Suicide prevention

A person with a diagnosis of bipolar disorder carries an increased risk for suicide compared to other mental health disorders. (1) Clinician's should be vigilant to identify patients at risk for suicide. People with bipolar disorders have a suicide rate 20 times higher than the general population. About ⅓ to ½ of those with bipolar disorders will attempt suicide at least one time. Approximately 15-20 percent of the attempts will be fatal. (2)

A 2016 meta-analysis of suicide risk factors in longitudinal cohort studies determined that those identified as high-risk accounted for 56 percent of suicides at follow-up. This means 44 percent of completed suicides were those who were considered lower risk. (3) There are multiple risk factors the clinician should be aware of when assessing for suicide. Clinicians should also be aware that suicide risk scales are not wholly predictive of who may, or may not, attempt or complete suicide. (4) Clinical judgement is critical when assessing for suicide risk.

Protective factors are also an important consideration and can mitigate risk factors.

To prevent suicides, clinicians can:

- Approach each patient and their unique psycho-social circumstances with universal concern for potential risk of self-harm and suicide. Do not assume a suicide screening tool is a substitute for this approach.
- Use suicide screening tools such as the Columbia Suicide Severity Rating Scale (5) to establish a framework to gauge risk.
- Ask the patient about any thoughts, plans, intent and means to carry out an attempt if suicidal ideation is suspected or a suicide screening tool identifies an elevated risk.
- Modify as many identified risk factors as possible, as quickly as possible. Examples:
  - » Remove the means to suicide
  - » Promote the patient's connection to others -ensure the patient is not alone until risk is no longer imminent
  - » Remove or mitigate barriers to receiving treatment
  - » Teach coping skills for stress
  - » Adequately treat underlying physical and mental illnesses
  - » Connect with social services
  - » Emphasize already existing positive coping techniques
  - » Use natural supports
- Admit the patient to inpatient psychiatric services when necessary

- Help hospital, jail and prison staff to coordinate optimal continuity of care for post-release treatment and services. This includes any necessary medications.
- Provide follow up care within seven days. Optimally, the follow-up care should occur as soon as possible within that seven day timeframe to facilitate a safe transition from an inpatient unit or emergency department.* It is well established that the highest risk for suicide is in the first week after emergency care after a person experiences a behavioral health crisis. (6)
- Coordinate with the patient and guardian to schedule regular follow-ups with a community provider.

For more information see SAFE-T: Suicide Assessment Five-step Evaluation and Triage from Substance Abuse and Mental Health Services Administration (SAMHSA)

Web: https://store.samhsa.gov/system/files/sma09-4432.pdf

Endnotes

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6. Chung D, Hadzi-Pavlovic D, Wang M, Swaraj S, Olfson M, Large M. Meta-analysis of suicide rates in the first week and the first month after psychiatric hospitalisation. BMJ Open. 2019;9(3):e023883.

* See Discharge Planning for Patients Presenting with Behavioral Health Crisis or Hospitalized for Mental Health Treatment Fact Sheet

Unless noted in the endnotes, the source is the Centers for Disease Control and Prevention https://www.cdc.gov/violenceprevention/suicide/riskprotectivefactors.html

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