IDENTIFICATION OF RISK FACTORS FOR SUICIDE AMONGST PSYCHIATRIC PATIENTS: CAN STRUCTURED MEASUREMENT TOOLS BE MORE SPECIFIC?

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Lack of specific treatment of suicide behavior

Knowledge of specific risk factors can change outcome of intervention.

Abstract:
Background
One of the main challenges in suicide prevention is that it cannot be predicted. Significant number of patients attempt suicide while being under psychiatric treatment. Lethality and intent of each risk factor varies and remains inconsistent. Though structured instruments have also been useful with limited success search for newer methods remains an urgent clinical need.

We believe risk is multifactorial and a scale based upon fundamental domains of biological, psychological, social, emotional, spiritual and clinical origin can elucidate more specific factors.

Scale for impact of suicidality-Management, Assessment & Planning of care-brief screener (SISMAP-boc) is 23 item scale which is valid, reliable and easy to administer. In this study we are trying to examine significant risk factors for suicide based upon findings of this scale.

Method
This is open level, naturalistic study. Consenting psychiatric patients from out patient and in patient facility of a tertiary psychiatric hospital were recruited. All patients were assessed on clinical, phenomenological and psychopathological parameters using standard psychometric tools and SIS-MAP brief screener was used for assessment of suicide related variables. We completed assessment of 79 patients, in this sample 37 were males, mean age was 38.26 (SD 14.78, range 19-75). 44 patients were hospitalized and 35 were on outpatient treatment. The score of SIS-MAP cut-off score is 6 for outpatient treatment, 7 and 8 for decision based upon clinical judgment and 9 and above for hospitalization. A score of 8 and above was suggestive of high risk. Our findings suggest significant factors for suicide. 1) Shorter duration of illness (p=0.0034, r = 0.05) 2) Severity of depressive symptoms (p=0.62, r = 0.001) 3) Severity of psychotic symptoms (p=0.413, r = 0.014) 4) Being single (p=3.071, r = 0.042) 5) Suicide being reason for admission (p=0.238, r = 0.008) 6) History of physical assault ifp=0.078, r = 0.031) and 7) Interpersonal problem in family (p=7.931, r = 0.008). The scale also identified the questions, which were most significant. Few such questions are 1) Is your family supportive of your problem? 2) When you have thoughts about hurting yourself or about death, 3) can you control these thoughts? 4) Do you savour life’? 5) Do you find it difficult to know where to find/access health care services? 6) Do you ever feel like there is no meaning or purpose in your life?

Conclusion
The study shows that of the clinically relevant factors which were indicative of high suicidality. The study also identifies significant risk factors associated with high risk of suicide. We conclude that a number of clinical factors, which suggest high risk, can be captured by multidimensional assessment scale in routine clinical work. The future research may suggest lethality of combinations.