Assessment of suicide is an essential component in evaluating and treating depression. An evaluation of the patient’s suicidal potential should be performed whenever the diagnosis of depression is considered and especially if an antidepressant is prescribed (2). Identification of depression and suicidal ideation is particularly important in the medical setting, as physicians are likely to have contact with people who soon thereafter commit suicide. About 80% of people who end their lives talk about suicide before taking action. Some evidence indicates that half of people (and 75% of elderly) who kill themselves have seen their physicians within a month before they died. Suicide ranks as the ninth leading cause of death each year, with over 30,000 suicides annually. There are at least 10 suicide attempts for each completed suicide. Physicians have the potential to help prevent morbidity and mortality from suicide. Their skill in identifying, evaluating, and interviewing for suicidal ideation/intent can make a crucial difference. Key risk factors for suicide can be identified in the patient’s demographics (table 1), history (table 2), and current state (table 3) (2) (4).

### Table 1: Demographic Risk Factors for Suicide

<table>
<thead>
<tr>
<th>Age</th>
<th>The highest risk is in adolescence, and in the elderly</th>
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<tbody>
<tr>
<td>Gender</td>
<td>Women make 10 times more attempts than men, but men succeed at suicide</td>
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</table>
three times more often because they use more lethal methods (four times more likely to die).

**Marital Status:** Separated, widowed, or divorced

**Race:** Caucasian men and women account for a disproportionate 90% of all suicides.

**Sexual identity:** Homosexuals are at higher risk

**Gun ownership:** People who live in homes with firearms are five times more likely to die by suicide than those in gun free homes.

**Relationships:** Persons are at higher risk when living alone and have no social supports

**Employment:** Unemployed or have lost status in their jobs

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**Table 2: Patient History Risk Factors for Suicide**

- Prior suicide attempts, even if minor
- Family history of suicide or attempts
- Suicide of a close friend, particularly if an adolescent
- Psychotic or bipolar depression
- Poor coping ability
- Substance abuse
- Personality disorder
- Anniversary of a loss
- Chronic pain
- Chronic debilitating illness (e.g., AIDS, ESRD)

**Table 3: Current State Risk Factors for Suicide**

- A direct or indirect expression of intent to harm self
- A plan that is well developed
- Poor judgment or impulse control
• Use of alcohol or other substances
• Giving away of possessions
• A significant deterioration in functioning and appearance
• A rapid elevation in mood. The patient may have decided upon a plan and feels a sense of relief.
• More energy may also help a patient follow through with a plan
• A fantasy of reuniting with deceased loved one.
Case 1:
Mr. L’s wife died of breast cancer 6 months ago. He now comes for his “yearly check-up.” Though Mr. L denies “depression,” he has stopped hunting and fishing with his friends, which are long-time interests. He is Caucasian, 63 years old, recently retired with COPD and rheumatoid arthritis.

Many patients with Major Depression deny feeling depressed, though they usually endorse specific symptoms if asked. Mr. L’s withdrawal from pleasurable activities is suggestive. Mr. L has many risk factors for suicide (older white male, widowed, not working, chronic illness, chronic pain, and access to guns). His physician should evaluate for depression, and directly ask about any alcohol use and suicidal thoughts. The next section reviews how to discuss suicidal ideation with patients.

**Discussing Suicidal Ideation and Plans With the Patient**
Patients’ anxiety or shame and physicians’ discomfort may lead to skirting the topic of suicide. The best approach is to ask the patient directly. A good, empathic initial question is “Have you felt so bad that life did not seem worth living?” If answered affirmatively (or not answered), the next question would be “Was it bad enough that you thought of ending your life?”

Further steps are:
1. Ask about the frequency of the thoughts (pervasive, intermittent)
2. Are the thoughts directly related to a recent or upcoming situation?
3. Does the patient have a plan? If so, how well developed is the plan?
4. How lethal is the method described?
5. What is the patient’s access to the method? Is there a gun or drugs in the home?
6. Does the patient have any thoughts or impulses of hurting someone else? It is not uncommon for suicidal and homicidal thoughts to occur together, particularly if domestic violence is involved.
Suicidal Ideation and Planning: Immediate Safety

Prevention of suicide requires specific and immediate interventions to increase patients’ safety. Emergent referral to a mental health practitioner is always indicated with acute suicidal thoughts or plans, or recent attempts. An inpatient admission may also be needed if the patient’s or others’ safety cannot be protected. Depending upon the severity of the crisis, the physician should consider the actions below in the interim before evaluation, admission or treatment by a mental health provider. If the patient has expressed suicidal ideation or intent, the physician has to determine the extent to which

- the patient will cooperate around safety issues (e.g. giving up guns)
- the availability of friends and family to ensure safety or to follow through with more restrictive options
- the risk to another person if violence is also threatened

The range of alternatives for the physician will depend upon the degree to which the patient’s safety can be assured. Assessment will be contingent upon:

1. The patient’s willingness to engage in a plan with the physician to not harm himself/herself. This plan can be verbal or written. It can be as simple as the patient’s clear agreement to call the practice if they are feeling unable to control thoughts or impulses to harm themselves (3).

2. The availability of family or friends to provide a “suicide watch” (if needed) for a defined period of time or to help in the removal of lethal items from the home. They should also be familiar with the procedures if more restrictive intervention is required (i.e. psychiatric emergency room, involuntary hospitalization).

3. Increased contact with the physician or medical practice until the patient can see a mental health practitioner.

4. The physician will need to implement more restrictive options for the patient’s safety if prevention of self-harm cannot be negotiated. The patient can be given the opportunity for a voluntary admission to a hospital. Refusal to agree to this alternative requires an involuntary process. Procedures vary by state or province.
While these precautions are usually not difficult to implement, they are not always effective. Patients who become unambivalently and persistently intent on killing themselves may succeed despite others’ best efforts.

(See the entire chapter section for references)