VCMC/SANTA PAULA HOSPITAL CLINICAL PRACTICE GUIDELINE
Suicide Risk Assessment

The contents of this clinical practice guideline are to be used as a guide. Healthcare professionals should use sound clinical judgment and individualize patient care in the appropriate clinical setting. This CPG is not meant to be a replacement for training, experience, CME or studying the latest literature and drug information.

BACKGROUND: Approximately 37,000 people in the United States and one million worldwide die by suicide each year, and 650,000 people in the United States receive emergency treatment each year after attempting suicide.

Despite this, there are no data to show that screening for suicide reduces mortality. Additionally, predicting which patients with suicidal thoughts will go on to attempt suicide cannot be achieved with a high degree of sensitivity or specificity.

Nevertheless, the fact that clinicians see a large portion of the patients who subsequently commit suicide suggests that an approach to case finding based upon risk factors, sensitivity to high-risk situations, and assessment of suicidality may uncover occasional patients who make their intent known and are amenable to intervention.

This clinical practice guideline reviews risk factors for suicide, and the evaluation, initial management, and appropriate follow-up of the suicidal patient.

GUIDELINES

The provision of effective services for the patient at risk for suicide results from listening to the patient, using open-ended questions, and assuming a compassionate stance.

RISK ASSESSMENT:

Interview:
The Cognitive Triad of Suicide: Ideation, intent, and plan. Patients suspected to be at risk for suicide should be asked about suicidal ideation and intent, and, if present, the lethality of the plan should be evaluated. Clinicians worry at times that asking about suicide will initiate suicidal thoughts or actions, but there are no data to support this concern.

Risk can be simplified into three categories:
1. Fixed (sometimes also called Static or Demographic) Risk Factors
2. Modifiable (sometimes also called Dynamic) Risk Factors
3. Protective Factors

Fixed Risk Factors
These are the factors which statistically increase the risk of suicide.
- Race: Native American/Alaskan > Caucasian >> Hispanic > Asian/Pacific Islander > African-American.
- Gender: Male >> female (males with more lethal attempts and females with more frequent attempts).
- Age: Older adults and adolescents.
- Highest risk group by race and age: Caucasian men over 65.
- Marital status: Divorced.
- Veterans.
- Sexual orientation: Lesbian, gay, bisexual, transgendered (higher in adolescents).
- History of previous suicide attempts.
- Personality style (higher in Cluster B personality disorders).
- Childhood physical/sexual abuse.
- Family history of suicide.
- Intellectual disabilities.
- Chronic medical etiologies such as malignancies, HIV, head and neck cancers, Huntington's chorea, multiple sclerosis, spinal cord injury, lupus, and other serious and potentially terminal diseases and disorders.
- History of violent threats and behaviors.

Modifiable Risk Factors

- Depression.
- Mania.
- Mixed bipolar states.
- Anxiety.
- Panic attacks.
- Psychosis.
- Sleep disorders (higher for insomnia).
- Eating disorders.
- Substance use.
- Impulsivity.
- Agitation and irritability.
- Polarized thinking and cognitive distortions.
- Temporary physical illness and pain.
- Situation, especially recent loss (e.g. relationship, housing, family, work).
- Lethal means and access to means (e.g. guns, drugs).
- Drug effects (e.g. akathisia).

Protective Factors:

- Lack of suicidal ideation, intent, and plan.
- Hopefulness.
- Seeking treatment (e.g. therapeutic alliance)
- Future orientated.
- Social support and family connectedness
- Religiosity and participating in religious activities.
- Fear of death/the unknown.
- Parents/guardians who are the primary provider for children under their care.
- Pregnancy.

Additional factors to be assessed in children and adolescents:

- Pre-existing/current psychiatric disorders seen in children (e.g. disruptive behavior disorders).
- Stress events: loss, disciplinary problems (school, law), academic difficulties, sexual or physical abuse, and brief adjustment reaction.
- Family discord.
- Poor parent-child communication.

MANAGEMENT/TREATMENT:

Outpatient management:

- Reduce immediate risk.
- Manage underlying factors.
- Engage social supports and family.
- Appropriate referrals and/or an increase in frequency of contact.
- Refer for psychotherapy resources as appropriate.
- Evaluate need for adjustments to medication regimen.
- Reassess and adjust treatment plan as needed.
- Continue to build rapport.

Hospitalization: Psychiatric holds to be used based on provider's clinical judgment of current risk factors and dangerousness.

DOCUMENTATION:

Subjective: Patient statements that affect suicide risk including ideation, intent, and plan.
Objective: Suicide risk factors based on demographics, mental status exam, and other objective findings.
Assessment: Summary of current level of risk based on clinical judgment that directs treatment course.
Plan: Consider available resources for safe clinical intervention, treatment, and management. Monitor and update treatment plan as necessary.

References:

Murray CJ, Atkinson C, Bhalla K, et al. The state of US health, 1990-2010: burden of diseases, injuries, and risk factors. JAMA 2013; 310:591.

Simon, Robert I. 2011. Preventing Patient Suicide: Clinical Assessment and Management. Arlington, VA: American Psychiatric Publishing, Inc.

The American Psychiatric Association Practice Guidelines for the Psychiatric Evaluation of Adults. Third Edition Guideline III. Assessment of Suicide Risk pp. 18-23 2016

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