Suicide Risk Management: A Manual for Health Professionals is a short, clearly written book that provides practical guidance on how to manage the suicidal or potentially suicidal patient. Written by two expert teachers, the book has been used in courses for trainee psychiatrists and for health professionals throughout the world. Feedback from participants on these courses has informed revision of the new edition. This book is of interest for all mental health professionals who come into contact with patients who present with suicide potential, i.e. all mental health professionals, as well as general health professionals who are often the first point of contact for a suicidal patient.

The book opens with a review of the epidemiology, risk factors and associated aspects of suicide. It then presents two assessment tools: The Tool for Assessment of Suicide Risk (TASR) provides instruction on how to use it appropriately in the clinic. The Suicide Risk Assessment Guide (SRAG) acts as a self-study program to assess clinical evaluation skills. Both tools were created for use in the authors’ own practice and are now successfully taught to and used by health professionals around the world. Refined through actual experience, these proven tools help assess and evaluate patients with confidence.

Case vignettes allow the reader to practice using the information they have learned from the book.

Throughout the book, bulleted lists, tables and flowcharts effectively describe how to use the many factors to assess the risk of suicide in an individual patient.
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Understanding suicide is unachievable. The underpinnings of suicide are diverse and multifaceted, involving a unique fusion of biological, psychosocial and cultural factors for each individual. Suicide is not an event that occurs in a vacuum. It is the ultimate consequence of a process.

For many people who take the decision to end their own life we will never be able to answer the question ‘Why?’ For some, self-inflicted death may be:

- an escape from despair and suffering
- a relief from intractable emotional, psychological or physical pain
- a response to a stigmatizing illness
- an escape from feelings of hopelessness
- a consequence of acute intoxication
- a response to commanding homicidal or self-harm auditory hallucinations
- a manifestation of bizarre or grandiose delusions
- a declaration of religious devotion
- a testimony of nationalist or political allegiance
- a means of atonement
- a means of reunification with a deceased loved one
- a means of rebirth
- a method of revenge
- a way to protect family honour

This does not mean that health professionals should not know how to recognize, assess and manage the suicidal patient. Indeed, all health professionals should be proficient in this core competency as many of
their patients may face the prospect of suicide at some time in their lives. Many patients who experience suicidal thoughts or make suicide plans will change their minds about committing suicide. Many people who attempt suicide and are not successful go on to live productive lives. For some, a suicide attempt is an event that leads to a first contact with a helping professional. Some of these individuals may be suffering from a mental disorder that will respond to appropriate and effective treatment. Some may be suffering from chronic physical disorders; others may be overwhelmed by life stressors. In any case, many of these individuals may consider suicide as a viable solution to their problems or the only means to ending their suffering. By being aware of suicide risk factors and knowing how to identify and provide appropriate targeted interventions for suicidal individuals, health professionals can assist in the patient choosing life rather than death.

Cultural, religious, geographical and socioeconomic factors all impact on the expression of suicidality and the completion of suicide. Thus, health professionals from various countries or regions may need to adapt some of the material in this book to reflect local perspectives. However, we all need to remember, whenever a clinician and a suicidal person interact, that careful, considerate application of suicide risk management will need to be applied – regardless of context. Contexts differ but people are similar.
Objectives

1. To provide information regarding the epidemiology, risk factors and associated aspects of suicide.
2. To provide information that will assist in the understanding and assessment of suicide risk.
3. To provide a continuous self-study programme pertaining to clinical evaluation of suicide, using the Suicide Risk Assessment Guide (SRAG).
4. To introduce the Tool for Assessment of Suicide Risk (TASR) and provide instruction on its appropriate clinical application.
Why is it important to know about suicide?

Suicide is a significant public health problem worldwide. Suicide represents 1.4% of the Global Burden of Disease and accounts for nearly half of all violent deaths and almost one million fatalities globally each year. Although these numbers may seem alarming, it is widely believed that they are underestimates of the true global prevalence and global burden of suicide.

For every life lost to suicide there are many more left in the wake of the tragedy – parents, children, siblings, friends and communities.

‘For every suicide death there are scores of family and friends whose lives are devastated emotionally, socially and economically . . . Suicide is a tragic global public health problem. Worldwide, more people die from suicide than from all homicides and wars combined. There is an urgent need for coordinated and intensified global action to prevent this needless toll.’

Dr Catherine Le Galès-Camus, WHO Assistant-Director General, World Mental Health Day 2006
Challenges to understanding global suicide rates and suicide risk

Estimating suicide prevalence in different countries is problematic. Suicide rates range substantially between countries (WHO, 2009) and the variability of data collection and reporting makes national comparisons difficult if not impossible. Many countries lack a standard surveillance system that accurately captures suicide death. Where surveillance systems exist, data validity can be obscured by variability in the classification of suicide deaths, procedures for recording suicide deaths, procedures for completing death certificates, and the bodies responsible for determining the cause of unexpected death. The stigma associated with suicide is also a significant barrier to estimating true prevalence rates. In many cultures suicide is hidden by affected families to avoid shame, disgrace, ridicule or social exclusion. Worldwide, cultural, religious and social values and beliefs have significantly influenced what has been reported in official death records and are believed to continue to contribute to the misclassification of suicide deaths as accidental or due to unknown causes in many countries. Therefore, ‘prevalence estimates’ taken from country records globally likely underestimate actual suicide rates.

The pervasive stigma, shame and humiliation associated with a suicide death are perpetuated by legislation that continues to classify suicide as a criminal offence in many developing countries. Although such laws may now rarely, if ever, be enforced in most jurisdictions, in some, persons who survive a suicide attempt may be tried and convicted in court. So too might family members of a suicide victim be charged with stiff penalties or be subject to social humiliation. Not surprisingly, reported prevalence figures in countries where such laws are upheld are consistently reported to be extremely low. Nevertheless, based on available data, globally suicide is believed to account for an average of 10–15 deaths for every 100,000 persons each year, and for each completed suicide there are believed to be up to 20 failed suicide attempts.

Another compounding issue in understanding global and national suicide rates is the large jurisdictional variations in reported suicides even within countries where suicide data are relatively well collected. Suicide rates vary widely across different states in the USA and across provinces and territories in Canada, for example. Historically, suicide rates within jurisdictions, countries and regions have demonstrated
secular trends that are poorly understood. The complexity of factors outside the suicidal individual that may contribute to increased risk is substantial. The underpinnings of suicide are diverse and multifaceted, involving a unique fusion of biological, psychosocial, political, economic and cultural factors for each individual. The significance of each factor or combination of factors in any location at any one time is difficult to deconstruct. For example, in many developed countries, including Canada and the USA, historical prevalence data demonstrate that suicide in young adults and teens started increasing in the 1950s. In the last decade and a half this longstanding trend shifted, with youth suicide rates in many developed countries decreasing or reaching a plateau. This shift has not been strongly correlated with the presence or absence of national suicide prevention strategies and it is not clear what factors have been most important in changing this suicide trend in young people, although considerations have included the more effective identification and treatment of depression and control of lethal means. Nonetheless, in the USA and many other countries (particularly in wealthy or developed states), suicide continues to be one of the three leading causes of death in young people between the ages of 15 and 24.

The majority of studies on risk factors for suicide have been conducted in developed countries using the psychological autopsy methodology. Psychological autopsy studies in the West have consistently demonstrated strong associations between suicide and mental disorder, reporting that 90% of people who die by suicide have one or more diagnosable mental illness. The most common diagnoses found to be associated with suicide death include the affective (mood) disorders, anxiety disorders, substance abuse disorders, personality disorders and schizophrenia. These studies have identified the presence of an untreated mental disorder – particularly depression and substance abuse – as the greatest attributable risk factor for suicide.

Using the same type of psychological autopsy methodology, studies conducted in developing countries have not demonstrated as robust an association between suicide and mental disorder as purported in the West. Undoubtedly there are many factors that may explain this discrepancy. In developing countries, suicide may be less clearly correlated with mental disorder and may be more often influenced by cultural, religious, social, economic and political factors. The dearth
of mental health resources in most developing countries and the lack of accessible and available mental health services may lead to a systematic under-diagnosis of mental illnesses. Stigma, cultural understandings of mental health and mental disorder, and traditional methods for the care and treatment of the mentally ill may also contribute to this difference. Despite the apparent variability between studies conducted in different parts of the world, a strong and consistent association between suicide and mental disorders is undeniable. Thus, the scaling up of mental health services to improve early detection, intervention and management of mental illness – particularly in primary care, where most conditions first present – is recognized as the cornerstone of any suicide prevention strategy.

Not negating the significance of mental disorder to suicide risk, it is important to recognize that the vast majority of people with mental disorders will not die by suicide and that many people who die by suicide do not have a diagnosable mental disorder. Thus, having a mental disorder is neither necessary nor sufficient in itself to account for suicide deaths. Other identified significant risk factors include current or past suicide behaviour, availability of and access to lethal means, exposure to trauma or abuse, severe psychosocial stressors, interpersonal loss, family history of suicide and mental disorder, alcohol and drug misuse, lack of significant relationships and social isolation, chronic physical illness, disabling pain, lack of internal coping abilities, and lack of access to health and social services and supports. Thus, in addition to scaling up mental health services, suicide prevention activities must also address identified modifiable socio-cultural-political-environmental factors that influence suicide risk.

Suicide prevention is not the purview of health alone. Suicide prevention is everyone’s responsibility – individuals, families, community organizations and agencies including faith-based organizations, private business, and all levels of government – and requires a multi-sectoral response to achieve success.

**Role of health professionals in suicide risk mgmt**

Suicide risk assessment is a necessary core competency required by all health providers. Regardless of location or setting, health providers
are often the first point of contact for individuals and families who may be at risk for suicide. In North America, studies indicate that the majority (up to two-thirds) of those who die by suicide have had contact with a health care professional for various physical and emotional complaints in the month before their death. Unfortunately, many patients who are contemplating suicide do not spontaneously voice suicidal thoughts or plans to their health care provider, and the majority of those at risk are never asked about suicidality during general clinical assessments. Consequently, individuals at risk are often never identified and do not receive needed intervention and support. Failure to identify individuals at risk for suicide may stem from a lack of training in the identification of suicide risk factors, lack of comfort or confidence on the part of the health care professional in addressing suicide risk, time and resource constraints of busy clinical practices, or a combination of these and other factors. Working with patients at risk for suicide is difficult and anxiety-provoking for many health providers. Even among mental health professionals who work with recognized populations at risk for suicide, working with a suicidal patient is considered one of the most stressful and challenging components of their clinical practice. Nonetheless, all health providers must have the knowledge, skills and competencies necessary to identify, assess and manage suicide risk with confidence, care and respect. Once the health care provider has developed necessary suicide risk-assessment competencies she/he can apply them in any setting where individual evaluation occurs.

What are some of the barriers to detection and prevention of suicide?

Several factors can impede the detection and prevention of suicide:
- stigma
- failure to seek help
- lack of suicide knowledge and awareness among health professionals
- suicide is a rare event.

**Stigma**

Stigma refers to the shame, disgrace or reproach attached to something that is considered socially unacceptable. In many cultures
suicide is seen as shameful, sinful, weak, selfish or manipulative. These beliefs are held both by society as a whole and by those who are contemplating suicide. Stigma acts to reinforce both secrecy and silence and contributes to feelings of isolation, self-contempt and self-deprecation in individuals experiencing thoughts of suicide, and shame and guilt in those with loved ones who have committed suicide.

The social stigma of suicide is compounded by the link between mental disorder and suicide. People with mental disorders continue to be amongst the most marginalized in their society and experience greater misaddress of human rights than any other group of ill people, regardless of their religious affiliation, cultural identity or place of residence. In many parts of the world mental illness fails to be recognized as a legitimate health disorder and people with mental illness continue to be misunderstood as weak, lazy, attention seeking, crazy or stupid. Fear of being thought of or being labelled as mentally ill and fear of the ridicule, discrimination, social exclusion, loss of friends, loss of employment or loss of opportunity that may result likely contributes to the secrecy and silence that keeps people from reaching out and receiving help.

Sadly, the stigma associated with mental illness, as with suicide, is based on misinformation and misunderstanding.

**Failure to seek help**

As stated above, the stigma attached to suicide and the consequent fear of social sanctions, discrimination, loss of dignity and self-respect can prevent people from seeking help or disclosing suicidal thoughts and plans. For some, contemplating disclosure of suicidality may be associated with such intense feelings of personal shame, humiliation or embarrassment – as well as fear of judgment and ridicule by friends, family, community and health providers – that suffering in silence or ending their life may seem a more acceptable solution. Others may fear that disclosure will result in the forced interruption of a process to which they have committed. Some may fear loss of control over their situation or that disclosure will result in involuntary hospitalization. In jurisdictions in which suicide is considered a criminal offence, individuals may not disclose suicidal thoughts or plans for fear of