Suicide can be described as a fatal act of self-harm initiated with the intention of ending one’s own life. Although often seen as impulsive, it may be associated with years of suicidal behaviour including suicidal ideation or acts of deliberate self-harm. Self-harm is defined as any act of self-poisoning or self injury irrespective of motivation, and is associated with an increased risk of suicide. [1]

Epidemiology [2]

- In 2012, there were 5,981 suicides in the UK in people over the age of 15. This equates to 11.6 deaths per 100,000 of the population.
- Male suicides are three times as common. In 2012 in the UK there were 18.2 male deaths per 100,000 population, and 5.2 female deaths per 100,000.
- The highest suicide rate is in men aged 40-44. In this group there were 25.9 deaths per 100,000 population.
- Suicide rates in 2012 in the UK were higher than five years before, but lower than 20 years before. Suicides in the under-25 age group have significantly reduced in the last 20 years.
- The most common methods of suicide are hanging, strangulation and suffocation, followed by poisoning.
- Comparison of suicide rates between countries within and outside the UK is difficult due to differing definitions and age included in reported rates. In the UK, suicide rates are published for those over the age of 15.

Aetiology

Risk factors for suicide [1, 3]

- Previous suicide attempt or previous self-harm.
- Male gender (three times more likely than women).
- Age (currently highest in the age group 40-44 years).
- Concurrent mental disorders or previous psychiatric treatment. (See ‘Mental disorders and risk of suicide’, below)
- Unemployment.
- Homelessness
- Alcohol and drug abuse.
- Physically disabling or painful illness, including chronic pain.
- Low socio-economic status, loss of a job.
- Certain professions - this has changed in recent years. Historically, professions with the means/knowledge to kill themselves (vets, doctors, dentists, pharmacists, farmers) had the highest rates of suicide. More recently, rates in these professions have reduced significantly (although remaining comparatively high) and higher numbers are seen amongst manual occupations such as construction workers and plant/machine operatives [10, 11].
- Low social support/living alone.
- Significant life events - bereavement, family breakdown.
- Institutionalised - eg, prisons, army.
- Bullying (sometimes a factor in children and adolescents where social media and/or pro-suicide websites play a part).

Mental disorders and risk of suicide [7]

The risk of suicide in patients with mental disorders is 5-15 times higher than that for patients without co-existent mental disorders. Around 90% of individuals who die by suicide have mental illness, although this varies globally. Around 25% in the UK have been in contact with mental health services prior to death. Risk is thought to be greatly increased following discharge from inpatient mental health wards, although inpatient suicides have reduced significantly over a period of 20 years.

In the UK the most common diagnoses among those dying from suicide are:

- Affective disorders (32-47%) particularly depression.
- Schizophrenia (15-20%).
- Alcohol dependence (8-17%).
- Personality disorder (8-11%).
- Drug dependence (3-9%).

The level of risk varies in different disorders. For example, studies suggest that patients with schizophrenia have an 8.5-fold greater risk of suicide than the general population. [12]

Suicidal ideation and behaviour, however, may occur in the absence of mental health disorders. One UK household survey showed 17% of the general population have had suicidal thoughts in their lifetime. [13]
Assessment\[1\]

Assessing the risk of suicide in a person expressing suicidal thoughts, or presenting with self-harm or a suicide attempt is crucial in attempting to prevent deaths. There are a number of risk-predicting score systems for determining suicidal intent. However, none have good predictive ability, and National Institute for Health and Care Excellence (NICE) guidelines advise these should NOT be used.\[14\] Instead a comprehensive clinical interview should be used for assessment as follows:

General

- Establish rapport, develop a trusting relationship.
- Use open questions.
- Establish current anxieties or problems.

Assess risk factors

- Assessment of mental health:
  - Past psychiatric history.
  - Depressive and other psychiatric symptoms.
  - Medication.
  - History of alcohol and illicit drug use.
  - Observe verbal and non-verbal indicators of mental state (eye contact, apparent mood, hallucinations and unusual beliefs, agitation, speed of speech).

- Previous self-harm or suicide attempts.
- Age, gender, social situation.
- Relationships which may be supportive/protective, or which may pose a threat (abuse or neglect).
- Access to lethal methods.

Assess current intent and plans

- Wish to be dead.
- Feelings of hopelessness.
- Regret/remorse over current/previous attempt.
- Expectation about outcome of self-harming behaviour or suicide attempt/threat.
- Specific plans.
- Lethality and frequency of plans or attempts.
- Other self-harming behaviour.
- Assess current suicidal intent/wishes.
- Length of time suicidal feelings have been present.
- Mental state at time of self-harm or suicide attempt or threat (alcohol or drug intake, social situation, relationship changes, bereavements).
- Plans for others after death: suicide notes, changes to will, consequences.

Assess needs\[14\]

- Social problems.
- Untreated mental health disorders.
- Physical symptoms and disorders.
- Coping strategies.
- Skills, strengths and assets.
- Psychosocial and occupational functioning.
- Personal and financial difficulties.
- Needs of dependants.

Management\[1, 14\]

General

- Following assessment as above, form a summary and a risk assessment. There will be a balance of risk and protective factors, which will vary between individuals and which may further vary between situations in any one individual (for example, after consumption of alcohol, with fluctuating moods in mental disorders, or with changing life events). It is inevitably not entirely precise or predictable. However, accurate assessment followed by appropriate support and treatment may save lives.
- Subsequent action will depend on the level of risk believed to be present. It will also be guided by specific risk factors identified.
- Aim to be supportive, empathetic and reassuring in developing a relationship.
- Remove access to preferred means of suicide where possible.

Care plans

Form and agree a care plan. Aims may include:
Prevent self-harm or suicide attempts, or escalation of either behaviour.
Reduce level of injury from self-harming behaviour.
Improve quality of life.
Improve social or occupational functioning.
Improve mental health conditions.
Improve physical symptoms.

Care plans should:

- Be multidisciplinary (and be shared with the person's GP if not involved).
- Be developed collaboratively with the person who has self-harming or suicidal behaviour.
- Identify short- and long-term goals, steps to achieve them, and professionals responsible for helping achieve them.
- Include a risk management plan:
  - Address specific identified risk factors where these can be modified.
  - Include a crisis plan (self-management strategies, and how to access services in a crisis).

Specific treatment options may include:

- Medication.
- Counselling.
- Cognitive behavioural therapy (CBT).
- Dialectical behaviour therapy (DBT) - a specific type of CBT which has the largest evidence base, although more studies are needed to establish the most effective psychological therapy.[13] DBT focuses on acceptance techniques, and change techniques, helping people change damaging patterns of behaviour.

Provide follow-up at regular intervals, depending on assessed level of risk, but probably within 24 hours.

**Management of high-risk individuals**

If high level of risk is established, ensure safety with 24-hour support through the crisis team of the local mental health service. Consider grounds for psychiatric evaluation and detention under the Mental Health Act if the person refuses. See separate articles Compulsory Hospitalisation and Consent To Treatment (Mental Capacity and Mental Health Legislation) for further details. Involuntary detention cannot be used in the UK if the mental state is due to alcohol or drug intoxication alone.

**Further reading & references**

- Suicide statistics report 2014. Including data from 2010-2012; Samartans
- Self-harm, suicide and risk: helping people who self-harm; Royal College of Psychiatrists, 2010
- Self-harm in over 8s; short-term management and prevention of recurrence; NICE Clinical Guideline (2004)

2. Suicides in the UK 2012 registrations; Office for National Statistics
4. Talk to me. The National action plan to reduce suicide and self harm in Wales 2009-2014; Welsh Assembly Government
13. Mental health facts and statistics; MIND, 2012

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