Detecting suicide risk in psychiatric emergency services

Detecção do risco de suicídio nos serviços de emergência psiquiátrica

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Abstract

Objective: To provide guidelines for the identification of suicide risk and protective factors and the management of suicidal patients in emergency settings. **Method:** Literature review to identify relevant and illustrative key cases. **Results:** The clinical interview is the best method to evaluate the suicidal risk and has a twofold purpose: 1) providing emotional support and creating a bond; 2) collecting information. There is a substantial amount of information to be collected during the clinical interview, including risk and protective factors, epidemiologic data, characterization of the event, psychodynamic aspects, personal and family history, identification models, data on physical health, and social support network. Difficulties can emerge during the clinical interview, but a trained and informed professional will be able to approach and adequately deal with the patient. Although several scales have been proposed, none of them have shown reliable efficiency in determining the suicidal risk. **Conclusion:** There is no method to predict who is going to commit suicide; nevertheless, it is possible to evaluate the individual risk of each patient by means of a detailed and empathic clinical interview. Keeping the patient alive is the first and fundamental rule.

Descriptors: Suicide; Emergency services, psychiatric; Interview; Risk factors; Protection

Resumo

Objetivo: *Auxiliar o profissional de saúde na identificação dos fatores de risco e de proteção, e no manejo de pacientes com risco de suicídio, por meio de entrevista clinica, no contexto de emergência médica.* ***Método:*** *Revisão seletiva da literatura para identificar achados clínicos relevantes e ilustrativos.* ***Resultados:*** *A entrevista clinica é o melhor método para avaliar o risco suicida e tem dois objetivos: 1) apoio emocional e de estabelecimento de vínculo; 2) coleta de informações. Existe um número considerável de informações a serem coletadas durante a entrevista: fatores de risco e proteção (predisponentes e precipitantes), dados epidemiológicos, caracterização do ato, aspectos psicodinâmicos, antecedentes pessoais e familiares, modelos de identificação, dados sobre saúde física e rede de apoio social. Dificuldades ao longo da entrevista serão encontradas, mas com conhecimento e treinamento adequado, o profissional poderá abordar e ajudar adequadamente o paciente. Embora várias escalas tenham sido propostas, nenhuma delas demonstrou eficiência para a detecção de risco de suicídio.* ***Conclusão:*** *Não há como prever quem cometerá suicídio, mas é possível avaliar o risco individual que cada paciente apresenta, tendo em vista a investigação detalhada e empática da entrevista clinica. Impedir que o paciente venha a se matar é regra preliminar e fundamental.*

Descritores: *Suicídio; Serviço de emergência psiquiátrica; Entrevista; Fatores de risco; Proteção*

Introduction

Suicidal behavior is an umbrella term covering a number of phenomena related to suicide, the most important of which are suicide itself (death) and attempted suicide.

According to the World Health Organization (WHO), suicide is the act of killing oneself that results from an action or omission initiated with the intention of causing death and in the expectation of a fatal outcome.[1]

Suicide attempts have the same phenomenological characteristics as suicide, differing from the latter only in relation to the outcome, which is not fatal. Accordingly, attempted suicide must be

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differentiated from other self-destructive behaviors not deliberately directed at taking one's life, although external factors may be common to both.

It is important to highlight that a given behavior does not necessarily constitute a disorder; therefore, suicidal behavior is not a disorder in itself, although in most cases it is associated with different mental disorders, among which mood disorders (especially depression), substance use disorders (particularly alcohol dependence), schizophrenia, and personality disorders are the most frequent.[2] Furthermore, certain physical conditions are also significantly associated with suicidal behaviors, including chronic pain syndromes, neurological disorders (epilepsy, spinal and central neurological injuries, and sequelae of cerebrovascular accidents), HIV infection, AIDS and some neoplasias.[3] Ultimately, all these disorders and diseases represent a potential risk of suicidal behaviors.

It must be highlighted, however, that a serious clinical condition alone is not associated with potential suicide. As seen in the general population, most suicides are committed by people who, in addition to having a clinical condition, suffer from psychiatric disorders such as depression and agitation, the latter frequently as a result of confusional states (delirium). A history of attempted suicide is another factor that greatly increases the risk of suicide.[4]

Although there are reasonably trustworthy local and national records of deaths from suicide,[5] systematic records of suicide attempts are inexistent. Obviously, the lack of these data is an obstacle to a better understanding of the situation and of individual characteristics leading to suicide attempts, as well as to the planning of services. Nonetheless, as far as the prevention of suicidal behaviors is concerned, such records are less useful than clinical and sociodemographic data.

The three main functions of the psychiatrist (particularly) and of the healthcare staff (in general) in the management of suicidal behaviors are: risk identification, patient protection, and removal or treatment of risk factors.

In psychiatric emergency, the main clinical situations associated with suicidal behavior are patients presenting with important suicidal ideation and attempted suicide survivors who have already had any existing clinical and surgical conditions stabilized. In both cases, the psychiatrist is responsible for determining the short- to long-term procedures to reduce the risk of suicide, including a possible decision for psychiatric hospitalization. This article focuses the main functions of psychiatrists in the management of suicidal behaviors, with a specific emphasis on psychiatric emergency services.

Severity of suicidal behavior

The rate of deaths from suicide has increased progressively in absolute numbers, although suicide rates vary according to the geographic region in which they are measured. Nowadays, more than 870.000 deaths from suicide are recorded worldwide every year, which represents 49% of all deaths from external causes.[6] Unfortunately, there are no equivalent records for attempted suicide. Local studies have shown that attempted suicide rates can be 10 to 40 times higher than the rates of suicide.[7]

In general, suicide is more prevalent in men, in the approximate proportion of 3:1, although an inverse relationship is observed in relation to attempted suicide. It must be pointed out, however, that these differences are decreasing.[7]

In respect to age, the highest suicide rates are usually reported in elderly people (current peak among people aged over 75 years), although in some countries this situation is radically diverse, as in New Zealand, where the peak of suicides occurs between 25 and 34 years of age, and in Japan, between 55 and 64 yearas.[8]

In Brazil, suicide rates have also had a progressive increase of 21% in an interval of 20 years. These rates have increased with age, especially in men. The proportion of men committing suicide is always higher than that of women, in all age ranges. Considering the total rates, Brazilian men have committed two to four times more suicides than Brazilian women. In relation to the age range, people aged over 65 respond for the highest suicide rates. The effect of age is a growing tendency from the range of 45-54 years and on, rapidly increasing until the age of 75 years or more. Suicide among individuals aged between 5 and 14 years is infrequent; however, a tenfold increase has been observed in the 15-24 age range over the past years.[9]

Risk factors for suicidal behavior

Usually, the risk of suicidal behavior is calculated from sociodemographic and clinical indicators. There are also genetic factors whose direct accuracy is still a matter of speculation, but which can be inferred from the family history. It is believed that a history of suicide (especially in first-degree relatives) and psychiatric disorders in the family is associated with an increased risk of suicidal behavior. Nevertheless, a distinction should me made between predisposing factors – distal factors that set the base on which suicidal behaviors may appear - and proximal factors that precipitate suicide attempts (also called stressors) associated with the risk of suicidal behavior.[10] Precipitating factors for suicidal behavior are associated with a number of situations implying losses (real or imagined) or changes in status, usually in the direction of worsening. Predisposing and precipitating factors are described in Table 1.

The presence of mental disorders is one of the most important risk factors for suicide. It is generally admitted that from 90% to 98% of people who commit suicide are suffering from a mental disorder by the time of their death (Table 2). Mood disorders (especially depression) are the most frequent diagnoses among people with mental disorders who commit suicide. According to the WHO, a diagnosis of mood disorder is present in between 20.8% and 35.8% of suicides. Associated mood and substance use disorders (in fact, depression and alcoholism) is the most frequent diagnosis.[11]

Protective factors for suicidal behavior

Most prevention strategies are based on the identification of risk factors for suicide, since data concerning protective factors

Table 1 – Predisposing and precipitating factors in suicidal behavior

Predisposing factors	Precipitating factors
Gender (males: suicide; females: attempts)	Marital separation
Age (youth: attempts; elderly: suicide)	Relationship breakup
Family history of suicidal behavior, alcoholism or other mental disorders	Affective and/or social rejection
Previous attempts(s)	Recent discharge from psychiatric hospitalization
Presence of mental disorders	Severe family disturbances
Presence of physical diseases	Job loss
Feelings of hopelessness	Changes in economic or financial situation
Marital status (divorced, widower, single)	Undesired pregnancy (especially for single females)
Physical, emotional, or sexual abuse in childhood	Shame
Unemployment and retirement	Fear of being discovered (for socially disapproved acts)
Social isolation	
Belonging to ethnical minorities	
Belonging to sexual minorities (homosexuals and transsexuals)	
Low intelligence levels[6]	

are scarce. The little we know or suppose comes from indirect sources. It seems valid to suppose that factors like a safe shelter, general security, and proper feeding and resting periods may not only contribute to the consolidation of health, but also to reduce the impact of adverse factors such as distressing situations or the presence of mental disorders. However, the specific roles of these factors in suicidal behavior are unknown.[12]

Conversely, it is believed that emotional resilience, the capacity to solve problems, and social skills capable to reduce the impact of adverse environmental or intrapsychic events might counterbalance the effects of some risk factors. The factors described in Table 3 are believed to protect the individual from suicidal behavior, although there is no enough scientific evidence to support this.[13]

A thorough examination of the risk and protective factors shows that some of them are useful in the very community in which one lives and works, whereas others become relevant or are only apparent in clinical settings.

It is important to note that none of these factors alone is strong enough to cause or to prevent suicidal behavior, and that it is the combination of these factors that leads to the crisis that triggers this behavior. In fact, Mann and Arango described the suicidal process as a diathesis or predisposition derived from complex interactions between socio-cultural factors, traumatic experiences, psychiatric history, and genetic vulnerability.[14]

Ambivalence in patients with suicidal behavior

Most suicidal patients are ambivalent, incorporating an internal battle between the desire to live and to die. At the same time that the patient wishes to die, he or she also wants to be rescued or saved. Stereotyped acts such as taking psychotropic drugs and calling relatives or friends for help express the twofold nature of the act.[14]

In a relevant number of suicide attempts, the suicidal intention is weak. Only one-fourth of patients who survived a suicide attempt admit their desire to die; the remaining say that they only wanted to sleep or escape from their problems.[15] Although this may not be consciously acknowledged, it can be inferred that suicidal behaviors are aimed, in many cases, at changing a situation of poor adaptation and suffering by influencing relevant people around. These situations constitute a cry for help that can be successful to the extent that it might create a movement of support and restructuring or, in the opposite direction, it may elicit even greater aggressiveness from close people or from a professional team poorly prepared to manage suicide attempts.

Risk assessment of suicidal behavior in clinical settings

There is no way to predict which individuals are going to commit suicide, but, during a clinical interview it is possible to assess the individual risk presented by each patient based on the investigation of risk and protective factors. A good interview is the best tool to assess the risk of suicidal behavior. In clinical settings, there is always an opportunity to investigate these risks, although this opportunity is frequently missed, with the consequent loss of many lives. Therefore, health professionals must be well prepared and trained in order to manage such cases.

1. The interview

In cases of attempted suicide, the objective of the initial interview is twofold: it is a privileged moment for the collection of information (semiological aspect) and also for the provision of

Table 2 – Commonly found diagnoses in suicide patients according to frequency

Diagnosis	Frequency
Mood disorders	30.2%
Substance use disorders (alcohol)	17.6%
Schizophrenia	14.1%
Personality disorders	13%
Organic mental disorders	6.3%
Anxiety/somatoform disorders	4.8%
Other psychotic disorders	4.1%
Adjustment disorders	2.3%
Other diagnoses	5.5%
No diagnosis	2%

emotional support and establishment of a bond with the patient. The first contact may take place under not so favorable conditions, often in the emergency room with the patient still reserved or drowsy or under intensive care. The patient may even deny his/her attempt to die, although the family and the medical staff report a suicide attempt. Efforts should be made from the very beginning to establish a bond with the patient in order to ensure trust and collaboration in a moment in which the person may feel weakened, hostile, and unwilling to cooperate.

The interview has the purpose of collecting a considerable amount of information: characterization of the suicidal act (method, circumstances, intentionality), epidemiologic data (risk factors, relevant events), predisposing and precipitating factors, psychodynamic aspects (conflicts, motivation, death-related fantasies), individual and family history, identification models, physical health, and social support network (people related to the patient and on whom he can count upon at home, work, church, and associations). It is important to form an idea regarding the patient's personality, especially in what concerns ego defense and coping mechanisms in the face of challenging situations. In the end, a global diagnosis of the patient's situation and an estimate of the risk of suicide should be obtained.

Initially, it is important to focus on the contents expressed by the patient (frustration, conflict, needs). This is a requirement in the management of crises. But it is also important to be aware of the latent contents in the account, of uncertain and conflicting feelings, false beliefs, automatic thoughts that create obstacles to broader or alternative views, and the dynamics of the patient's most important relationships. If necessary, all this can be examined at a later opportunity, under calmer conditions and when there is greater capacity for reflection.

It is common for the professional to feel as if he/she were between two poles: on the one hand, the feelings of the patient must be respected, including his/her desire to die and ambivalence between life and death; on the other hand, immediately after the end of the first consultation with the patient, concrete measures must be taken to keep a disturbed patient from taking his/her life, which includes the possibility of involuntary hospitalization.

Table 3 – Protective factors against suicidal behavior

Protective factors
Absence of mental disorders
Pregnancy
Sense of responsibility with the family
Social support
Religion
Employment
Satisfaction with life
Presence of children in the family
Capacity to solve problems
Capacity for positive adaptation
Preserved reality test
Positive therapeutic relationship

It is undeniable that caretakers and health professionals, when faced with the urgency and anguish imposed by suicidal acts and ideation, might be led to conduct the patient to something that they really believe in (an ideology or faith). Nevertheless, the maintenance of a distance between such beliefs, feelings or desires and the clinical decision-taking process is part of the training - usually complex and painstaking - of health professionals.

Except for measures to protect life, it is necessary to reflect upon the urgency of doing something concrete for the patient. We must remember that it is fundamental to listen to and to stand by the patient. This implies not trying to change the patients' feelings and ideas at all costs. If one feels that we are standing by him/her, one might calm down and think, instead of acting – talking about one's desire to die is different from actually putting one's life at risk. From then on, the patient himself can help us to continue to help him/her.

2. Beliefs

Many health professionals have false beliefs concerning suicidal behavior. The two most common of such beliefs are:

"If I inquire about suicide-related ideas, will I not be inducing suicide?";

"What if the person says yes, does he/she thinks about taking his/her life? Am I going to have to bear this responsibility?"

It is necessary to demystify the issue of asking direct questions about suicide, because this is a misconception that is frequent even among professionals. Instead, it is important to consider that patients with suicidal thoughts usually feel relieved for having an opportunity to disclose their thoughts and feelings related to suicide.

Such scruples hinder the clinical assessment and the first step in suicide prevention – the existence of the suicide risk itself – is not given due consideration. Under the influence of negative attitudes and erroneous beliefs, the professional will find it difficult to comprehend the patient in an empathic manner, to properly assess the risk of suicide and, in case it is present, to implement therapeutic actions. Instead of empathy, an affective dissonance will develop between patient and professional that will hamper the clinical task.

3. The initial approach of the patient

The patient should be approached in a calm, unprejudiced, and empathic manner. The subject must be introduced tactfully, but clearly. In the context of the clinical interview, for example, the following questions can be progressively asked as affirmative answers are given:

- Have you been thinking about death lately/more than you usually do?
- Have you been thinking of dying?
- Have you thought of taking you life?
- Have you made any plans in this sense?
- Are you willing to talk more about this?

1) When to ask?

- After establishing a good rapport with the patient.

• When the patient appears to feel comfortable enough to express his feelings.

• When the patient is in a process of expressing negative feelings.

2) Additional questions

The process does not finish with the confirmation of the presence of suicidal thoughts. It continues with additional questions to assess the frequency and severity of suicidal ideation, as well as the actual possibility of suicide. It is important to find out whether the patient has any plans and access to the means to commit suicide; if access to the chosen method is easy, the risk of suicide is higher. Finally, it is crucial that the questions do not sound intimidating, but that they are asked in a soft way so as to create empathy between patient and physician.[16]

The more intense and persistent suicidal thoughts are, the higher the risk of an eventual suicide. In order to determine the nature and lethal potential of suicidal thoughts, it is necessary to gauge the intensity, frequency, depth, duration, and persistence of suicidal ideation. Following the risk assessment, the professional should offer help, evaluate the support systems available in the medical service, and provide a psychosocial support network.

The emergency health professional must be prepared to deal with the characteristics normally presented by suicidal patients; that is, thoughts permeated by despair, hopelessness, and desolation. Hopelessness, whether in the presence or absence of a mental disorder, increases the risk of suicide. During the suicide risk assessment, the presence, persistence, and degree of hopelessness must be evaluated.

The act of relying on intuition alone, after a brief interview where little information is available, is temerarious. One of the best indicators for the assessment of the risk of self-destruction is the awareness of the rater in regard to his own anxiety before the patient. The inability to experience anxiety in these occasions resulting from a poorly empathic, quick, or excessively defensive contact hamper the clinical assessment and the therapeutic work.

Some patients deliberately conceal their suicidal intentions. In many situations, experienced clinicians have had enough reasons not to rely on the negative answers provided by patients denying their intention to kill themselves. Dramatic conditions of life, mental disorders, or the patients' mental state suggested the opposite of what they stated. It is likely that these patients denied their actual intentions in order to be promptly discharged, but the clinician would not believe this apparent calm and denial of suicidal ideation. Fake "improvements" are not to be trusted, especially when critical situations remain unsolved or have only been temporarily relieved by hospitalization. There are also unstable clinical conditions - especially delirium and anxious depression – that can precipitate suicidal behavior among apparently calm patients. In emergency settings, where the clinician or psychiatrist usually sees the suicidal patient for the first time, objective information provided by an accompanying person is of great value, including the reports of police officers or ambulance staff, colleagues and friends, and especially partners and relatives who may be present at the time of the assessment. Special care should be taken in the case of accompanying people with clearly conflicting relationships with the suicidal patient. In these cases, it is advisable to search for another informant regarded as reliable by the patient in order to establish a clear picture of the patient's psychosocial status.

4. The "no-suicide contract"

The establishment of a no-suicide contract is a useful technique in suicide prevention. It can be used in emergency settings, although with caution, because the success of a no-suicide contract is based mainly on a positive therapeutic relationship between patient and physician. In emergency settings, this relationship may be impaired, with consequences for the physician's capacity to judge the actual risk of suicide. The negotiation must involve the discussion of several aspects that are relevant to prevent the patient from committing suicide. Most of the times the patient respects the promise made to the physician, but the contract alone is not an effective measure and all the other support measures available are also necessary. The establishment of a contract is only valid when the patient has control over his actions; that is, when judgment is not affected by the presence of mental disorders.[17]

The use of scales

Although a number of scales and strategies have been proposed for this purpose, unfortunately none of them has proved to be fully efficient to detect the risk of suicide.[18] Notwithstanding this problem, the high prevalence of suicidal ideation among inpatients of clinical emergency departments and non-psychiatric wards and the low recognition rates of these conditions[19] make it fundamental that a brief assessment of suicidal thoughts and suicide risk factors be performed with all patients.[20] In an attempt to advise mainly the clinical staff with no psychiatric training (physicians and nursing staff), the WHO has issued a series of documents on suicide prevention, one of them directed to general physicians[16] and the other to primary health care workers.[17] These documents provide a simple method to assess the risk of suicide based on signs and symptoms that can be easily identified by non-specialized health care workers. This plan is described in Table 4.

In the practical guidelines for the assessment and treatment of patients with suicidal behaviors published by the American Psychiatric Association,[21] some of the guidelines dealing with the referral of patients with suicidal behaviors were formulated by an expert committee taking into account risk factors, social and family status, personal history, and other elements with the purpose of indicating the appropriate therapeutics according to the clinical status of the suicidal patient, described in Table 5.

Managing the patient

Preventing the patient from killing him-/herfself, regardless of considerations by different therapeutic, ethical, or philosophical schools, is the preliminary and fundamental rule. In relation to the attending professional, there is a thin line between the preservation of the patient's intimacy (when the risk of suicide is low) and his

Table 4 – Suicide risk assessment scale and recommended conducts for health professionals suggested by the WHO

Suicide risk	Signal/Symptom	Investigation	Conduct
0	No disturbance or discomfort.	-	-
1	Mild emotional disturbance.	Inquire about suicidal ideation.	Listen with empathy.
2	Vague death-related ideas.	Inquire about suicidal ideation.	Listen with empathy.
3	Vague suicide-related ideas.	Investigate intention (plan and method).	Investigate support possibilities.
4	Suicide-related ideas with **no** mental disorder.	Investigate intention (plan and method).	Investigate support possibilities.
5	Suicide-related ideas **with** mental disorders **or** important social stressor.	Investigate intention (plan and method). Establish rapport.	Refer to psychiatric care.
6	Suicide-related ideas **with** mental disorders **or** agitation **and** previous suicide attempt.	Patient should not be left alone (in order to block the access to means to commit suicide).	Hospitalization.

responsibility to save the patient's life (when suicide is imminent). If imminent suicide risk is present, psychiatric hospitalization is advised, even if it is involuntary.

In most cases, the transfer to a psychiatric ward or institution is impossible. Even at psychiatric emergency departments, the physical structure and the training of medical and paramedical teams are often far from ideal, including the existence, for example, of facilities that make no distinction between suicidal and clinical inpatients. How can a clinical or surgical ward be transformed into a safe environment for potentially suicidal patients? It is important to enter the risk of suicide into the patient's and the nursing records, as well as the treatment implemented. More important than this, however, is the exchange of ideas within the staff in relation to the risk and measures to be taken.

Some precautions should be taken in relation to the suicidal patient, such as removing dangerous objects (cutting and piercing instruments, belts, lighters, and drugs) and choosing a bed that can be easily watched, if possible on the ground level, with locked or barred windows and constantly supervised bathroom access. Allowing an accompanying person to be always present is an alternative to be adopted.

Patients with delirium, clouding of consciousness, and agitation should be sedated and physical restraint should be used with discretion. In the event that examinations or procedures must be performed outside of the ward, these patients must be transported while sedated and restrained, considering the possibility of psychomotor agitation and impulsive suicidal acts. The treatment plan must be flexible and submitted to periodic review. The availability and qualification of the staff are as important as any environmental changes implemented to avoid suicide. Regular discussions facilitate the qualification of the staff to deal with these cases.

Some of the suicide attempts in general hospitals are impulsive, occurring in people with no psychotic symptoms, clouding of consciousness, depression, or suicidal ideation. Some patients who decide to take their lives can deliberately hide this from the staff. Once their decision is taken, these patients no longer present the same despair, appearing to be calm and transmitting a false impression of improvement. The distance from distressing situations provided by hospitalization can also convey apparent improvement and lead to early – and reckless – hospital discharge.[22]

Particular attention should be paid to such periods as nursing shift changes, hospital leaves (when between one-third and half of the suicides among hospitalized patients occur), the first week of hospitalization, and the first month after hospital discharge. Even with all the care dispensed, some patients still commit suicide while under medical supervision. These acts have a great impact on the other patients, relatives, and staff, eliciting feelings of guilt, anger, and anxiety. Meetings with these groups of people are important so that the event can be discussed and elaborated.

In summary, the basic elements of the care to be delivered to suicidal patients include[23]:

- Listening. In general, it is necessary to listen extensively because patients may need to talk about their feelings and thoughts. There are situations, however, in which the professional has to be more active, encouraging dialogue in search of solutions.
- Acceptance of one's own feelings, including the tolerance of ambivalence (fairly disturbing coexistence of opposite feelings). The professional should make an alliance with that part of the patient that wishes to survive.
- Creation of a "support point", like a float onto which the therapist/patient pair may hold in order to breath and move on. Sometimes, already at the end of the first contact, it is necessary to define a point from which to start the process of organizing the emotional chaos of the patient.

Very often, a proper referral represents the first supporting "point" in the effort to organize the patient's emotional turmoil. The psychiatrist or another clinician assisting the suicidal patient should have access to and an adequate contact with mental health services which are able to provide prompt care and apropriate

Table 5 – General guidelines concerning treatment indications for patients at risk of suicide or suicidal behavior

Conditions indicating hospitalization after a suicide attempt
Psychotic patient
Violent, almost lethal, or premeditated attempt
Precautions were taken to avoid rescue or discovery
Persistence of the plan or clear intention
Patient feels regret for being alive or no regret for having attempted suicide
Male patient, age over 45, with recent onset psychiatric disorder and suicidal thoughts
Patient with limited family contact, poor social support, including loss of socioeconomic status
Persistent impulsive behavior, severe agitation, impaired judgment or open refusal of help
Patient with alterations in mental state due to metabolic disturbances, toxic, or infectious alterations or with another etiology requiring clinical investigation
In the presence of suicidal ideation with:
Specific, highly lethal planning
Strong suicidal intention
Condition in which hospitalization should be thoughtfully considered after a suicide attempt
In the presence of suicidal ideation:
Psychotic episode
Severe mental disorder
Previous suicide attempts, particularly with serious clinical consequences
Pre-existing clinical conditions (neurological disorders, cancer, infections, etc.)
Impaired judgment or incapacity to collaborate with the hospital structure, or impossibility to comply with outpatient treatment
Need for help from staff to take medications or perform electroconvulsive therapy
Need for constant supervision, clinical tests or diagnostic screening requiring hospital structure to be performed
Limited family and social support, including impaired social status
Lack of a good patient-physician relationship hindering outpatient follow-up
In the absence of suicide attempts or reports of suicidal ideation:
Suicide planning and intention is evident from the psychiatric evolution of the case and/or from previous history suggesting high risk of suicide, and recent increase in suicide risk factors
Discharge from the emergency service and referral to outpatient treatment
After a suicide attempt or after the presence of suicidal ideation:
The event was a reaction to precipitating factors (e.g., failure in a test, relationship issues), especially when the patient's view in relation to his difficulties has changed after admission in the emergency service
Low-lethality planning, method, and intention
Patient with stable family and psychosocial support
Patient is able to comply with outpatient treatment conditions, keeping contact with his physician and with conditions for continuous outpatient treatment
Outpatient treatment
Patient with chronic suicidal ideation and or self-provoked injury with no serious clinical consequences, with stable family and psychosocial support or ongoing psychiatric outpatient follow-up

therapeutic follow-up. Difficulties in receiving assistance from the service indicated by the professional might strengthen the patient's hopelessness, facilitating the non-compliance to the treatment and the loss of the opportunity to reduce the risk of suicide.

An example of systematic management

Based on international experiences and on a number of local projects, in 2000 the WHO published an international multisite study (SUPRE-MISS) involving eight countries [Brazil, China, Estonia, India, Iran, Sri Lanka (former Ceylon), South Africa, and Vietnam], in five of which controlled clinical trials were performed to assess an innovative strategy to seek for and maintain the treatment of people admitted in urgency/emergency services after a suicide attempt.[24] Two groups were compared:

1) Psychosocial intervention including motivational interview and regular telephone follow-up, according to the flowchart presented in Figure 1 (at the moment of discharge from the hospital, patients were referred to one of the services of the public health network);

2) Treatment as usual (single referral to the public health network after hospital discharge).

The outcomes of the two groups were analyzed after 18 months.

The results of this complex and extensive study indicated a clear reduction in general and specific mortality rates associated with suicide in all the countries involved.[25] In respect to repeated suicide attempts not leading to death, the results varied according to the country: suicide attempt rates decreased in China and Sri Lanka and increased in Iran in Brazil (although attempts were significantly less severe).[26]

In Brazil, the study was performed in the city of Campinas and involved a total of 2.238 participants. In most cases, follow-up was conducted by means of periodic phone calls, although some

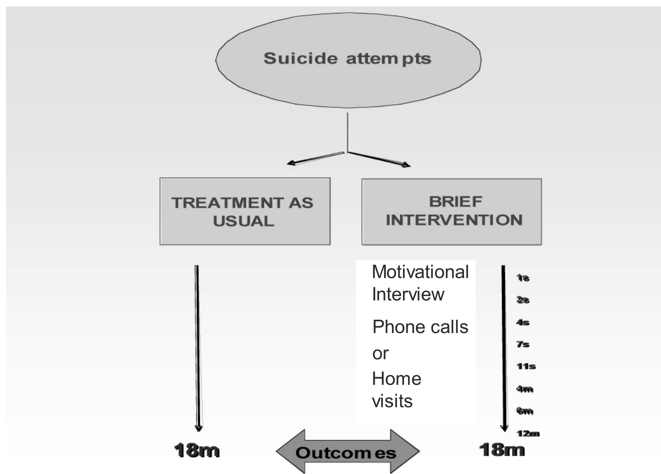

Figure 1 – Flowchart of the SUPRE-MISS with individuals who were followed-up after suicide attempts.

cases required home visits. After 18 months, the percentage of suicides in the group that was not followed-up by telephone was 10 times higher as compared with the intervention group, although the intervention was unable to reduce the number of suicide attempts.[27]

Conclusion

Due to the diversity of factors and problems associated with suicide, there is no single "recipe" that is effective for all the people at risk of suicide. The multifactorial determination of suicide implies the careful analysis of each one of the risk and protective factors involved. Statistical correlations do not show the causes of suicide, but rather they enable the formulation of hypotheses with varying degrees of certainty. Only prospective studies assessing prevention methods based on these hypotheses are able to support the implementation of prevention and management policies for suicide.

The systematic assessment of suicide risk in emergency services should be part of the routine clinical practice so that potentially fatal cases could be properly managed and referred. In a review about suicide prevention strategies, Morgan and Owen state that the best strategy for populations at high risk, such as patients with a history of previous suicide attempts, is to improve healthcare services and develop effective interventions for groups of patients who have attempted suicide, with adequate follow-up procedures.[28] Due to the paucity of national studies to support the creation of a protocol for interventions with these groups of patients, there is a lack of specific intervention strategies for individuals arriving at our emergency services after a suicide attempt.

Not all cases of suicide can be prevented; however, the ability to deal with suicide makes the difference, for thousands of lives can be saved every year if all individuals who have attempted suicide are properly approached and treated. This perspective is particularly important for suicidology, since reductions in morbidity (suicidal ideation and suicide attempts) can certainly lead to a decrease in mortality rates.[29]

Disclosures

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** Modest*
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For more information, see Instructions for Authors.

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