

## **CLINICAL PRACTICE GUIDELINE FOR ASSESSMENT AND MANAGEMENT OF PATIENTS AT RISK FOR SUICIDE (2013)**

### QUALIFYING STATEMENTS

The Department of Veterans Affairs (VA) and The Department of Defense (DoD) guidelines are based upon the best information available at the time of publication. They are designed to provide information and assist decision-making. They are not intended to define a standard of care and should not be construed as one. Neither should they be interpreted as prescribing an exclusive course of management.

Variations in practice will inevitably and appropriately occur when providers take into account the needs of individual patients, available resources, and limitations unique to an institution or type of practice. Every health care professional making use of these guidelines is responsible for evaluating the appropriateness of applying them in the setting of any particular clinical situation.

## **Assessment of Risk for Suicide**

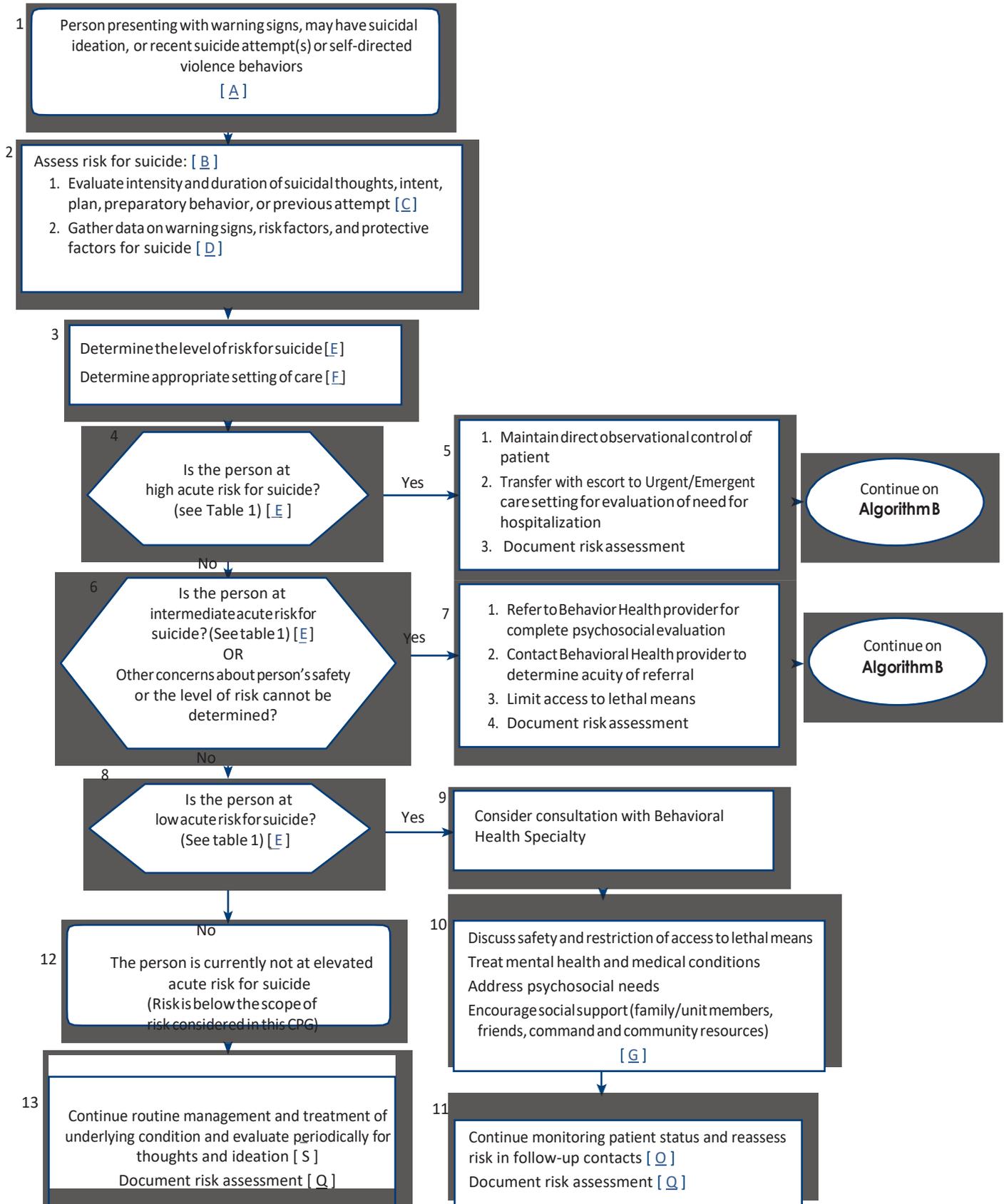
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Ideally, a patient is identified before any suicidal behavior occurs. Early identification of suicidal ideation presents the greatest opportunity to reduce the risk of suicide attempt and death. We understand the suicide continuum to begin with suicidal thoughts, evolving into a wish to die, consolidated into an intention to act, and resulting in a methodology or plan formulated to end one's life. The evolution of these steps can occur over minutes or years. Each step along the continuum presents an opportunity to intervene and prevent the act of suicidal self-directed violence. All too often, a patient is identified after a suicide attempt is made. Often the first opportunity to assess an individual's suicide risk occurs because of the demonstration of warning signs that are identified by a caregiver, gatekeeper, or loved one. Recognition of warning signs is the key to creating an opportunity for early assessment and intervention. Three direct warning signs are particularly indicative of suicide risk: communicating suicidal thought verbally or in writing; seeking access to lethal means such as firearms or medications; and demonstrating preparatory behaviors such as putting affairs in order. Presence of one or more of these warning signs is a strong indication that further assessment is needed.

Suicide risk assessment is not absolute. There are no clear, validated predictive models or risk stratification definitions. For simplicity's sake, this guideline will recommend a three-tier stratification system to define those patients in need of immediate intervention in order to prevent a suicide attempt; those patients at elevated risk of suicidal behavior in the future are in need of a clinical intervention; and those for whom the risk of suicide is not significantly elevated, but may benefit from an intervention. The stratification of assigned level of the acute risk (High, Intermediate, and Low) was developed by consensus, with full recognition that an equally good case could be made for other terms. The importance of determining the level of risk is that it will inform the decision regarding the choice of care setting, management and treatment plan to follow. It is worth remembering that no individual is at "no risk" of suicide, so these strata are an imperfect attempt to rationalize clear distinctions from within a continuum of risk with no absolute cutoffs.

The stakes when managing suicidal patients are high. Underestimation of risk can lead to inadequate treatment planning and a missed opportunity to prevent death. Beyond the tragedy of the loss of life, a completed suicide often results in litigation and recrimination. On the other hand, overestimation of risk leads to unnecessary hospital admissions, with a significant potential for infringement of civil liberties. The seriousness of the risk assessment process often places at odds the goals of safety versus patient autonomy and creates a great deal of tension between the patient, the clinician, the health care system and the law. As such, this important clinical evaluation can easily become adversarial and seriously impact the reliability of information gathering and set a negative tone for future treatment. Hence, it is imperative that the evaluation be guided by objectivity and evidence.

## Algorithm A: Assessment and management of Risk for Suicide in Primary Care



## RECOMMENDATIONS

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1. A suicide risk assessment should first evaluate the three domains: suicidal thoughts, intent, and behavior including warning signs that may increase the patient's acuity. (See [Annotation C](#))
2. The suicide risk assessment should then include consideration of risk and protective factors that may increase or decrease the patient's risk of suicide. (See [Annotation D](#))
3. Observation and existence of warning signs and the evaluation of suicidal thoughts, intent, behaviors, and other risk and protective factors should be used to inform any decision about referral to a higher level of care. (See [Annotation E](#))
4. Mental state and suicidal ideation can fluctuate considerably over time. Any person at risk for suicide should be re-assessed regularly, particularly if their circumstances have changed.
5. The clinician should observe the patient's behavior during the clinical interview. Disconnectedness or a lack of rapport may indicate increased risk for suicide.
6. The provider evaluating suicide risk should remain both empathetic and objective throughout the course of the evaluation. A direct non-judgmental approach allows the provider to gather the most reliable information in a collaborative way, and the patient to accept help.

## RECOMMENDATIONS:

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1. Gather collateral history from family/unit members, the medical record, escorts, unit commanders (or their representatives), referring physicians, EMS, and police as appropriate.
2. Approach the patient with a non-judgmental, collaborative attitude with the aim of fully understanding the patient's suicidality.
3. Secure all belongings to prevent access to lethal means and elopement from the clinic.
4. Choose the setting for the initial evaluation to ensure the safety of the patient and the clinical staff so that potentially life-threatening conditions can be managed effectively. If the patient is intoxicated, re-evaluate when intoxication has resolved.
5. Conduct a mental status examination and a comprehensive assessment of mental health history that includes:
  - a. Past and present suicidal thoughts, intent, and behaviors, impulsivity, hopelessness and the patient view of the future
  - b. Alcohol use assessed per standardized tools (Audit-C), and other substance abuse history, since impaired judgment may increase the severity of the suicidality and risk for suicide act
  - c. Psychiatric illness, comorbid diagnoses, and history of treatment interventions.
  - d. Elicit family history of suicidal behavior.
6. Assess for access and past use of lethal means (firearms, drugs, toxic agents).
7. Assess social history of support system, living situation and potential stressful life events.
8. Consider suicidal thinking, intent, behavior, risk factors and protective factors to stratify the risk.
9. Consider the use of a standardized suicide risk assessment framework to inform the evaluation for estimating the risk for suicide.
10. Determine appropriate setting for further evaluation and management based on level of risk, legal guidance, and local policy.
11. Document in detail the data supporting the assigned level of risk, the level of care required, and treatment plans to reduce suicide risk.

## *Annotation C. Assessment of Suicidal Ideation, Intent and Behavior*

Assess the patient's thoughts of suicide, the intention to act on those thoughts, and behaviors that demonstrate warning signs.

## *Annotation C1. Suicidal Ideation/Thoughts*

Ask the patient if he/she has thoughts about wishing to die by suicide, or thoughts of engaging in suicide-related behavior. The distinction between non-suicidal self-directed violence and suicidal behavior is important.

### **BACKGROUND**

The assessment of risk for suicide begins with query regarding ideation and gaining an understanding of the patient's suicidal thoughts with the goal of identifying suicidal intent. Suicidal thoughts can lead to suicidal behavior. Thoughts may be persistent or fleeting, with the former being more likely to compel action than the latter. Therefore it is important to understand the nature, intensity, frequency and duration of any suicidal thoughts a person is experiencing as part of any suicide risk assessment. Inquire about recent ideation (preceding 2 weeks) and past events. In addition, explore if the suicidal thoughts are current, being experienced by the patient during the interview itself.

The nature and frequency may or may not be related to suicidal intent. Suicidal ideation is assumed to be present in the majority of suicide attempts and completed suicides; however many who attempt suicide deny suicidal ideation prior to attempt, and many individuals have suicidal thoughts without making attempts.

Remember, asking directly does not increase patient's ideation, but rather indicates that you are ready to listen and help.

### **RECOMMENDATIONS**

1. Patients should be directly asked if they have thoughts of suicide and to describe them. The evaluation of suicidal thoughts should include the following:
  - a. Onset (When did it begin)
  - b. Duration (Acute, Chronic, Recurrent) Intensity (Fleeting, Nagging, Intense)
  - c. Frequency (Rare, Intermittent, Daily, Unabating)
  - d. Active or passive nature of the ideation ('Wish I was dead' vs. 'Thinking of killing myself')
  - e. Whether the individual wishes to kill themselves, or is thinking about or engaging in potentially dangerous behavior for some other reason (e.g., cutting oneself as a means of relieving emotional distress)
  - f. Lethality of the plan (No plan, Overdose, Hanging, Firearm)
  - g. Triggering events or stressors (Relationship, Illness, Loss)
  - h. What intensifies the thoughts
  - i. What distract the thoughts
  - j. Association with states of intoxication (Are episodes of ideation present or exacerbated only when individual is intoxicated? This does not make them less serious; however may provide a specific target for treatment)
  - k. Understanding regarding the consequences of future potential actions

<i>Example of Questions on Ideation:</i>
<i>"With everything that has been going on, have you been experiencing any thoughts of killing yourself?"</i>
• <i>When did you begin having suicidal thoughts?</i>
• <i>Did any event (stressor) precipitate the thoughts?</i>
• <i>How often do you have thoughts of suicide?</i>
• <i>How long do they last?</i>
• <i>How strong are the thoughts of suicide?</i>
• <i>What is the worst they have ever been?</i>
• <i>What do you do when you have these (suicidal) thoughts?</i>
• <i>What did you do when they were the strongest ever?</i>
• <i>Do thoughts occur or intensify when you drink or use drugs?</i>

**Annotation C2. Suicidal Intent**

Assess for past or present evidence (implicit or explicit) that the individual wishes to die, means to kill him/herself, and understands the probable consequences of his/her actions or potential actions.

**BACKGROUND**

Assessing for current intent and the degree of intent for suicide is a key component of the assessment process. The presence of intent to act upon suicidal thoughts is generally indicative of high risk for suicide. Therefore it is important to understand the extent to which the patient: 1) wishes to die; 2) means to kill him/herself; 3) and understands the probable consequences of his/her actions or potential actions.

Patients with active suicidal ideation may have the intent to act, a plan to act, both, or neither. The evolution of intent can occur over minutes or years. In some cases the intent stage may be very brief and the suicidal ideation may propel to a behavior or suicide act.

**RECOMMENDATIONS**

1. Patients should be asked the degree to which they wish to die, mean to kill him/herself, and understand the probable consequences of his/her actions or potential actions
2. The evaluation of intent to die should be characterized by:
  - a. Strength of the desire to die
  - b. Strength of determination to act
  - c. Strength of impulse to act or ability to resist the impulse to act
3. The evaluation of suicidal intent should be based on indication that the individual:
  - a. Wishes to die
  - b. Means to kill him/herself
  - c. Understands the probable consequences of the actions or potential actions
  - d. These factors may be highlighted by querying regarding how much the individual has thought about a lethal plan, has the ability to engage that plan, and is likely to carry out the plan

*Example of Questions on Intent:*

- Do you wish you were dead?
- Do you intend to try to kill yourself?
- Do you have a plan regarding how you might kill yourself?
- Have you taken any actions towards putting that plan in place?
- How likely do you think it is that you will carry out your plans?

**Annotation C3. Preparatory Behavior**

Assess if the patient has begun to show actual behavior of preparation for engaging in Self-Directed Violence (e.g., assembling a method, preparing for one's death).

**BACKGROUND**

Assessment of risk for suicide may find that the patient has already begun to take specific action in implementing their plan to kill themselves (e.g., buying a gun, collecting pills, assembling methods), or started to make preparation for the aftermath of their death (e.g., giving away their belonging, changing a will, or sending notes to loved ones). These acts and behaviors are defined as preparatory behaviors and put the patient at the high risk for suicide. Research has shown that resolved plans and preparatory behavior predicted death by suicide and history of suicide attempts.

Gathering information regarding preparatory behaviors may require exploring other sources of information about the patient. This may require a careful discussion with the patient and obtaining the patient's consent. Peers, unit members, and command elements may play a critical role in corroborating information regarding psychosocial functioning and preparatory behavior.

**RECOMMENDATIONS**

1. Clinicians should evaluate preparatory behaviors by inquiring about:
  - a. Preparatory behavior like practicing a suicide plan. For example:
    - Mentally walking through the attempt
    - Walking to the bridge
    - Handling the weapon
    - Researching for methods on the internet
  - b. Thoughts about where they would do it and the likelihood of being found or interrupted?
  - c. Action to seek access to lethal means or explore the lethality of means.  
For example: (See [Annotation D5](#))
    - Acquiring a firearm or ammunition
    - Hoarding medication
    - Purchasing a rope, blade, etc.
    - Researching ways to kill oneself on the internet
  - b. Action taken or other steps in preparing to end one's life:
    - Writing a will, suicide note
    - Giving away possessing
    - Reviewing life insurance policy
2. Obtain collateral information from sources such as family members, medical records, and therapists.

<i>Examples of Questions on Preparation:</i>
• <i>Do you have a plan or have you been planning to kill yourself?</i>
<i>If so, how would you do it? Where would you do it?</i>
• <i>Do you have the (drugs, gun, rope) that you would use? Where is it right now?</i>
• <i>Do you have a timeline in mind for killing yourself?</i>
• <i>Is there something (an event) that would trigger acting on the plan?</i>
• <i>How confident are you that your plan will end your life?</i>
• <i>What have you done to begin to carry out the plan?</i>
• <i>Have you made other preparations (e.g., updated life insurance, made arrangements for pets)?</i>

**Annotation C4. Previous Suicide Attempt**

Obtain information from the patient and other sources about previous suicide attempts. Historical suicide attempts may or may not have resulted in injury, and may have been interrupted by the patient or by another person prior to fatal injury.

**RECOMMENDATIONS**

1. The assessment of risk for suicide should include information from the patient and collateral sources about previous suicide attempt and circumstances surrounding the event (i.e., triggering events, method used, consequences of behavior, role of substances of abuse) to determine the lethality of any previous attempt:
  - a. Inquire if the attempt was interrupted by self or other, and other evidence of effort to isolate or prevent discovery
  - b. Inquire about other previous and possible multiple attempts
  - c. For patients who have evidence of previous interrupted (by self or other) attempts, obtain additional details to determine factors that enabled the patient to resist the impulse to act (if self-interrupted) and prevent future attempts.

**Annotation C5. Warning Signs – Indications for Urgent/Immediate Action**

Recognize precipitating emotions, thoughts, or behaviors that are most proximally associated with a suicidal act and reflect high risk

Many suicidal individuals reveal warning signs or signals of their intention to engage suicidal behaviors, thereby providing clinicians or other supportive persons the opportunity to recognize an impending suicidal crisis and intervene.

Three **direct** warning signs portend the highest likelihood of suicidal behaviors occurring in the near future. Observing these warning signs warrants immediate attention, mental health evaluation, referral, or consideration of hospitalization to ensure the safety, stability and security of the individual:

- **Suicidal communication** – writing or talking about suicide, wish to die, or death (threatening to hurt or kill self))
- **Seeking access or recent use of lethal means:** such as weapons, medications, or other lethal means
- **Preparations for suicide** – evidence or expression of suicide intent, and/or taking steps towards implementation of a plan. Makes arrangements to divest responsibility for dependent others (children, pets, elders), or making other preparations such as updating wills, making financial arrangements for paying bills, saying goodbye to loved ones, etc.

These signals are likely to be even more dangerous if the person has previously attempted suicide, has a family history of suicide and/or intends to use a method that is lethal and to which he/she has access.

Other indirect warning sign presentation(s) or behavioral expressions that may indicate increased suicide risk and urgency in a patient at risk for suicide

## RECOMMENDATIONS

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1. Assess for other warning signs that may indicate likelihood of suicidal behaviors occurring in the near future, and require immediate attention:
  - **Substance abuse** – increasing or excessive substance use (alcohol, drugs, smoking)
  - **Hopelessness** – expresses feeling that nothing can be done to improve the situation
  - **Purposelessness** – express no sense of purpose, no reason for living, decreased self-esteem
  - **Anger** – rage, seeking revenge
  - **Recklessness** – engaging impulsively in risky behavior
  - **Feeling Trapped** – expressing feelings of being trapped with no way out
  - **Social Withdrawal** – withdrawing from family, friends, society
  - **Anxiety** – agitation, irritability, angry outbursts, feeling like wants to “jump out of my skin”
  - **Mood changes** – dramatic changes in mood, lack of interest in usual activities/friends
  - **Sleep Disturbances** – insomnia, unable to sleep or sleeping all the time
  - **Guilt or Shame** – Expressing overwhelming self-blame or remorse

### *Annotation D. Assessment of Factors that Contribute to the Risk for Suicide*

Assess factors that are known to be associated with suicide (i.e., risk factors, precipitants) and those that may decrease the risk (i.e., protective factors).

## RECOMMENDATIONS

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1. Providers should obtain information about risk factors during a baseline evaluation – recognizing that risk factors have limited utility in predicting future behavior.
2. Providers should draw on available information including prior history available in the patient’s record, inquiry and observation of the patient, family or military unit members and other sources where available.
3. Assessment tools may be used to evaluate risk factors, in addition to the clinical interview, although there is insufficient evidence to recommend one tool over another.
4. The baseline assessment should include information about risk factors sufficient to inform further assessment if conditions change such as firearm in the home, social isolation, history of depression, etc.
5. Risk factors should be considered to denote higher risk individuals (e.g., those with a history of depression) and higher risk periods (e.g., recent interpersonal difficulties).
6. Risk factors should be solicited and considered in the formulation of a patient’s care.
7. Reassessment of risk should occur when there is a change in the patient’s condition (e.g., relapse of alcoholism) or psychosocial situation (e.g., break-up of intimate relationship) to suggest increased risk. Providers should update information about risk factors when there are changes in the individual’s symptoms or circumstances to suggest increased risk.
8. Patients ages 18 to 25 who are prescribed an antidepressant are at increased risk for suicidal ideation and warrant increase in the frequency of monitoring of these patients for such behavior

9. For Military Service person in transition the provider should:
  - a. Inquire about changes in the patient's life and be aware of other indicators of change (retirement physical, overseas duty screening, etc.).
  - b. Be willing to discuss and consider methods to strengthen social support during the transition time if there are other risk factors present.

### **Annotation D1. Risk Factors / Precipitants**

Risk factors distinguish a higher risk group from a lower risk group. Risk factors may be modifiable or non-modifiable and both inform the formulation of risk for suicide. Modifiable risk factors may also be targets of intervention.

#### **PSYCHOLOGICAL FACTORS**

- Suicide of relative, someone famous, or a peer
- Suicide bereavement
- Loss of loved one (grief)
- Loss of relationship (divorce, separation)
- Loss of status/respect/rank (public humiliation, being bullied or abused, failure work/task)

#### **SOCIAL FACTORS**

##### **Stressful Life Events (acute experiences)**

- w Breakups and other threats to prized relationships
- w Other events (e.g., fired, arrested, evicted, assaulted)

##### **Chronic Stressors (ongoing difficulties)**

- Financial Problems
  - w Unemployment, underemployment
  - w Unstable housing, homeless
  - w Excessive debt, poor finances (foreclosure, alimony, child support)
- Legal Problems (difficulties)
  - w DUI/DWI
  - w Lawsuit
  - w Criminal offence and incarceration
- Social Support
  - w Poor interpersonal relationship (partner, parents, children)
  - w Geographic isolation from support
  - w Barriers to accessing mental health care
  - w Recent change in level of care (discharge from inpatient psychiatry)

#### **MENTAL DISORDERS**

- Mood or affective disorder (major depression, bipolar, post-partum)
- Personality disorder (especially borderline and antisocial)
- Schizophrenia
- Anxiety (PTSD, Panic)
- Substance Use Disorder (alcohol, illicit drugs, nicotine)

- Eating disorder
- Sleep disturbance or disorder (See [Appendix B-4](#))
- Trauma (psychological)

#### **MEDICAL CONDITIONS**

- History of Traumatic Brain Injury (TBI)
- Terminal disease
- HIV/AIDS
- New diagnosis of major illness
- Having a medical condition
- Worsening of chronic illness
- Intoxication
- Substance withdrawal (alcohol, opiates, cocaine, amphetamines)
- Use of prescribed medication w/ warning for increased risk of suicide (See [Appendix B-3](#))

#### **Physical Symptoms**

- w Chronic pain
- w Insomnia
- w Function limitation

#### **MILITARY-SPECIFIC**

- Disciplinary actions (UCMJ, NJP)
- Reduction in rank
- Career threatening change in fitness for duty
- Perceived sense of injustice or betrayal (unit/command)
- Command/leadership stress, isolation from unit
- Transferring duty station (PCS)
- Administrative separation from service/unit
- Adverse deployment experience
- Deployment to a combat theater

#### **PRE-EXISTING & NON-MODIFIABLE**

- Age (young & elderly)
- Gender (male)
- Race (white)
- Marital status (divorce, separate, widowed)
- Family history of:
  - w Suicide/ attempt
  - w Mental illness (including SUD)
  - w Child maltreatment trauma-physical/psychological/sexual
  - w Sexual trauma
- Lower education level
- Same sex orientation (LGBT)
- Cultural or religious beliefs

## *Annotation D2.      Impulsivity*

### **RECOMMENDATIONS**

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1. The assessment of risk for suicide should include evaluation of impulsivity by determining whether the patient is feeling out of control, engaging impulsively in risky behavior
2. Assess if impulsive recklessness and risk-taking characterize the pattern of behavior and life style of the individual and therefore may limit the ability to control his/her behavior.

## *Annotation D3.      Protective Factors*

Protective factors are capacities, qualities, environmental and personal resources that drive individuals towards growth, stability, and health and may reduce the risk for suicide.

### **RECOMMENDATIONS**

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1. Assessment should include evaluation of protective factors, patient's reason to for living, or other factors that mitigate the risk for suicide.

#### **Social Context Support System**

- Strong interpersonal bonds to family/unit members and community support
- Employed
- Intact marriage
- Child rearing responsibilities
- Responsibilities/duties to others
- A reasonably safe and stable environment

#### **Positive Personal Traits**

- Help seeking
- Good impulse control
- Good skills in problem solving, coping and conflict resolution
- Sense of belonging, sense of identity, and good self-esteem
- Cultural, spiritual, and religious beliefs about the meaning and value of life
- Optimistic outlook – Identification of future goals
- Constructive use of leisure time (enjoyable activities)
- Resilience

#### **Access to Health Care**

- Support through ongoing medical and mental health care relationships
- Effective clinical care for mental, physical and substance use disorders
- Good treatment engagement and a sense of the importance of health and wellness

## **BACKGROUND**

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Substance use disorders are a prevalent and strong risk factor for suicide attempts and suicide. The recommendations for assessment of risk for suicide in this (Module) guideline generally apply to individuals with substance use disorders and should be followed.

Three key additional issues to bear in mind in working with this population refer to assessing intoxicated patients, differentiating unintentional and intentional overdose events, and special assessment considerations.

Individuals at acute risk for suicidal behavior who appear to be under the influence of alcohol or other drugs, either based on clinical presentation or objective data (e.g., breath or laboratory tests), should be maintained in a secure setting until intoxication has resolved. Risk assessment needs to be repeated once the patient is sober in order to determine appropriate next steps. Risk management options include, but are not limited to, admitting the patient for inpatient hospital care, making a referral for residential care, detoxification, or ambulatory care, or scheduling outpatient follow-up in the near future.

Intentional overdose is the most common method of attempted suicide. Therefore, the possibility that an overdose event was an intentional act of self-directed violence should always be considered. Obtaining additional information from family members, treatment providers, medical records, etc., can be invaluable in making the determination between intentional and unintentional overdose in equivocal cases.

The same factors that confer risk for suicidal behavior in non-substance abusers generally also confer risk among individuals with substance use disorders. For example, depression is a potent risk factor in both substance abusers and non-substance abusers. The presence of comorbidities (e.g., substance use disorder plus mood disorder) is the rule rather than the exception in high-risk clinical populations.

## **RECOMMENDATIONS**

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1. All patients at acute risk for suicide who are under the influence (intoxicated by drugs or alcohol) should be evaluated in an urgent care setting and be kept under observation until they are sober.
  - a. Patients who are under the influence should be reassessed for risk for suicide when the patient is no longer acutely intoxicated, demonstrating signs or symptoms of intoxication, or acute withdrawal
  - b. Obtaining additional information from family members, treatment providers, medical records, etc., can be invaluable in making the determination between intentional and unintentional overdose in equivocal cases.
  - c. Intoxicated or psychotic patients who are unknown to the clinician and who are suspected to be in at acute risk for suicide should be transported securely to the nearest crisis center or emergency department for evaluation and management. These patients can be dangerous and impulsive; assistance in transfer from law enforcement may be considered.
2. Intoxication with drugs or alcohol impairs judgment and increases the risk of suicide attempt. Use of drugs or alcohol should routinely be assessed with all persons at any risk for suicide.
3. Assess the presence of psychiatric and behavioral comorbidities (e.g., mood, anxiety disorder, aggression) in patients with substance use disorder at risk for suicide.
4. Recognize that assessment of social risk factors such as disruptions in relationships and legal and financial difficulties are important in individuals with substance use disorders.

## **Annotation D5.      *Assess Access to Lethal Means***

Assess the availability or intent to acquire lethal means including firearms and ammunition, drugs, poisons and other means in the patient's home. For Service members, this includes assessing privately owned firearms.

### **BACKGROUND**

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Military Service members and Veterans are at risk for lethal suicidal behavior and are more likely to use firearms as the suicide method; the increased risk for use of firearms is notable, given that this population has extensive exposure to firearms, and ample opportunities to have access to them. Certain military occupations have daily access to firearms; and the majority of military personnel have at least some weapons training.

Providers should assess the presence and the access to lethal means including firearms and ammunition, as well as prescribed and over the counter drugs, poisons and other means in the patient's home.

### **RECOMMENDATIONS**

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1. Assessment of presence and access to lethal means should include:
  - a. Fire Arms: Always inquire about access to fire arms and ammunition (including privately-owned firearm) and how they are stored
  - b. Medications: Perform medication reconciliation for all patients. For any current and/or proposed medications consider the risk/benefit of any medications which could be used as a lethal agent to facilitate suicide. Consider prescribing limited supplies for those at elevated risk for suicide, or with histories of overdose or the availability of a caregiver to oversee the administration of the medications.
  - c. Household poisons: Assess availability of chemical poisons, especially agricultural and household chemicals. Many of these are highly toxic.

## **Annotation E.      *Determine the Level of Risk for Suicidal Self-Directed Violence (Severity of Suicidality)***

Determine the level of the risk for suicidal self-directed violence to establish the appropriate setting of care and to implement treatment interventions targeting the specific level of risk.

### **BACKGROUND**

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The formulation of the level of risk for suicide guides the most appropriate care environment in which to address the risk and provide safety and care needs. The first priority is safety. Patients assessed as having a clear intention of taking their lives will require higher levels of safety protection than those with less inclination toward dying. Patients who are at high-risk for suicide may require inpatient care to provide for increased level of supervision and higher intensity of care. Those at intermediate and low acute risk may be referred to an outpatient care setting and with appropriate supports and safety plans, may be able to be followed-up in the community.

Considering all the information gathered in the assessment, the clinician will formulate the level of risk in one of the following categories: (See Table 1 on Page 32, for indications of risk level)

## HIGH ACUTE RISK FOR SUICIDE

**High-acute risk patients** include those with warning signs, serious thoughts of suicide, a plan and/or intent to engage in lethal self-directed violence, a recent suicide attempt, and/or those with prominent agitation, impulsivity, psychosis. In such cases, clinicians should ensure constant observation and monitoring before arranging for immediate transfer for psychiatric evaluation or hospitalization.

## INTERMEDIATE ACUTE RISK FOR SUICIDE

**Intermediate acute risk patients** include those patients with suicidal ideation and a plan but with no intent or preparatory behavior. Combination of warning signs and risk factors to include history of self-directed violence (suicide attempt) increases a person's risk for suicide. Patients at intermediate risk should be evaluated by a Behavioral Health provider. The decision whether to urgently refer a patient to a mental health professional or emergency department depends on that patient's presentation. Patient who is referred may be hospitalized if further evaluation reveals that the level of illness or other clinical findings warrant it. The patient may be managed in outpatient care if patient and provider collectively determine that the individual is capable of maintaining safety by utilizing non-injurious coping methods and utilize a safety plan.

## LOW ACUTE RISK FOR SUICIDE

**Low acute risk patients** include those with recent suicidal ideation who have no specific plans or intent to engage in lethal self-directed violence and have no history of active suicidal behavior. Consider consultation with Behavioral Health to determine need for referral to treatment addressing symptoms, and safety issues. These patients should be followed up for reassessment.

**NOT AT ELEVATED ACUTE RISK FOR SUICIDE** (Risk outside the scope of risk classification considered in this CPG for the purpose of determining action)

Persons with mental disorder who are managed appropriately according to evidence-based guidelines and do not report suicidal thoughts are outside the scope of the classification of risk for suicide in this CPG. Patients that at some point in the past had reported thoughts about death or suicide, but currently don't have any of these symptoms are not considered to be at acute risk of suicide. There is no indication to consult with behavioral health specialty in these cases, and the patients should be followed in routine care, continue to receive treatment for their disorder and be re-evaluated periodically for thoughts and ideation.

## RECOMMENDATIONS

1. Patients at HIGH ACUTE RISK should be immediately referred for a specialty evaluation with particular concern for insuring the patient's safety and consideration for hospitalization.
2. Patients at INTERMEDIATE ACUTE RISK should be evaluated by Behavioral Health specialty.
3. Patients at LOW ACUTE RISK should be considered for consultation with or referral to a Behavioral Health Practitioner.
4. Patients at NO elevated ACUTE RISK should be followed in routine care with treatment of their underlying condition, and evaluated periodically for ideation or suicidal thoughts.
5. Patient for whom the risk remains UNDETERMINED (no collaboration of the patient or provider concerns about the patients despite denial of risk) should be evaluated by a Behavioral Health Practitioner.

**Table 1. Determine Level of Risk for Suicide and Appropriate Action in Primary Care**

Risk of Suicide	Indicators of Suicide Risk	Contributing Factors †	Initial Action Based on Level of Risk
High Acute Risk	<ul style="list-style-type: none"> <li>∨ Persistent suicidal <b>ideation</b> or thoughts</li> <li>∨ Strong <b>intention</b> to act or plan</li> <li>∨ <b>Not</b> able to control <b>impulse</b> OR</li> <li>∨ Recent <b>suicide attempt</b> or preparatory behavior ††</li> </ul>	<ul style="list-style-type: none"> <li>∨ Acute state of mental disorder or acute psychiatric symptoms</li> <li>∨ Acute <b>precipitating</b> event(s)</li> <li>∨ Inadequate <b>protective</b> factors</li> </ul>	Maintain direct observational control of the patient. Limit access to lethal means Immediate transfer with escort to Urgent/ Emergency Care setting for Hospitalization
Intermediate Acute Risk	<ul style="list-style-type: none"> <li>∨ Current suicidal <b>ideation</b> or thoughts</li> <li>∨ <b>No</b> intention to act</li> <li>∨ Able to control the <b>impulse</b></li> <li>∨ <b>No recent suicide attempt</b> or <b>preparatory behavior</b> or rehearsal of act</li> </ul>	<ul style="list-style-type: none"> <li>∨ Existence of <b>warning signs</b> or <b>risk factors</b> †† AND</li> <li>∨ Limited <b>protective</b> factor</li> </ul>	Refer to Behavioral Health provider for complete evaluation and interventions Contact Behavioral Health provider to determine acuity of the referral Limit access to lethal means
Low Acute Risk	<ul style="list-style-type: none"> <li>∨ Recent suicidal <b>ideation</b> or thoughts</li> <li>∨ <b>No intention</b> to act or plan</li> <li>∨ Able to control the <b>impulse</b></li> <li>∨ <b>No</b> planning or rehearsing a suicide act</li> <li>∨ <b>No</b> previous attempt</li> </ul>	<ul style="list-style-type: none"> <li>∨ Existence of <b>protective factors</b> AND</li> <li>∨ Limited <b>risk factors</b></li> </ul>	Consider consultation with Behavioral Health to determine: <ul style="list-style-type: none"> <li>– Need for referral</li> <li>– Treatment</li> </ul> Treat presenting problems Address safety issues Document care and rational for action

† Modifiers that increase the level of risk for suicide of any defined level:

- Acute state of Substance Use: Alcohol or substance abuse history is associated with impaired judgment and may increase the severity of the suicidality and risk for suicide act
- Access to means: (firearms, medications) may increase the risk for suicide act
- Existence of multiple risk factors or warning signs or lack of protective factors

†† Evidence of suicidal behavior warning signs in the context of denial of ideation should call for concern (e.g., contemplation of plan with denial of thoughts or ideation)

### *Annotation E1. Suicide Risk Assessment Instruments*

Risk factors can inform the assessment for any given individual, but are not predictive by themselves. While suicide risk assessment scales are no substitute for comprehensive evaluation and clinical judgment based on the history of the person, they may provide a structure for systematic inquiry about risk factors for repeated suicide attempts.

#### **BACKGROUND**

Rating scales can be helpful in the assessment process. However, a clinical assessment by a trained professional is required to assess suicide risk. This professional must have the skills to engage patients in crisis and to elicit candid disclosures of suicide risk in a non-threatening environment. The assessment should comprise a physical and psychiatric

examination including a comprehensive history (with information from patient, parents and significant others whenever possible) to obtain information about acute psychosocial stressors, psychiatric diagnoses, current mental status and circumstances of prior suicide attempts. Assessment tools may be used to evaluate risk factors, in addition to the clinical interview, although there is insufficient evidence to recommend one tool over another.

## RECOMMENDATIONS

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1. Formulation of the level of suicide risk should be based on a comprehensive clinical evaluation that is aimed to assess suicidal thoughts, intent and behavior and information about risk and protective factors for estimating the level of risk.
2. Behavioral Health provider use of a standardized assessment framework may serve to inform a comprehensive clinical evaluation. The framework should:
  - a. Estimate the level of risk
  - b. Support clinical decision-making
  - c. Determine the level of intervention and indication for referral
  - d. Allow monitoring of risk level over time
  - e. Serve as the foundation for clinical documentation
  - f. Facilitate consistent data collection for process improvement
3. Assessment of risk for suicide should not be based on any single assessment instrument alone and cannot replace a clinical evaluation. The assessment should reflect the understanding [recognizing] that an absolute risk for suicide cannot be predicted with certainty.
4. There is insufficient evidence to recommend any specific measurement scale to determine suicide risk.

### *Annotation E2. Detection, Recognition and Referral (in Primary Care)*

#### **Assessment of Suicide Risk in the Primary Care Settings:**

##### **BACKGROUND**

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An integrated understanding of the individual biological, psychological, social and cultural factors impacting suicide and recognition of warning signs is necessary for effective risk assessment and determination. This understanding needs to be translated into effective evidence based screening and assessment framework that can be efficiently and broadly applied in the general medical setting.

The primary care provider must have a high index of suspicion to identify patients at risk for suicide. Somatic complaints are often a proxy for depression and anxiety. Patients presenting with insomnia, fatigue, pain, headaches, or memory loss should be screened for depression, anxiety, substance use and presence of acute stressors. When present, suicide screening and assessment may be appropriate.

Several risk-stratification protocols are used in primary care to recognize the urgency of medical conditions (e.g., chest pain, respiratory distress) and identify those patients needing referral and/or hospitalization. Similarly, primary care providers would benefit having an efficient way for assessing suicide risk in patients who have potential thoughts of self-harm. The assessment should distinguish the rare patient that need urgent referral to an emergency department/hospital from the majority of patients who can have initial treatment in collaboration with a behavioral health provider.

Primary care providers may find it useful to develop an office, or clinic, protocol that they can follow to streamline the process once a patient is identified as being at high or imminent risk--particularly if referral to emergency services is indicated. Also, it may be useful for PCPs to identify a mental health provider in the area who they can call for assistance or a quick consultation.

Providers should follow a consistent framework that will structure the assessment process and include the key component for assessment of suicide risk. Real time availability for consultation with Behavioral Health staff is essential. Formulation of the level of risk will allow matching treatment in the appropriate context for the individual patient.

## RECOMMENDATIONS

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1. Whether they have mental disorder or not, patients identified as having suicidal ideation (e.g., through routine screening for major depression or other health conditions) should receive a complete suicide risk assessment as defined in this guideline (See [Annotation B](#)).
2. When evidence of a mood, anxiety, or substance use disorder is present, patients should be asked about suicidal thoughts and behavior directly.
3. If suicidal ideation is present, the initial suicide risk assessment should be performed (See [Annotation B](#)).
4. Referral to specialty behavioral health care should be based on the level of risk and the available resources:
  - a. Patients at HIGH ACUTE RISK should remain under constant observation and monitoring before arranging for immediate transfer for psychiatric evaluation or hospitalization
  - b. Patients at INTERMEDIATE ACUTE RISK should be referred to, and managed by Behavioral Health Specialty Provider.
  - c. Patients at LOW ACUTE RISK should be considered for consultation with a Behavioral Health Practitioner.
  - d. When risk is UNDETERMINED (due to difficulty in determining the level of risk, or provider concerns about the patient despite denial of ideation or intent) the patient should be immediately referred for an evaluation by a Behavioral Health Specialty Provider.

### Guidance for the Assessment of Suicide Risk in Emergency Department / Urgent care Settings:

Patient at HIGH ACUTE-RISK for suicide should be assessed and initially treated in emergency acute care setting

## BACKGROUND

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There are many paths to the Emergency Department for patients at risk for suicide. Patients may be referred by a healthcare provider, a Suicide Lifeline, EMS or Police, a friend or loved one, or on their own initiative. As in primary care, a low index of suspicion is appropriate to screen for suicidal ideation or attempt. When suicidal ideation or behavior becomes the focus of attention, the patient should be managed to minimize the risk of death. In a busy Emergency Department, psychiatric patients can often be triaged as a low acuity; or placed out of sight, out of mind in a quiet room for evaluation by the behavioral health consultant. This approach places the patient and staff at risk of harm due to inadequate medical assessment and inadequate management of potentially disruptive behavior.

The evaluating clinician must also consider the safety of the clinic, the availability of support staff, and the availability of the necessary additional diagnostic capability when deciding on the appropriate setting for the evaluation.

## RECOMMENDATIONS

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1. The setting for the initial evaluation should ensure the safety of the patient and the clinical staff so that potentially life-threatening conditions can be managed effectively. Providers should make the appropriate steps to:
  - a. Secure all belongings to prevent access to lethal means and elopement from the Emergency Department.
  - b. Monitor the patient in a visible area, away from exits, with limited access to equipment that may be used to harm self or others.
  - c. Conduct a focused medical assessment to identify and manage any life-threatening conditions such as overdose, and assess medical stability.
    - Vital Signs, Physical Exam, Neurologic Exam, Mental Status Exam
    - ECG, Toxicology Screen, BAL, and other tests as indicated.
    - Treat life-threatening conditions.
  - d. Request Behavioral Health Consultation to conduct a thorough suicide risk assessment and recommend a treatment plan.

An experienced behavioral health practitioner should evaluate patients at intermediate to high acute risk for suicide

**BACKGROUND**

The initial assessment of suicide risk must consider the existence of medically unstable conditions, and these must be evaluated and stabilized before the psychological and suicide evaluation can be safely performed. The initial medical evaluation should include a thorough history of recent suicidal behavior, use of any medications or substances of abuse, and any recent self-injurious behavior. A physical examination to include vital signs, cardiopulmonary examination, mental status examination, and neurological examination should be performed. When indicated, further diagnostic evaluation to include electrocardiogram, and laboratory screening to include hematology, renal and hepatic function, toxicology and alcohol/drug testing should also be considered.

After determining that the patient is medically stable, the goal is to gain a complete understanding of the patient’s medical, social, and mental health history and recognize current risk factors for suicide as well as any signs and symptoms of psychiatric illness for diagnostic and treatment purposes.

The Behavioral Health practitioner must evaluate and integrate all available information to determine the patient’s risk for suicide and formulate a plan that ensures the patient’s safety as suicide-specific treatments are initiated. While the practitioner seeks to gain all available information and insights, many barriers exist that can obscure the assessment. Patients may present barriers to gaining a full assessment by withholding information due to defensiveness or embarrassment, or by simply being too depressed or intoxicated to reliably recall important aspects of their history. Due to the potential for unreliability in the acute crisis, collateral sources of information should be sought to validate the history. The accessibility of collateral sources also informs the treatment plan as it identifies potential sources of support for the patient.

<i>Components of the Clinical Assessment of the Patient with Suicide Risk</i>
<i>1. Medical history to rule out relevant conditions</i>
<i>2. Psychiatric history</i>
<i>3. Suicidal behavior history (previous attempts)</i>
<i>4. Substance use history</i>
<i>5. Psychosocial history to include history of life stressors, impulsivity, aggression and relationships</i>
<i>6. Family psychiatric history to include history of suicide</i>
<i>7. Physical examination</i>
<i>8. Mental status examination (MSE)</i>
<i>9. Relevant laboratory tests</i>
<i>10. Drug inventory, including over-the-counter (OTC) drugs and supplements</i>

**RECOMMENDATIONS**

1. Gather collateral history from family/unit members, the medical record, escorts, unit commanders (or their representatives), referring physicians, EMS, and police as appropriate.
2. Approach the patient with a non-judgmental, collaborative attitude with the aim of fully understanding the patient’s suicidality.

3. Secure all belongings to prevent access to lethal means and elopement from the clinic.
4. Choose the setting for the initial evaluation to ensure the safety of the patient and the clinical staff so that potentially life-threatening conditions can be managed effectively. If the patient is intoxicated, re-evaluate when intoxication has resolved.
5. Conduct a mental status examination and a comprehensive assessment of mental health history that includes:
  - a. Past and present suicidal thoughts, intent, and behaviors, impulsivity, hopelessness and the patient view of the future
  - b. Alcohol use assessed per standardized tools (Audit-C), and other substance abuse history, since impaired judgment may increase the severity of the suicidality and risk for suicide act
  - c. Psychiatric illness, comorbid diagnoses, and history of treatment interventions.
  - d. Elicit family history of suicidal behavior.
6. Assess for access and past use of lethal means (firearms, drugs, toxic agents).
7. Assess social history of support system, living situation and potential stressful life events.
8. Consider suicidal thinking, intent, behavior, risk factors and protective factors to stratify the risk.
9. Consider the use of a standardized suicide risk assessment framework to inform the evaluation for estimating the risk for suicide.
10. Determine appropriate setting for further evaluation and management based on level of risk, legal guidance, and local policy.
11. Document in detail the data supporting the assigned level of risk, the level of care required, and treatment plans to reduce suicide risk.