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Editorial

Schizophrenia and bipolar disorder: no recovery without suicide prevention

Tom Foster

Summary
Suicide prevention for people with schizophrenia or bipolar disorder warrants an evidence-based approach to service design as well as clinical practice. The issue of personal responsibility (diminished when mental capacity is impaired) contributing to reduction of suicide risk has, arguably, been neglected.

Declaration of interest
None.

As Principal Investigator of the Northern Ireland Suicide Study (case–control psychological autopsy) Tom Foster was a joint winner of the Royal College of Psychiatrists' Research Prize and Bronze Medal. Following retirement he works intermittently as a locum consultant in general adult psychiatry.

Three key aspects of the recovery model are: personal resilience and robustness; receipt of evidence-based treatment; and recovery of hope and ambition for living a full, purposeful life whatever the circumstances.[1] On closer inspection each aspect is germane to suicide prevention. If recovery-oriented services can sustain and strengthen patients' resilience to mental illness and to adversity, notably interpersonal conflict, they should reduce suicide risk. There is sound evidence for specific treatments that lessen the likelihood of suicide. If the recovery model successfully challenges hopelessness, a well-established clinical risk factor for suicide, it should decrease risk.

Prevention of death is logically accepted as the first step towards recovery for people with life-threatening physical illness. Parity of esteem suggests that suicide prevention should be afforded the same primacy in caring for people with mental illness who may be at (acute-on-chronic) risk of suicide. Suicide prevention for people with mental illness warrants an evidence-based approach to service design as well as clinical practice. While striving for as positive a trajectory as possible for each patient, (mental) health professionals must not neglect the ongoing need to assess and manage suicide risk.

Suicide prevention: clinical practice and service design

Suicide risk assessment and management should be embedded within ongoing biopsychosocial engagement with patients, and mental health services should resist attempted impositions of simplistic short-cuts by officials who are remote from real-world clinical practice.[2] The Royal College of Psychiatrists[3] rejected the use of locally developed risk assessment tools, and Appleby[4] has opined that the 'checklist model of risk assessment . . . is of limited benefit and can be harmful'. Personalised suicide prevention requires empathic engagement with each patient's unique experience in a specific social context. Tactful exploration of a patient's reasons for contemplating suicide should be followed by sensitive consideration of possible reasons for living that may rekindle hope and constitute a basis for collaborative therapy.

Suicide prevention for people with schizophrenia or bipolar disorder requires ongoing vigilance by carers and professionals in contact with them, particularly those with a history of self-harm, men, young people, those near illness onset, people with a family history of suicidal behaviour (especially suicide), childhood abuse victims, those with a history of head injury, people with aggressive/impulsive personalities, those who have expressed hopelessness and patients frequently admitted to hospital.[5,6] Carers, community-based keyworkers and crisis-resolution home treatment teams have crucial contributions to make to suicide prevention for patients before admission to acute wards and after discharge.

Research indicates that suicide risk in schizophrenia and bipolar disorder should be reduced by restricting access to high-lethality means, timely admissions to hospital (sufficient beds is imperative), local dual diagnosis policies, improving psychiatric in-patient ward safety, reducing absconding from wards, restricting duration of drug prescriptions available to high-risk patients and improving access to psychological therapies, notably cognitive–behavioural therapy, interpersonal therapy and family therapy.[5,6] Risk should also be reduced by early intervention, assertive outreach, optimising treatment adherence, effective treatment of comorbid depression, enforced antipsychotic medication if necessary, use of electroconvulsive therapy in suitable high-risk patients and provision of early, intensive, sustained follow-up for patients after discharge from wards.

Evidence is emerging for a link between mental health service provision of 24 h crisis care and lower suicide rates.[7] Suicide risk may be reduced by facilitating easy access to support (practical and emotional) for people with mental illness experiencing adverse life events. The interaction between adversity and mental illness warrants closer clinical consideration and scientific scrutiny in pursuit of suicide prevention and recovery. Deficits in suicide risk assessment and management among practitioners in primary care and secondary mental health services should be corrected by recurrent, mandatory, evidence-based training. Such training may also relieve some of the stress associated with this challenging facet of engagement with patients with mental illness.

Suicide prevention and psychotropic medication

Against the background of a well-established specific antisuicide effect of clozapine, a nested case–control study[8] revealed a lower suicide risk in patients with schizophrenia or schizoaffective disorder who had been prescribed a second-generation antipsychotic (clozapine, olanzapine, risperidone or ziprasidone). The lower risk persisted when those prescribed clozapine were excluded. Unlike

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the USA and many other countries where clozapine is officially licensed for reducing suicide risk in patients with schizophrenia or schizoaffective disorder, this is regrettably not the case in most European countries. Adding to an already strong body of evidence, an updated systematic review and meta-analysis recently revealed that lithium reduces the risk of suicide and overall death compared with placebo in people with bipolar disorder or unipolar depression receiving long-term treatment.[9] Lithium is unquestionably the first choice prophylactic drug for decreasing suicide risk in bipolar disorder and its prescription should be encouraged.

Suicide prevention: personal responsibility and person-centred safety planning

The issue of personal responsibility (diminished when mental capacity is impaired) contributing to reduction of suicide risk has arguably been neglected.[2] Effective public education about risk factors and protective factors for suicide may enable many people, including those with schizophrenia or bipolar disorder, to assume more responsibility for reducing their own risk. For patients with mental illness such public education will need to be enhanced intermittently by keyworkers and other (mental) health professionals. Some critics of the recovery model have referred to its perceived failure to address the issue of risk. However, a recent Implementing Recovery through Organisational Change briefing paper[10] proposed co-produced (patients, carers, staff, etc), person-centred safety planning for assessment and management of all risks including suicide. One of the key conditions necessary to support person-centred safety planning was 'promoting understanding that people need to take or share responsibility for the choices they make in response to risks' and one of the key practical actions needed to implement the approach was 'clarification of personal and collective responsibilities and accountability for risk'. The authors acknowledged the need to pursue an evidence base for their proposal. An Irish proverb refers to hope as the physician of each misery. Psychiatrists, as personal physicians to people with mental illness, and other (mental) health professionals have vital roles to play in fostering authentic hope.

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