

Have we been trying to prevent suicides wrongly all this time?

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Traditional approaches to preventing suicide have focused on "who is at risk?" The aim is to identify an individual and to help them get support.

But that approach doesn't seem to be working. Australia's suicide rates have remained stubbornly high. There was an increase in the rate of suicides from [2012 to 2022](#).

We often do not know who is most vulnerable to suicide, and if we do, we struggle to efficiently target resources to them when they need it most. So we need a fresh approach.

Maybe we've been asking the wrong question all this time. Rather than asking "who is at risk?" we should also ask "when is a person at risk?"

We know depression increases [suicide risk](#), but on a given day, most [depressed people](#) will not consider suicide. We need to know when a person's risk has risen to help them access support immediately.

Our preliminary research conducted in a Perth [psychiatric hospital](#), and [published recently](#), suggests this might be worth pursuing.

We conducted a "proof of concept" study involving inpatients at the psychiatric hospital Perth Clinic. Patients were invited to complete questionnaires on iPads in each room. Over more than a decade, more than 20,000 patients participated in the study, resulting in about 350,000 completed questionnaires.

We then examined questionnaire data from 110 inpatients who attempted suicide in the hospital over an average 25-day period. These

patients were typically female (78%) and had a diagnosis of major depression or an anxiety disorder. They were 14 to 77 years old.

Of note, nurses had rated roughly half as having "no" to "low risk" of suicide, based on interviews with patients.

We then looked for patterns in the data to see if we could see who and *when* someone was at increased short-term risk of attempting suicide.

We found that on the day of a suicide attempt, a person's perception they were a [burden](#) to friends and family increased greatly.

The day before a [suicide attempt](#), patients reported an increased loss of hope in their lives. They perceived they could not change things that mattered to them.

We used this data to develop an algorithm to monitor spikes in these and other key risk factors that may signal increased short-term risk of suicide attempts.

This algorithm, now live in the hospital, alerts staff to at-risk patients to facilitate targeted and immediate interventions when the risk of attempted suicide is at its highest.

How can we apply these findings?

Key signals we identified as indicators of short-term risk of suicide—perceptions of burden or hopelessness—are often [not matched by reality](#).

While people may think they are a burden, their friends and [family members](#) disagree. Far from being burdened, those friends and family are the ones who struggle to know how and when to give the assistance

they desperately want to provide. Likewise, a [perception of hopelessness](#) is often transient and doesn't always reflect reality.

So clinical staff can work with patients to help them re-evaluate these misguided beliefs, and to collaboratively develop coping strategies.

For instance, a core belief of "I am a burden" is replaced by "I wouldn't think a loved one was a burden if they were suffering."

Where to now?

The aim now is to trial our approach in a larger number of psychiatric patients, across multiple sites across Australia, to see if this gives staff enough time to intervene and prevent imminent suicides.

We're also hoping to test our methods in the community. This includes predicting the risk of suicide among [school students](#), and remotely monitoring people at risk of suicide who present to primary care, such as their GP.

For instance, we are working with GPs to extend Perth Clinic's daily monitoring system to track the symptoms of GP [patients](#) between appointments. Through this approach the GPs can monitor the effectiveness of medications or identify periods of heightened risk that can be addressed at future appointments.

Our approach is just one aspect of suicide prevention. We also need to address the complex web of societal, socioeconomic and other factors that contribute to the type of distress we see in people contemplating [suicide](#).

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