

Beacon Clinical Topic: **Suicide and Suicide Prevention**

The French Nobel laureate author Albert Camus opens *The Myth of Sisyphus* with this ominous thought: There is but one truly serious philosophical problem, and that is suicide. Judging whether life is or is not worth living amounts to answering the fundamental question of philosophy.

With millennia of religious and philosophical background, suicide is today also a public and mental health priority. According to the CDC, [42,773 Americans died of suicide in 2014](#), vastly outnumbering the number of homicides at 15,809, and placing it among the country's top 10 causes of death. Views regarding its treatment have evolved over the years. We now have an evidence base to support treating suicide as a condition in its own right, rather than focusing on treating co-occurring conditions.

1. DEFINITION

Suicide is the act of deliberately killing oneself. Suicidal behavior is a complex set of actions ranging from suicidal ideation, planning and attempting.

- a. **Epidemiology:** Suicide may occur at any age, but it is rare in children under 5 (APA, 2013). Males are at a much higher risk – out of the 42,773 suicides in 2014, 33,113 were by males – though women attempt it more frequently. The US suicide rate stands at 13.4 per 100,000 population, which is above the world average of 11.4, and it [varies across states](#). The suicide rate also [varies by country](#). Regarding service utilization, in the month prior, almost half (45%) of people who die from suicide visited their PCP, but only a fifth (19%) visited mental health services.
- b. **Risk factors and comorbidities:** One method to study completed suicide is by psychological autopsies, and [one paper](#) divided the risk factors into demographic, stressful life events, and psychiatric diagnoses. Compared to those dying of natural causes, those dying of suicide are more likely to be male, Caucasian, and divorced, separated or widowed; suicide completers were also more likely to meet criteria for a depressive disorder or a substance use disorder, as well as experience interpersonal difficulties during the six months prior to their death. Other strong correlates are diagnoses of bipolar disorder and [schizophrenia](#); family history of suicide; and poor adherence to treatment. For teens, [bullying victimization](#) has been associated with suicide risk.

2. DIAGNOSIS

The *DSM-5* included among the “Conditions for Further Study” the following criteria for Suicidal Behavior Disorder:

- a. Within the last 24 months, the individual has made a suicide attempt.
- b. The act does not meet criteria for non-suicidal self-injury – that is, it does not involve self-injury directed to the surface of the body undertaken to induce relief from a negative feeling/cognitive state or to achieve a positive mood state.
- c. The diagnosis is not applied to suicidal ideation or to preparatory acts.
- d. The act was not initiated during a state of delirium or confusion.
- e. The act was not undertaken solely for a political or religious objective.

Specify whether:

- Current: Not more than 12 months since last attempt
- In early remission: 12-24 months since last attempt

Screening: Two scales are available to screen for suicidal behavior, the [Columbia Suicide Severity Rating Scale](#) (C-SSRS) and the [Suicide Assessment Five-Step Evaluation and Triage](#) (SAFE-T).

3. TREATMENT

- a. **Psychopharmacology:** There are no medications indicated for suicidal behavior. However, lithium, clozapine, and some antidepressants have been shown to reduce suicide risk.
- b. **Psychotherapy:** Dialectical Behavior Therapy (DBT) is considered the most effective evidence-based psychotherapy for suicidal behavior. DBT was originally designed for suicidality in borderline personality disorder and is now recommended more generally. Compared to other non-behavioral psychotherapies, DBT is uniquely effective at reducing suicide attempts and increasing engagement with services. Cognitive Behavior Therapy for Suicide Prevention (CBT-SP) is a tailored version of CBT, specifically for individuals with suicidal thoughts and behaviors. Among people who had recently tried to take their own lives, those receiving CBT-SP were 50% less likely to try again within 18 months compared to those in usual care. A [systematic review](#) of interventions for suicide attempt in adolescents found support for DBT, CBT, as well as Mentalization-Based Therapy (MBT).

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- c. **Implementation strategies for evidenced-based practices:** Non-demand caring contacts, such as check-in phone calls or text messages, have been shown to reduce suicide rates. Additionally, the Collaborative Assessment and Management of Suicide (CAMS) therapeutic framework promotes collaborating with suicidal patients to improve engagement and to empower them as a partner in designing their own care plan, particularly a safety plan. Brief educational interventions, such as a one-hour, individual informational session combined with regular, long-term follow-up, have also been shown to reduce suicide deaths.
 - d. **Suicide prevention strategies:** The [National Strategy for Suicide Prevention](#) was released in 2012 with four directions: healthy and empowered individuals, families, and communities; clinical and community preventive services; treatment and support services; and surveillance, research and evaluation. This document builds on successful experiences both nationally – the US Air Force Suicide Prevention Program, for example – and internationally – such as the nine suicide prevention recommendations implemented by the UK public sector mental health service, which are as follows:
 1. Providing 24-hour crisis teams
 2. Removing ligature points (materials that could be used for suicide)
 3. Conducting follow-up with patients within 7 days of discharge
 4. Conducting assertive community outreach, including intensive support for those with severe mental illnesses
 5. Providing regular training to frontline clinical staff on the management of suicide risk
 6. Managing patients with co-occurring disorders (mental and substance use disorder)
 7. Responding to patients who are not complying with treatment
 8. Sharing information with criminal justice agencies
 9. Conducting multidisciplinary reviews and sharing information with families after a suicide

This National Strategy also led to the development of the [Zero Suicide](#) concept that holds that suicide deaths for individuals under care within health and behavioral health systems are preventable.

4. SUMMARY AND TAKEAWAYS

Suicide is tragically common but also mostly preventable and treatable. Measures can be taken at the individual level, at the health systems level, and at the social/community level to decrease its incidence.

5. QUESTIONS FOR CLINICAL TEAM DISCUSSION

- a. A year ago, [a fascinating study](#) found a significant increase in mortality, accounted in part by increase in suicide, among middle-aged, white non-Hispanic adults in the United States between 1999 and 2013. What factors could explain this increase?
- b. What can be done to decrease suicide risk in the period post-discharge of psychiatric hospitalizations given we know this is a high-risk time?
- c. A [recent opinion in JAMA](#) showed a correlation between the decline in psychiatric beds and the increase in the US suicide rate. How should we interpret these results in light of the [National Strategy for Suicide Prevention](#) priorities?

6. KEY REFERENCES AND RESOURCES FOR FURTHER INFORMATION

The National Suicide Prevention Lifeline Phone Number is 1-800-273-8255. There are practice guidelines for the assessment and management of suicidal behaviors by the [APA](#) and the [NHS/NICE](#). The VA/DoD has its clinical practice guideline for patients at risk for suicide [here](#). [SAMHSA](#) has a collection of tools and initiatives on suicide prevention. Beacon's 2017 White Paper is on suicide prevention and the Zero Suicide initiative.

References

APA. (2013). *DSM-5*. Washington, DC: American Psychiatric Association Press.