Protective factors can reduce the risk of someone dying by suicide.<sup>13</sup> Examples include<sup>2</sup>

- a strong religious faith
- family support to find alternative solutions to their problems
- having children at home
- a sense of responsibility for others
- problem solving skills.

This evidence base is generally weak. The relative importance of these protective factors varies greatly between individuals. Note that protective factors can change. Loss of protective factors should alert the health professional to an increased risk for the patient—for example, if a partner and children leave the patient.

**What can clinicians observe and feel?**

Pay attention to how the patient behaves and what emotions they project onto you, as this can aid in diagnosis and the assessment of risk. For example, patients who are very depressed can evoke feelings of boredom in the clinician or a sense that they are undeserving. Patients who are withdrawn, agitated, or simply very hopeless, can be at high risk.

Be alert to any mismatch between what patients report and your clinical instinct. In a small US case series, three quarters of patients who died by suicide denied suicidal thoughts at their last clinical contact.<sup>14</sup> Clinicians should use their judgment as to whether their patients are withholding such information.

**How could I explore thoughts of suicide?**

In those reporting thoughts of ending their life, and as part of the overall assessment for mental health problems, explore these thoughts of self harm further. There is little guidance or evidence on how best to do this; the suggestions below are based on our practice and that observed by others.

Exploring thoughts of self harm is perhaps best done once a rapport has been established. Consider introducing the subject of suicide gently, rather than asking directly “do you want to die?” Consider framing it in terms of “some people find...,” which can help to put patients at ease. For example:

- How is your mood?
- Sometimes people who feel down can start to feel hopeless about the future. Has this happened to you?
- Have you ever had any thoughts come into your head about life not being worth living?
- What sort of thoughts have you had?
- Have you ever thought about how you might end your life?
- Have you done anything to prepare for ending your life—eg, writing a will?
- Have you ever tried to harm yourself in any way?
- Is there anything that would make life worth living?

Talking about suicide can be upsetting, so you should work back down to less emotive subjects, such as support available to the patient, before drawing a consultation to a close.

**What decisions do I need to make?**

Use the information you have gathered to form a more accurate judgment of the risk of harm. Go back to gather any further information and ask specific questions if needed. The infographic that accompanies this article is based on guidance formed by expert opinion.<sup>2</sup>

Key issues to address include a judgment on

- The level of risk based on the balance between protective factors and risk factors and an understanding of which might be modifiable
- To what extent the patient is willing and able to engage with a management plan
- Whether the patient is safe to go home
- Whether urgent but voluntary advice or referral to psychiatry is needed<sup>2 15</sup>
- Whether a mental health act assessment is appropriate, in discussion with mental health services.

**How do I generate a management plan?**

The management plan will be driven by the assessment of risk and also by the local services available.<sup>2 15</sup>

Irrespective of which doctor or clinical team cares for the patient, or whether the patient will lead with self care, it might be helpful to touch on the following areas when forming a management plan for patients with thoughts of ending their life:

- Are any dynamic risk factors present that are amenable to treatment—eg, mental illness, use of alcohol/illicit drugs?
- What steps can be taken to improve safety and reduce access to methods of self harm?
- Is social support available to the patient?
- Give information on relevant non-statutory services such as the Samaritans
- Give information on where practical support can be obtained—eg, housing or finance
- Assist patient with problem solving, which can be severely impaired in patients in crisis.

Table 2<sup>1</sup> shows a worked example of a hypothetical case seen in UK primary care, based on the assessment structure outlined in the accompanying infographic. Possible sources of advice for patients and carers are given in the box. It is important to work with patients and carers to identify a management plan that they agree with.

Provenance and peer review: Encouraged and externally peer reviewed. We have read and understood the BMJ policy on declaration of interests and have no interests to declare.

**Contributions** LS had the original idea for this article, which was then written by both authors.

### Advice for patients and carers

#### Sources of support

##### Samaritans

A national charity that provides confidential emotional support 24/7 for those feeling distressed or unable to cope. Tel: 116 123, <http://www.samaritans.org/>

##### Self injury support

A Bristol based charity which runs a part time national support line for women and provides text based support for those aged under 24. Their website also has a comprehensive list of other UK based self harm charities and support services. <http://www.selfinjurysupport.org.uk/>

##### CALM

A nationwide charity that aims to prevent male suicide. Their helpline is available from 5pm to 12am all year round. Tel: 0800 58 58 58. <https://www.thecalmzone.net/>

##### SANE

A national charity that supports those with mental illness, including self harm. Their helpline (0300 304 7000) is open from 6pm to 11pm 365 all year round. <http://www.sane.org.uk/home>

#### Websites

##### National self harm network

This website provides a forum where individuals who self harm can receive support from others in a similar situation. <http://nshn.co.uk/>

##### Selfharm<sup>UK</sup>

A website offering information and advice on self harm. <https://www.selfharm.co.uk/>

##### Royal College of Psychiatrists

A helpful leaflet on self harm. <http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/self-harm.aspx>

### How patients were involved in the creation of this article

We are very grateful to the Swindon Service User Forum and to the Swindon Survivors of Bereavement by Suicide groups for their comments on a draft version of this article. They were keen to stress the need for sensitivity when asking patients about thoughts of harming themselves.

### Education into practice

Have you seen a patient with thoughts of self harm recently? How did they make you feel? Did you feel confident in generating a management plan?

Do you ask all of your patients with depression about thoughts of self injury?

### Sources and Selection Criteria

We searched the National Institute for Health and Care Excellence, American Psychiatric Association, and the Royal College of Psychiatrists websites for relevant guidelines. We searched PubMed using the search terms suicide+ guideline, suicide risk assessment + guideline, suicidal ideation, suicide attempted, self-harm, self-harm + risk assessment. Abstracts and titles were reviewed for relevance. Some of the articles were already known to us from our routine clinical work.

- Michail M, Tait L. Exploring general practitioners' views and experiences on suicide risk assessment and management of young people in primary care: a qualitative study in the UK. *BMJ Open* 2016;6:e009654. doi:10.1136/bmjopen-2015-009654 pmid:26758263.
- Fowler JC. Suicide risk assessment in clinical practice: pragmatic guidelines for imperfect assessments. *Psychotherapy (Chic)* 2012;49:81-90. doi:10.1037/a0026148 pmid:22369082.
- Dazzi T, Gribble R, Wessely S, Fear NT. Does asking about suicide and related behaviours induce suicidal ideation? What is the evidence? *Psychol Med* 2014;44:3361-3. doi:10.1017/S0033291714001299 pmid:24998511.
- Office for National Statistics. Suicides in the United Kingdom: 2014 registrations: 2016 Available from: <http://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2014registrations>.
- Crosby AE, Han B, Ortega LA, Parks SE, Groerger J. Centers for Disease Control and Prevention (CDC). Suicidal thoughts and behaviors among adults aged ≥18 years—United States, 2008-2009. *MMWR Surveill Summ* 2011;60:1-22. pmid:22012169.
- McManus S, Hassiotis A, Jenkins R, Dennis M, Aznar C, Appleby L. Chapter 12: suicidal thoughts, suicide attempts, and self-harm Leeds: NHS digital; 2016.
- Chan MKY, Bhatti H, Meader N, et al. Predicting suicide following self-harm: systematic review of risk factors and risk scales. *Br J Psychiatry* 2016;209:277-83. doi:10.1192/bjp.bp.115.170050 pmid:27340111.
- National confidential inquiry into suicide and homicide by people with mental illness. Annual report and 20 year review, October 2016. University of Manchester; 2016.
- McManus S, Bebbington P, Jenkins R, Brugha T. *Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014*. NHS Digital, 2016.
- Office for National Statistics. 2011 Census: 2011. Available: <https://www.ons.gov.uk/census/2011census>.
- Office for National Statistics. Unemployment 2016. Available from: <https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/unemployment>.
- Bouch J, Marshall JJ. Suicide risk: structured professional judgement. *Adv Psychiatr Treat* 2005;11:84-91 doi:10.1192/apt.11.2.84.
- Jacobs D, Baldessarini R, Conwell Y, et al. Practice guideline for the assessment and treatment of patients with suicidal behaviors: American Psychiatric Association; 2010 [Available from: [http://psychiatryonline.org/pb/assets/raw/sitewide/practice\\_guidelines/guidelines/suicide.pdf](http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/suicide.pdf)].
- Busch KA, Fawcett J, Jacobs DG. Clinical correlates of inpatient suicide. *J Clin Psychiatry* 2003;64:14-9. doi:10.4088/JCP.v64n0105 pmid:12590618.
- Hart C, Colley R, Harrison A. Using a risk assessment matrix with mental health patients in emergency departments. *Emerg Nurse* 2005;12:21-8. doi:10.7748/en2005.02.12.9.21.c1181 pmid:15751465.

Accepted: 15 02 2017

Published by the BMJ Publishing Group Limited. For permission to use (where not already granted under a licence) please go to <http://group.bmj.com/group/rights-licensing/permissions>

## Tables

**Table 1 | Summary of patient characteristics identified in the national confidential inquiry and a comparison with rates in the general population**

Patient characteristic	Prevalence in individuals who died by suicide in England in 2004-14 <sup>8</sup>	1 week prevalence in UK adult population in APMS' survey 2014 <sup>9</sup> or ONS whole population data	Adjusted hazard ratio from Chan et al <sup>7</sup>
Male	66%	49.1% ONS census 2011 <sup>10</sup>	<b>2.05 (1.70-2.46)</b>
Unmarried	71%		
Living alone	47%	31% ONS census 2011 <sup>10</sup>	
Unemployed	41%	6.4% ONS 2014 <sup>11</sup>	1.08 (0.65-1.8)
History of self harm	68%	ever self harmed 7.3%	<b>1.68 (1.38-2.05)</b>
Last contact with services within 7 days of death	49%		
Symptoms of mental illness at last contact	64%		
History of alcohol misuse	45%	3.1%	1.63 (1.00-2.65)
History of drug misuse	33%	3.1%	
Primary diagnosis of affective disorder	45%	depression 3.3%	
Primary diagnosis of schizophrenia	17%	psychotic disorder 0.7%	
Primary diagnosis of personality disorder	8%	screened positive 13.7%	

\*APMS, Adult Psychiatric Morbidity Survey; ONS, Office for National Statistics.

Table 2| Example management plans for differing levels of risk

Risk	Patient presentation	Suggested plan
Low	The patient has moved to live with a friend, has hope for the future, is applying for new jobs, and does not have any specific plans to harm himself	In this instance referral to mental health services would not be appropriate. The patient could be managed in primary care. Consider whether he is depressed, whether he wants treatment, and whether talking therapies, medication, or both would be most appropriate. The clinician could also consider giving the patient contact details for services such as the Samaritans and advice on where to obtain practical support. Plan with the patient, before he leaves, when his next appointment will be
Medium	The patient is living alone and has a dog that he would not leave. He is moderately depressed and has been thinking about hanging himself. He has not gone so far as to work out where he would do this and has not bought a rope. He is willing to accept treatment and admits that he needs help	In this instance consider whether the patient can be managed in primary care in the first instance or whether the risk is so high that he warrants referral to the local community mental health team. Have an open discussion with the patient about his support networks and whether he has friends or family who could help him through this difficult time. Give the patient contact details for services such as the Samaritans and advice on where to obtain practical support. Plan with the patient, before he leaves, when his next appointment will be
High	The patient is living alone, has given his dog away, and has recently updated his will. He is hopeless about the future, has bought a rope, and has decided where he is going to hang himself. He is severely depressed and can't see the point of treatment as "nothing will change"	Contact local mental health services urgently. Consider whether it is safe for the patient to leave the building alone and whether any measures can be put into place to control for risk—eg, asking a friend to be with him and to dispose of the rope. Consider whether a mental health act assessment is appropriate, in discussion with mental health services and approved mental health professionals