

ASSESSING AND TREATING SUICIDAL BEHAVIORS

A Quick Reference Guide



American Psychiatric Association

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Based on *Practice Guideline for the Assessment and Treatment of Patients With Suicidal Behaviors*, originally published in November 2003. A guideline watch, summarizing significant developments in the scientific literature since publication of this guideline, may be available in the Psychiatric Practice section of the APA web site at www.psych.org.

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as a necessary component of maintenance of certification.

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Introduction

“Assessing and Treating Suicidal Behaviors: A Quick Reference Guide” is a summary and synopsis of the American Psychiatric Association’s *Practice Guideline for the Assessment and Treatment of Patients With Suicidal Behaviors*, which was originally published in *The American Journal of Psychiatry* in November 2003 and is available through American Psychiatric Publishing, Inc. The Quick Reference Guide is not designed to stand on its own and should be used in conjunction with the full text of the Practice Guideline. The psychiatrist using this Quick Reference Guide should be familiar with the full-text Practice Guideline on which it is based. For clarification of a recommendation or for a review of the evidence supporting a particular strategy, the psychiatrist will find it helpful to return to the full-text Practice Guideline. Algorithms illustrating the assessment and treatment of patients with suicidal behaviors are included.

Statement of Intent

The Practice Guidelines and the Quick Reference Guides are not intended to be construed or to serve as a standard of medical care. Standards of medical care are determined on the basis of all clinical data available for an individual case and are subject to change as scientific knowledge and technology advance and practice patterns evolve. These parameters of practice should be considered guidelines only. Adherence to them will not ensure a successful outcome in every case, nor should they be construed as including all proper methods of care or excluding other acceptable methods of care aimed at the same results. The ultimate judgment regarding a particular clinical procedure or treatment plan must be made by the psychiatrist in light of the clinical data presented by the patient and the diagnostic and treatment options available.

The development of the APA Practice Guidelines and Quick Reference Guides has not been financially supported by any commercial organization.

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A. Assessment of Patients With Suicidal Behaviors

Refer to Table 1, p. 7, for circumstances in which suicide assessment may be indicated.

1. Conduct a thorough psychiatric evaluation.

Identify psychiatric signs and symptoms.

- Determine the presence or absence of signs and symptoms associated with specific psychiatric diagnoses.
- Identify specific psychiatric symptoms that may influence suicide risk, including aggression, violence toward others, impulsiveness, hopelessness, agitation, psychic anxiety, anhedonia, global insomnia, and panic attacks.

Assess past suicidal behavior, including intent of self-injurious acts.

- For each attempt, obtain details about the precipitants, timing, intent, consequences, and medical severity.
- Ascertain if alcohol and drugs were consumed before the attempt.
- Delineate interpersonal aspects of the attempt in order to understand issues that culminated in the attempt (e.g., persons present at the time of the attempt or to whom the attempt was communicated).
- Determine the patient's thoughts about the attempt (e.g., perception of potential for lethality, ambivalence toward living, visualization of death, degree of premeditation, persistence of suicidal ideation, and reaction to the attempt).

Review past treatment history and treatment relationships.

- Review psychiatric history (e.g., previous and comorbid diagnoses, prior hospitalizations and other treatment, past suicidal ideation).
- Review history of medical treatment (e.g., identify medically serious suicide attempts and past or current medical diagnoses).
- Gauge the strength and stability of current and past therapeutic relationships.

1. Conduct a thorough psychiatric evaluation (*continued*).

Identify family history of suicide, mental illness, and dysfunction.

- Inquire about family history of suicide and suicide attempts and psychiatric hospitalizations or mental illness, including substance use disorders.
- Determine the circumstances of suicides in first-degree relatives, including the patient's involvement and the patient's and relative's ages at the time.
- Determine childhood and current family milieu, including history of family conflict or separation, parental legal trouble, family substance use, domestic violence, and physical and/or sexual abuse.

Identify current psychosocial situation and nature of crisis.

Consider acute psychosocial crises or chronic psychosocial stressors that may augment suicide risk (e.g., financial or legal difficulties; interpersonal conflicts or losses; stressors in gay, lesbian, or bisexual youths; housing problems; job loss; educational failure).

Appreciate psychological strengths and vulnerabilities of the individual patient.

Consider how coping skills, personality traits, thinking style, and developmental and psychological needs may affect the patients' suicide risk and the formulation of the treatment plan.

TABLE 1. Circumstances in Which a Suicide Assessment May Be Indicated Clinically

- Emergency department or crisis evaluation
- Intake evaluation (on either an inpatient or an outpatient basis)
- Before a change in observation status or treatment setting (e.g., discontinuation of one-to-one observation, discharge from inpatient setting)
- Abrupt change in clinical presentation (either precipitous worsening or sudden, dramatic improvement)
- Lack of improvement or gradual worsening despite treatment
- Anticipation or experience of a significant interpersonal loss or psychosocial stressor (e.g., divorce, financial loss, legal problems, personal shame or humiliation)
- Onset of a physical illness (particularly if life threatening, disfiguring, or associated with severe pain or loss of executive functioning)

2. Specifically inquire about suicidal thoughts, plans, and behaviors.

Refer to Table 2, p. 9, for specific issues to address.

→ Elicit the presence or absence of suicidal ideation.

- Address the patient's feelings about living with questions such as "How does life seem to you at this point?" or "Have you ever felt that life was not worth living?" or "Did you ever wish you could go to sleep and just not wake up?"
- Focus on the nature, frequency, extent, and timing of suicidal thoughts, and consider their interpersonal, situational, and symptomatic context.
- Speak with family members or friends to determine whether they have observed behavior (e.g., recent purchase of a gun) or have been privy to thoughts that suggest suicidal ideation.
- If the patient is intoxicated with alcohol or other substances when initially interviewed, the patient's suicidality will need to be reassessed at a later time.

2. Specifically inquire about suicidal thoughts, plans, and behaviors (*continued*).

Elicit the presence or absence of a suicide plan.

- Probe for detailed information about specific plans for suicide and any steps that have been taken toward enacting those plans.
- Determine the patient's belief about the lethality of the method, which may be as important as the actual lethality of the method.
- Determine the conditions under which the patient would consider suicide (e.g., divorce, going to jail, housing loss) and estimate the likelihood that such a plan will be formed or acted on in the near future.
- Inquire about the presence of a firearm in the home or workplace. If a firearm is present, discuss with the patient or a significant other the importance of restricting access to, securing, or removing this and other weapons.

Assess the patient's degree of suicidality, including suicidal intent and lethality of plan.

Determine motivation for suicide, seriousness and extent of the patient's aim to die, associated behaviors or planning for suicide, and lethality of the method.

Recognize that suicide assessment scales have very low predictive values and do not provide reliable estimates of suicide risk.

Nonetheless, they may be useful in developing a thorough line of questioning about suicide or in opening communication with the patient.

TABLE 2. Questions That May Be Helpful in Inquiring About Specific Aspects of Suicidal Thoughts, Plans, and Behaviors

Begin with questions that address the patient's feelings about living:

- Have you ever felt that life was not worth living?
- Did you ever wish you could go to sleep and just not wake up?

Follow up with specific questions that ask about thoughts of death, self-harm, or suicide:

- Is death something you've thought about recently?
- Have things ever reached the point that you've thought of harming yourself?

For individuals who have thoughts of self-harm or suicide, ask:

- How often have those thoughts occurred (including frequency, obsessional quality, controllability)?
- How likely do you think it is that you will act on them in the future?
- What do you envision happening if you actually killed yourself (e.g., escape, reunion with significant other, rebirth, reactions of others)?
- Have you made a specific plan to harm or kill yourself? (If so, what does the plan include?)

For individuals who have attempted suicide or engaged in self-damaging action(s), parallel questions to those in the previous section can address the prior attempt(s). Additional questions can be asked in general terms or can refer to the specific method used and may include:

- Can you describe what happened (e.g., circumstances, precipitants, view of future, use of alcohol or other substances, method, intent, seriousness of injury)?
- What did you think would happen (e.g., going to sleep versus injury versus dying, getting a reaction out of a particular person)?
- Did you receive treatment afterward (e.g., medical versus psychiatric, emergency department versus inpatient versus outpatient)?

For individuals with repeated suicidal thoughts or attempts, ask:

- About how often have you tried to harm (or kill) yourself?
- When was the most recent time?
- Can you describe your thoughts at the time that you were thinking most seriously about suicide?

For individuals with psychosis, ask specifically about hallucinations and delusions:

- Have you ever done what the voices ask you to do? (What led you to obey the voices? If you tried to resist them, what made it difficult?)
- Have there been times when the voices told you to hurt or kill yourself? (How often? What happened?)
- Are there things that you've been feeling guilty about or blaming yourself for?

Consider assessing the patient's potential to harm others in addition to him- or herself:

- Are there others who you think may be responsible for what you're experiencing (e.g., persecutory ideas, passivity experiences)? Are you having any thoughts of harming them?
- Are there other people you would want to die with you?
- Are there others who you think would be unable to go on without you?

Questions are selected from Table 3 of APA's *Practice Guideline for the Assessment and Treatment of Patients With Suicidal Behaviors*. See that table for additional questions.

3. Establish a multiaxial diagnosis.

→ Note all current or past axis I or axis II diagnoses, including those that may currently be in remission.

→ Identify physical illnesses (axis III), since such diagnoses may also be associated with an increased risk of suicide.

→ Record psychosocial stressors (axis IV), which may be either acute or chronic. Consider the perceived importance of the life event for the individual patient.

→ Assess the patient's baseline and current levels of functioning (axis V).

4. Estimate suicide risk.

→ Identify factors that may increase or decrease the patient's level of risk.

- The presence of a psychiatric disorder is the most significant risk factor.
- Medical illness is also associated with increased likelihood of suicide. See Table 3, p. 11, for specific medical conditions that have been associated with increased risk.
- See Table 3 for additional factors that increase risk and Table 4 (p. 12) for protective effects.
- Almost all psychiatric disorders have been shown to increase suicide risk (Table 5, p. 12).

TABLE 3. Factors Associated With Increased Risk for Suicide**Suicidal thoughts/behaviors**

- Suicidal ideas (current or previous)
- Suicidal plans (current or previous)
- Suicide attempts (including aborted or interrupted attempts)
- Lethality of suicidal plans or attempts
- Suicidal intent

Psychiatric diagnoses

- Major depressive disorder
- Bipolar disorder (primarily in depressive or mixed episodes)
- Schizophrenia
- Anorexia nervosa
- Alcohol use disorder
- Other substance use disorders
- Cluster B personality disorders (particularly borderline personality disorder)
- Comorbidity of axis I and/or axis II disorders

Physical illnesses

- Diseases of the nervous system
 - Multiple sclerosis
 - Huntington's disease
 - Brain and spinal cord injury
 - Seizure disorders
- Malignant neoplasms
- HIV/AIDS
- Peptic ulcer disease
- Chronic obstructive pulmonary disease, especially in men
- Chronic hemodialysis-treated renal failure
- Systemic lupus erythematosus
- Pain syndromes
- Functional impairment

Psychosocial features

- Recent lack of social support (including living alone)
- Unemployment
- Drop in socioeconomic status
- Poor relationship with family^a
- Domestic partner violence^b
- Recent stressful life event

Childhood traumas

- Sexual abuse
- Physical abuse

Genetic and familial effects

- Family history of suicide (particularly in first-degree relatives)
- Family history of mental illness, including substance use disorders

Psychological features

- Hopelessness
- Psychic pain^a
- Severe or unremitting anxiety
- Panic attacks
- Shame or humiliation^a
- Psychological turmoil^a
- Decreased self-esteem^a
- Extreme narcissistic vulnerability^a
- Behavioral features
- Impulsiveness
- Aggression, including violence against others
- Agitation

Cognitive features

- Loss of executive function^b
- Thought constriction (tunnel vision)
- Polarized thinking
- Closed-mindedness

Demographic features

- Male gender^c
- Widowed, divorced, or single marital status, particularly for men
- Elderly age group (age group with greatest proportionate risk for suicide)
- Adolescent and young adult age groups (age groups with highest numbers of suicides)
- White race
- Gay, lesbian, or bisexual orientation^b

Additional features

- Access to firearms
- Substance intoxication (in the absence of a formal substance use disorder diagnosis)
- Unstable or poor therapeutic relationship^a

^aAssociation with increased rate of suicide is based on clinical experience rather than formal research evidence.

^bAssociated with increased rate of suicide attempts, but no evidence is available on suicide rates per se.

^cFor suicide attempts, females have increased risk, compared with males.

TABLE 4. Factors Associated With Protective Effects for Suicide

- Children in the home^a
- Sense of responsibility to family^b
- Pregnancy
- Religiosity
- Life satisfaction
- Reality testing ability^b
- Positive coping skills^b
- Positive problem-solving skills^b
- Positive social support
- Positive therapeutic relationship^b

^aExcept among those with postpartum psychosis or mood disorder.

^bAssociation with decreased rate of suicide is based on clinical experience rather than formal research evidence.

TABLE 5. Risk of Suicide in Persons With Previous Suicide Attempts and Psychiatric Disorders^a

Condition	Number of Studies	Standardized Mortality Ratio (SMR) ^b	Annual Suicide Rate (%)	Estimated Lifetime Suicide Rate (%)
Previous suicide attempts	9	38.4	0.549	27.5
Psychiatric disorders				
Eating disorders	15	23.1		
Major depression	23	20.4	0.292	14.6
Sedative abuse	3	20.3		
Mixed drug abuse	4	19.2	0.275	14.7
Bipolar disorder	15	15.0	0.310	15.5
Opioid abuse	10	14.0		
Dysthymia	9	12.1	0.173	8.6
Obsessive-compulsive disorder	3	11.5	0.143	8.2
Panic disorder	9	10.0	0.160	7.2
Schizophrenia	38	8.45	0.121	6.0
Personality disorders	5	7.08	0.101	5.1
Alcohol abuse	35	5.86	0.084	4.2
Pediatric psychiatric disorders	11	4.73		
Cannabis abuse	1	3.85		
Neuroses	8	3.72		
Mental retardation	5	0.88		

^aBased on a meta-analysis of 249 reports published between 1966 and 1993 (Harris EC, Barraclough B: "Suicide as an Outcome for Mental Disorders: A Meta-Analysis." *British Journal of Psychiatry* 170:205-228, 1997). Table adapted with permission.

^bThe SMR is the ratio of the observed mortality to the expected mortality and approximates the risk of mortality resulting from suicide in the presence of a particular condition. For the general population, the value of the SMR is 1.0, with an annual suicide rate of 0.014% per year and a lifetime rate of 0.72%.

B. Psychiatric Management

1. Establish and maintain a therapeutic alliance.

- Suicidal ideation and behaviors can be explored and addressed within the context of a cooperative doctor-patient relationship, with the ultimate goal of reducing suicide risk.
- Taking responsibility for a patient's care is not the same as taking responsibility for the patient's life.

2. Attend to the patient's safety.

For patients in emergency or inpatient settings, consider ordering observation on a one-to-one basis or by continuous closed-circuit television monitoring until an assessment of risk can be completed or if the patient is deemed to be at significant suicide risk.

Remove potentially hazardous items from the patient's room (if inpatient), and secure the patient's belongings.

Consider screening patients for potentially dangerous items by searching patients or scanning them with metal detectors.

3. Determine a treatment setting.

→ Treat in the setting that is least restrictive yet most likely to prove safe and effective (Table 6, p. 15).

→ Take into consideration the estimated suicide risk and the potential for dangerousness to others.

→ Reevaluate the optimal treatment setting and the patient's ability to benefit from a different level of care on an ongoing basis throughout the course of treatment.

4. Develop a plan of treatment.

→ Consider potential beneficial and adverse effects of each option along with information about the patient's preferences.

→ Address substance use disorders.

→ Provide more intense follow-up in the early stages of treatment to provide support and to rapidly institute treatment.

→ Review with outpatients guidelines for managing exacerbations of suicidal tendencies or other symptoms that may occur between scheduled sessions.

TABLE 6. Guidelines for Selecting a Treatment Setting for Patients at Risk for Suicide or Suicidal Behaviors

	Admission is generally indicated	Admission may be necessary	Release from emergency department with follow-up recommendations may be possible	Outpatient treatment may be more beneficial than hospitalization
After a suicide attempt or aborted suicide attempt . . .		Yes		
And patient is psychotic	Yes			
And attempt was violent, near-lethal, or premeditated	Yes			
And precautions were taken to avoid rescue or discovery	Yes			
And persistent plan and/or intent is present	Yes			
And distress is increased or patient regrets surviving	Yes			
And patient is male and older than age 45 years, especially with new onset of psychiatric illness or suicidal thinking	Yes			
And patient has limited family and/or social support, including lack of stable living situation	Yes			
And current impulsive behavior, severe agitation, poor judgment, or refusal of help is evident	Yes			
And patient has change in mental status with a metabolic, toxic, infectious, or other etiology requiring further workup in a structured setting	Yes			

TABLE 6. Guidelines for Selecting a Treatment Setting for Patients at Risk for Suicide or Suicidal Behaviors (continued)

	Admission is generally indicated	Admission may be necessary	Release from emergency department with follow-up recommendations may be possible	Outpatient treatment may be more beneficial than hospitalization
In the absence of a suicide attempt but in the presence of suicidal ideation . . .			Yes	
With specific plan with high lethality	Yes			
With high suicidal intent	Yes			
With psychosis		Yes		
With major psychiatric disorder		Yes		
With past attempts, particularly if medically serious		Yes		
With possibly contributing medical condition (e.g., acute neurological disorder, cancer, infection)		Yes		
With lack of response to or inability to cooperate with partial hospital or outpatient treatment		Yes		
With need for supervised setting for medication trial or ECT		Yes		
With need for skilled observation, clinical tests, or diagnostic assessments that require a structured setting		Yes		
With limited family and/or social support, including lack of stable living situation		Yes		
With lack of an ongoing clinician-patient relationship or lack of access to timely outpatient follow-up		Yes		

TABLE 6. Guidelines for Selecting a Treatment Setting for Patients at Risk for Suicide or Suicidal Behaviors (continued)

	Admission is generally indicated	Admission may be necessary	Release from emergency department with follow-up recommendations may be possible	Outpatient treatment may be more beneficial than hospitalization
In the absence of a suicide attempt but in the presence of suicidal ideation . . . (continued)			Yes	
But suicidality is a reaction to precipitating events (e.g., exam failure, relationship difficulties), particularly if the patient's view of situation has changed since coming to emergency department			Yes	
But plan/method and intent have low lethality			Yes	
But patient has stable and supportive living situation			Yes	
But patient is able to cooperate with recommendations for follow-up, with treater contacted, if possible, if patient is currently in treatment			Yes	
But without prior medically serious attempts, and if a safe and supportive living situation is available and outpatient psychiatric care is ongoing				Yes
In the absence of suicide attempts or reported suicidal ideation/plan/intent . . .				Yes
But evidence from the psychiatric evaluation and/or history from others suggests a high level of suicide risk and a recent acute increase in risk		Yes		

5. Coordinate care and collaborate with other clinicians.

→ Establish clear role definitions, regular communication among team members, and advance planning for management of crises.

→ Communicate with other caregivers, including other physicians providing treatment for significant general medical conditions or other mental health professionals who may be providing therapy. Establish guidelines for contact in the event of a significant clinical change.

6. Promote adherence to the treatment plan.

→ Establish a positive physician-patient relationship.

→ Create an atmosphere in which the patient feels free to discuss positive or negative aspects of the treatment process.

7. Provide education to the patient and family.

8. Reassess safety and suicide risk.

→ Repeat suicide assessments over time, because of the waxing and waning nature of suicidality (see Table 1, p. 7, for settings and circumstances).

→ Repeat suicide assessments in inpatient settings at critical stages of treatment (e.g., with a change in level of privilege, abrupt change in mental state, and before discharge).

→ Reassess suicidality if the patient was intoxicated with alcohol or other substances when initially interviewed.

9. Monitor psychiatric status and response to treatment.

-
- Monitoring is especially important during the early phases of treatment, since some medications may take several weeks to provide therapeutic benefit.
 - An early increase in suicide risk may occur as depressive symptoms begin to lift but before they are fully resolved.

10. Obtain consultation, if indicated.

-
- Consultation may be of help in monitoring and addressing countertransference issues.
 - Consultation may be important in affirming the appropriateness of the treatment plan or suggesting other possible therapeutic approaches.

C. Specific Treatment Modalities

1. Somatic Therapies

The strong association between depressive disorders and suicide supports the use of **antidepressants**.

Long-term maintenance treatment with **lithium salts** in patients with recurring bipolar disorder and major depressive disorder is associated with substantial reductions in risk of both suicide and suicide attempts.

There is no established evidence of a reduced risk of suicidal behavior with any other “**mood-stabilizing**” **anticonvulsant agents**.

Reductions in the rates of suicide attempts and suicide have been reported in specific studies of patients with schizophrenia treated with **clozapine**. Other first- and second-generation **antipsychotics** may also reduce suicide risk, particularly in highly agitated patients.

Because anxiety is a significant and modifiable risk factor for suicide, use of **antianxiety agents** may have the potential to decrease this risk. However, **benzodiazepines** occasionally disinhibit aggressive and dangerous behaviors and enhance impulsivity, particularly in patients with borderline personality disorder.

ECT may reduce suicidal ideation, at least in the short term.

2. Psychotherapies

Clinical consensus suggests that **psychosocial interventions** and **specific psychotherapeutic approaches** are of benefit.

D. Documentation and Risk Management

1. General Issues Specific to Suicide

- It is crucial for the suicide risk assessment to be documented in the medical record.
- See Table 7, p. 22, for general risk management considerations.

2. Suicide Prevention Contracts

- Reliance on a suicide prevention contract may falsely lower clinical vigilance without altering the patient's suicidal state.
- If a suicide prevention contract is used, a patient's unwillingness to commit to the contract mandates reassessment of the therapeutic alliance and the patient's level of suicide risk.
- Suicide prevention contracts are not recommended in emergency settings; with newly admitted and unknown inpatients; with agitated, psychotic, or impulsive patients; or when the patient is under the influence of an intoxicating substance.

TABLE 7. General Risk Management and Documentation Considerations in the Assessment and Management of Patients at Risk for Suicide

Good collaboration, communication, and alliance between clinician and patient

Careful and attentive documentation, including:

- Risk assessments
- Record of decision-making processes
- Descriptions of changes in treatment
- Record of communications with other clinicians
- Record of telephone calls from patients or family members
- Prescription log or copies of actual prescriptions
- Medical records of previous treatment, if available, particularly treatment related to past suicide attempts

Critical junctures for documentation:

- At first psychiatric assessment or admission
- With occurrence of any suicidal behavior or ideation
- Whenever there is any noteworthy clinical change
- For inpatients, before increasing privileges or giving passes and before discharge

Monitoring issues of transference and countertransference in order to optimize clinical judgment

Consultation, a second opinion, or both should be considered when necessary

Careful termination (with appropriate documentation)

Firearms:

- If present, document instructions given to the patient and significant others
- If absent, document as a pertinent negative

Planning for coverage

3. Communication With Significant Others

If a patient is (or is likely to become) dangerous to him- or herself or to others and will not consent to interventions intended to reduce those risks, the psychiatrist is justified in attenuating confidentiality to the extent needed to address the safety of the patient and others.

4. Management of Suicide in One's Practice

- If a patient dies by suicide, ensure that his or her records are complete.
- Conversations with family members can be appropriate and can allay grief and assist devastated family members in obtaining help.
- In speaking with survivors, care must be exercised not to reveal confidential information about the patient and not to make self-incriminating or self-exonerating statements.

5. Mental Health Interventions for Surviving Family and Friends After a Suicide

Suggest psychiatric intervention to family members and friends shortly after the death to reduce their risk for psychiatric impairment.

Consider referring surviving family members and friends to a survivor support group.