The Persistent Enigma and Challenge of Suicide

Andrew A. Nierenberg, MD

Death by suicide is increasing at an alarming rate and is the ultimate tragic outcome for psychiatric disorders and substance abuse disorders, as well as for those without a diagnosis. Sometimes preventable and all too often not, the great challenge is to find effective treatments. Paradoxically, researchers systematically exclude people at high risk of suicide from clinical trials because they (and the sponsors of trials) deem these people too risky. Rare exceptions are those studies that focus on interventions to prevent or treat suicidal ideation or behavior (eg, ketamine, electroconvulsive therapy, or dialectical-behavior therapy). Thus, we are left with the paradox of taking care of people who are at risk of dying by suicide without much data to know what could work and for whom.

We have not figured out the best ways to assess, track, prevent, or treat suicidal ideation or behavior. One cautionary tale comes from Australia where policy dictated that clinicians systematically screen patients for suicide risk.[1] A mirror-image (before and after clinicians implemented the policy) showed zero impact on the death rate from suicide. In one of our electronic medical record systems (Partners Health Care Epic), we are required to fill out a suicide risk form in the absence of any data that it has any effect on detection or prevention. Perhaps the form fulfills a regulatory requirement, but this burden of documentation seems unhelpful at best.

However, we do know that those at the highest risk are those who are discharged from inpatient units after being hospitalized for suicidal ideation or behavior.[2] Evidence-based interventions appear to be quite effective but are not yet widespread in actual practice.[3] Other effective techniques are harm reduction policies that include decreasing access to lethal means of self-harm (eg, barriers on bridges) and decreasing access to firearms. Ironically, in the firearms debate in the United States, proponents of owning guns seem to fail to address the statistic that two-thirds of gun deaths are from suicide.[4]

To complicate an already complicated situation, a recent report from the Centers for Disease Control and Prevention (CDC) found that the number of visits to emergency departments from January 2017 to December 2018 rose 25.5%, with the largest increase in males age 10 to 19 years (a 62.3% increase) and in females age 10 to 19 years (a 33.7% increase).[5] During those 24 months, the rate of visits for suicidal ideation or self-directed violence was about 1,300 per 100,000 emergency department visits.[5]

Beyond treating psychiatric disorders to reduce the risk of suicide, the CDC promotes several strategies to prevent suicide: strengthen economic supports, strengthen access and delivery of suicide care, create protective environments, promote connectedness, teach coping and problem-solving skills, identify and support people with risk factors, lessen harms, and prevent future risk.[6]

Where does all this leave us? What are the possible solutions? First, we need to be willing to include people at high risk of suicide into clinical trials. Second, we need to implement evidence-based interventions for people hospitalized for suicidal ideation or behavior. Third, we

Andrew A. Nierenberg, MD, is the Thomas P. Hackett, MD, Endowed Chair in Psychiatry, the Director of the Dauten Family Center for Bipolar Treatment Innovation, and the Co-Director, Center for Clinical Research Education, Massachusetts General Hospital; and a Professor of Psychiatry, Harvard Medical School.

Address correspondence to Andrew A. Nierenberg, MD, via email: psyann@Healio.com.

doi:10.3928/00485713-20200210-01

Copyright © SLACK Incorporated

need broad policies to reduce death by suicide with guns. Otherwise, the persistent enigma will persist.

REFERENCES

1. Tran T, Luo W, Phung D, et al. Risk stratification using data from electronic medical records better predicts suicide risks than clinician assessments. *BMC Psychiatry*. 2014;14(1):76. https://doi.org/10.1186/1471-244X-14-76 PMID:24628849
2. Chung DT, Ryan CJ, Hadzi-Pavlovic D, Singh SP, Stanton C, Large MM. Suicide rates after discharge from psychiatric facilities: a systematic review and meta-analysis. *JAMA Psychiatry*. 2017;74(7):694-702. https://doi.org/10.1001/jamapsychiatry.2017.1044 PMID:28564699
3. Lahoz T, Hvid M, Wang AG. Preventing repetition of attempted suicide-III. The Amager Project, 5-year follow-up of a randomized controlled trial. *Nord J Psychiatry*. 2016;70(7):547-553. https://doi.org/10.1080/08039488.2016.1180711 PMID:27187267
4. Fowler KA, Dahlberg LL, Haileyesus T, Annest JL. Firearm injuries in the United States. *Prev Med*. 2015;79:5-14. doi:10.1016/j.ypmed.2015.06.002
5. Zwald ML, Holland KM, Annor FB, et al. Syndromic surveillance of suicidal ideation and self-directed violence - United States, January 2017-December 2018. *MMWR Morb Mortal Wkly Rep*. 2020;69(4):103-108. https://doi.org/10.15585/mmwr.mm6904a3 PMID:31999688
6. Centers for Disease Control and Prevention. Preventing suicide: a technical package of policy, programs, and practices. https://www.cdc.gov/violenceprevention/pdf/suicide-TechnicalPackage.pdf. Accessed February 10, 2020.