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Guidelines for Identification, Assessment, and Treatment Planning for **Suicidality**



Guidelines for Suicidality: Identification and Assessment

Purposes

To provide a model for the assessment of suicidality in all clinical settings.

To provide information to be incorporated into institution-specific protocols.

These guidelines are not to be construed or to serve as a standard of 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 patterns evolve. This model should be considered only as a guideline. Adherence to it will not ensure a successful outcome in every case. It should not be construed as including all proper methods of assessment or excluding other acceptable assessment methods aimed at the same results. The ultimate judgment of suicidality regarding a particular patient must be made by the clinician in light of the clinical data presented by the patient and other available information.

(Adapted from Practice Guideline for Major Depressive Disorder in Adults. American Journal of Psychiatry. 150:4, April 1993 Supplement.)

When to Use These Guidelines

Assessment and documentation of suicidality are integral components of any psychiatric evaluation and become primary concerns in that evaluation at the following times:

1. During initial interview or on admission to a facility or program
2. With the occurrence of any suicidal/self-destructive behavior or ideation
3. On the occasion of any noteworthy clinical change (e.g. significant new symptoms, mental status changes, stressors)
4. For inpatients who have been assessed to be suicidal, the following situations may prompt an additional assessment:
 - a. On progression to a less restrictive level of precautions or privileges (including therapeutic passes).
 - b. At time of discharge from hospital.

Data for Assessing Suicidality/General Psychiatric Evaluation

The assessment of a potentially suicidal patient begins with a comprehensive psychiatric evaluation. At subsequent evaluations, the breadth of questioning will vary depending on circumstances. Such inquiry often includes relevant complaint(s) and history, a limited mental status examination, and relevant physical and laboratory examinations that do not unnecessarily duplicate previous assessments.



Guidelines for Suicidality: Identification and Assessment

Psychiatric Diagnosis

The clinician performs a diagnostic assessment to identify whether the patient suffers from a psychiatric illness associated with higher suicide risk, especially mood disorders, schizophrenia, substance abuse, anxiety disorders, borderline personality disorder, and other personality disorders and traits, or patients with comorbid illness. *Appendix 1* details suicide risk with specific diagnostic considerations.

Other Conditions Which Can Increase Suicide Risk

1. Physical illness, particularly associated with chronic pain
2. Delirium associated with organic illness
3. Other personality disorders/traits
4. Psychopathology in family and social milieu, including life stress and crisis
5. Family history of psychiatric illness and particularly of suicide
6. The presence of firearms in the home (particularly for adolescents)

The Detection of Suicidality

The assessment of suicidality is an active process during which clinicians evaluate:

1. Suicidal intent and lethality
2. Dynamic meanings and motivation for suicide
3. Presence of a suicidal plan
4. Presence of overt suicidal/self-destructive behavior
5. The patient's physiological, cognitive, and affective states
6. The patient's coping potential
7. The patient's epidemiologic risk factors

Many of these observations are made during the general psychiatric evaluation and mental status examination. However, a number of suicide-specific questions may be included in this process.



Guidelines for Suicidality: Identification and Assessment

Suicide-specific Questions

1. Is the patient able/competent to participate in treatment?
2. Is the patient able to develop a therapeutic alliance?
3. Are suicidal thoughts/feelings present?
4. What form does the patient's wish for suicide take?
5. What does suicide mean to the patient?
6. Has the patient lost or anticipates losing an essential sustaining relationship?
7. Has the patient lost or anticipates losing his/her main reason for living?
8. How far has the suicide planning process proceeded?
9. Have suicidal behaviors occurred in the past?
10. Has the patient engaged in self-mutilating behaviors?
11. Does the patient's mental state increase the potential for suicide?
12. Are depression and/or despair present?
13. Does the patient's physiologic state increase the potential for suicide? (e.g., physical illness, intoxication, pain, delirium, organic impairment)
14. Is the patient vulnerable to painful affects such as aloneness, self-contempt, murderous rage, shame, or panic?
15. Are there recent stresses in the patient's life?
16. What are the patient's capacities for self-regulation?
17. Is the patient able/competent to participate in treatment?
18. Loss of coping mechanism?
19. An expanded version with more detailed questions is included in *Appendix 2*.
20. Are Epidemiologic Risk Factors Present?
See *Appendix 3* for a list of these risk factors. These factors do not predict suicide. Rather, they are part of a suicide assessment because of their demonstrated statistical correlation with suicide.



Guidelines for Suicidality: Treatment Planning

Once an assessment of the patient's suicide risk has been made, an individual treatment plan must be designed. Treatment planning is a dynamic process, shaped by and communicated between the patient and involved caregivers in light of changing information or behaviors. Sometimes it may be possible and clinically indicated to include significant others in treatment planning. Because suicidality can be an acute (state) or chronic (trait) condition, treatment planning may need to consider both short and long term goals. Treatment planning takes into account the patient's potential for suicide, capacity to form a treatment alliance, and range of available treatment alternatives from outpatient follow-up to hospitalization with constant observation.

Collect Data Before Treatment Planning

Success is more likely when the treatment plan rests on a firm foundation of data and assessment.

Identify a Range of Treatment Alternatives

1. Weigh the risks and benefits of each alternative, including the alternative "no treatment."
2. There is no unique correct plan. Select a plan based upon assessment and judgment.

Involve the Patient and Family in the Treatment Planning Process to the Degree Possible

1. When a patient lacks the capacity to participate in treatment planning, the clinician must make judgments about the most appropriate treatment plan.
2. Information from the patient's significant others may be of use in the planning process.

Incorporate Existing Treatment Modalities Into the Plan

1. Involve a current treating clinician and/or appropriate significant others in planning and follow-up.
2. Continue or reassess ongoing pharmacotherapy, with involvement of prescribing physician.

Be Aware that Contracts Will Not Guarantee the Patient's Safety

1. Patient's ability to understand and participate in treatment should be assessed.
2. Treatment focus should be on alliance with the patient.
3. Contracts can play a role if utilized as part of a comprehensive evaluation and treatment plan.
4. However, contracts can give staff a false sense of security and interfere with a thorough suicide assessment.



Guidelines for Suicidality: Treatment Planning

Choose Appropriate Levels of Observation, Supervision, and Privileges

1. The inpatient unit is especially effective in the treatment of acute rather than chronic suicidality. It offers safety, support, and hope (although no unit is suicide proof). Inpatient treatment planning is determined on an individual basis to meet the patient's need for maximal safety in the least restrictive environment. Although precautions and privileges have restrictive elements, they are applied in the context of a treatment plan that aims to enable a patient to tolerate suicidal feelings.
2. Inpatient treatment of suicidal patients relies upon a progression through a hierarchy of observation levels, supervision levels, privileges, and therapeutic passes.
3. With clinical improvement, suicidality may still persist. Although the ultimate goal is toward a less restrictive environment, the clinical decision must be based on an assessment that the suicide risk has been reduced.

The Levels of Observation, Supervision, and Privileges Parallel the Patient's Potential for Suicidal Behavior

1. Examples of observation levels are:
 - a. Continuous observation (1:1 or remaining in sight of staff members)
 - b. Restricting the patient to an area where he or she can be seen at all times by staff
 - c. Restricting the patient to public areas; not allowing him or her to be alone in room
 - d. Checks at intervals of 5, 15, or 30 minutes
 - e. Periodic checks at intervals greater than every 30 minutes
2. Examples of when staff supervision is necessary include during the patient's use of:
 - a. Sharps (nail cutters, razors, scissors)
 - b. Cigarettes and matches
 - c. Poisons (cleaning supplies)
 - d. Bathroom
 - e. Kitchen
 - f. Occupational therapy
3. Examples of privilege levels are:
 - a. Restricted to unit
 - b. Accompanied off-unit by staff (specify 1:1 versus group, number and gender of staff person, legal status of patient when relevant)
 - c. Accompanied off-unit by non-staff (reliable family member or friend)
 - d. Unaccompanied off-unit



Guidelines for Suicidality: Treatment Planning

Document the Treatment Planning Process and the Plan

1. Document the range of options considered and why one was chosen over others.
2. Document communication with the patient. With suicidal inpatients, documentation of suicidality occurs, at (but not limited to) the following treatment stages:
 - a. Admission
 - b. First unaccompanied pass
 - c. Discharge (Especially at discharge, the issue of chronic suicide risk must be considered. The chronic risk can be assessed according to the same model, though a longer view is taken of the risks and benefits of various treatment options.)
3. Document discharge planning to include:
 - a. Living arrangements, work, communication with significant others
 - b. Follow-up appointments or contact with outpatient provider
 - c. Medications (include prescriptions)
 - d. Current suicide assessment

In Planning Treatment for a Chronically Suicidal Patient, Some of the Following Considerations May Apply:

1. Safety may wax and wane.
2. Despair over treatment failure may increase suicide potential.
3. The treatment team may decide to tolerate short term risk to foster long-term growth.
 - a. Such a decision should include informed consent.
 - b. Documentation should make clear the choices and rationale.
4. Assess the risk of continued hospitalization



Guidelines for Suicidality: Appendix 1

Disorders Correlated with Suicidal Behavior

The following five DSM IV disorders are correlated with suicide and suicidal behavior: *(Note: More than 90 percent of completed suicides carry a diagnosis of alcoholism, depression, schizophrenia, or some combination of these.)*

Mood Disorders

15 percent
lifetime risk
of suicide

1. The absence of psychosis does not imply safety.
2. A misleading reduction of anxious or depressed affect can occur in some patients who have resolved their ambivalence by deciding to commit suicide. A patient who has made the decision to die may appear at peace and not show signs of an inner struggle. Concern is warranted especially when the patient appears emotionally removed, shows constricted affect, or is known to have given away belongings.
3. The likelihood of suicide within one year is increased when the patient exhibits:
 - a. Panic attacks
 - b. Psychic anxiety
 - c. Anhedonia
 - d. Alcohol abuse
4. The likelihood of suicide during the ensuing 1-5 years is increased when the patient exhibits:
 - a. Increased hopelessness
 - b. Suicidal ideation
 - c. History of suicide attempts

Panic Disorder

7–15 percent
lifetime risk
of suicide

1. Suicide rate may be similar to that of mood disorders
2. Greater likelihood is correlated with more severe illness or comorbidity
3. Suicide does not necessarily occur during a panic attack
4. Demoralization or significant loss increase the likelihood of suicide
5. Agitation may increase the likelihood of translating impulses into action



Guidelines for Suicidality: Appendix 1

Disorders Correlated with Suicidal Behavior

Schizophrenia

10 percent
lifetime risk
of suicide

1. Suicide is relatively uncommon during psychotic episodes
2. The relationship between command hallucinations and actual suicide is not clearly causal
3. Suicidal ideation occurs in 60-80 percent of patients
4. Suicide attempts occur in 30-55 percent of patients
5. Suicide potential is increased by:
 - a. Good premorbid functioning
 - b. Early phase of illness
 - c. Hopelessness or depression
 - d. Recognition of deterioration, e.g., during a post-psychotic depressed phase

Alcoholism

3 percent
lifetime risk
of suicide

1. Abusers of alcohol/drugs compose 15-25 percent of suicides
2. Alcohol is associated with nearly half of all suicides
3. Increased suicide potential in an alcoholic patient correlates with:
 - a. Active substance abuse
 - b. Adolescence
 - c. Second or third decades of illness
 - d. Comorbid psychiatric illness
 - e. Recent or anticipated interpersonal loss
4. Substance abuse can represent self treatment to blunt the anxiety or mood disturbance associated with a masked, comorbid psychiatric disorder

Borderline Personality Disorder

7 percent
lifetime risk
of suicide

1. Much higher risk associated with comorbidity, especially with mood disorder and substance abuse
2. Psychopathology associated with increased risk:
 - a. Impulsivity, hopelessness/despair
 - b. Antisocial features (with dishonesty)
 - c. Interpersonal aloofness (“malignant narcissism”)
 - d. Self-mutilating tendencies
 - e. Psychosis with bizarre suicide attempts
3. Psychopathology associated with diminished risk:
 - a. Infantile personality (with hysterical features)
 - b. Masochistic personality



Guidelines for Suicidality: Appendix 2

Detection of Suicidality: Expanded Outline & Questions

Suicidal Intent and Lethality

1. Are suicidal thoughts/feelings present?
 - a. What are they?
 - b. Are they active/volitional or passive/non-volitional?
 - c. When did they begin?
 - d. How frequent are they?
 - e. How persistent are they?
 - f. Are they obsessive?
 - g. Can the patient control them?
 - h. What motivates the patient to die or to continue living?

Dynamic Meanings and Motivation for Suicide

1. What form does the patient's wish for suicide take?
Is there a wish to die, to hurt someone else, to escape, to punish self?
2. What does suicide mean to the patient?
 - a. Is there a wish for rebirth or reunion?
 - b. Is there an identification with a significant other?
 - c. What is the person's view of death and relationship to it?
 - d. Does death have a positive meaning for the patient?
3. Has the patient lost an essential sustaining relationship?
4. Has the patient lost his/her main reason for living? (These losses can be threatened)

Presence of a Suicidal Plan

1. How far has the suicide planning process proceeded?
2. Specific method, place, time?
 - a. Available means?
 - b. Planned sequence of events?
 - c. Intended goal? (e.g. death, self-injury, or another outcome)
3. Feasibility of plan?
Access to weapons (Document any conversation about access to guns or other lethal weapons. Consider the possibility of misinformation.)



Guidelines for Suicidality: Appendix 2

Detection of Suicidality: Expanded Outline & Questions

4. Lethality of planned actions?
 - a. Objectively assess danger to life.
 - b. Objectively question patient's conception of lethality.
 - c. Avoid terms such as gesture or manipulation, because they imply a motive that may be absent or irrelevant to lethality.
 - d. Bizarre methods have less predictable results and may therefore carry greater risk.
 - e. Pay attention to violent, irreversible methods such as shooting or jumping.
5. Likelihood of rescue?

Patients who contemplate a plan likely to end in discovery may be more ambivalent and/or attached to people than others who plan their suicidal behavior to occur in an isolated setting.
6. What preparations has the patient made (e.g., obtaining pills, suicide note, making financial arrangements)?
7. Has the patient rehearsed for suicide (e.g., rigging a noose, putting gun to head, driving near a bridge)?

History of Overt Suicidal/Self-destructive Behavior

1. Have suicidal behaviors occurred in the past?
2. It is useful to explore the circumstances of any past suicide attempts. If the patient can describe the past event, this may provide the best window into the current state of mind. Absence of previous suicidality, however, does not eliminate the risk of current or future attempts.
3. Statistical relationships of suicide attempts to suicide completion are:
 - a. Attempters are at increased risk for suicide over the general population by 7-10 percent .
 - b. 18-38 percent of those who died by suicide have made a prior attempt.
 - c. 90 percent of attempters do not go on to complete suicide.
 - d. One percent of past attempters kill themselves each year.
4. Has the patient engaged in self-mutilating behaviors?
 - a. Wrist-cutting or other self-mutilation suggests consideration of the diagnoses of PTSD or dissociative disorders among others. When a history of trauma or abuse is present, it may be valuable to assess the presence of a mood disorder.
 - b. Although self-mutilation is frequently an act of self soothing rather than an attempt to die, patients who self-mutilate do sometimes commit suicide.
 - c. In assessing risk of further self-mutilation, one useful question is, "How do you calm yourself down?"



Guidelines for Suicidality: Appendix 2

Detection of Suicidality: Expanded Outline & Questions

The Patient's Physiological, Cognitive, and Affective States

1. Does the patient's mental state increase the potential for suicide?
 - a. Does the patient have the capacity to act?
 1. Suicide requires both the ability to organize and the energy to implement a plan.
 2. Suicide potential may be heightened when there is greater energy (as in early recovery from depression) or lowered inhibition (as during intoxication or rage).
 - b. Is the patient hopeless?
 1. Hopelessness is a key psychological factor in suicidal intent and behavior.
 2. It is often accompanied by pervasive negative expectations.
2. Are depression and/or despair present?

Depression is a mood state or syndromal disorder associated with vegetative symptoms. Despair is a cognitive state that features a sense of futility about alternatives, no personal sense of a future role, and a lack of human connections that might offer support.

 - a. Is a diagnosable psychiatric disorder present that is correlated with suicidality or poor treatment compliance?
3. Does the patient's physiologic state increase the potential for suicide? (illness, intoxication, pain)
 - a. Are intoxicants present?
 1. Acute intoxication or withdrawal can lead to an acute increase in suicide risk
 - a. State dependent: decreased inhibition, poor judgement, denial
 - b. Importance of precipitants such as interpersonal loss
 2. Thorough evaluation difficult when patient is intoxicated
 - a. Provide safe place until sober
 - b. Reassess suicide risk when sober
 3. Chronic abuse or dependence leads to a chronic risk
 - a. Trait dependent self-destruction and decreased self-care
 - b. Suicide risk can be elevated when a relapse occurs
4. Is the patient vulnerable to painful affects such as aloneness, self-contempt, murderous rage, shame or panic?



Guidelines for Suicidality: Appendix 2

Detection of Suicidality: Expanded Outline & Questions

The Patient's Coping Potential

1. Are there recent stressors in the patient's life?
 - a. Is the patient facing a real or imagined loss, disappointment, humiliation or failure?
 - b. Has there been a disruption in the patient's support system (including treatment)?
2. What are the patient's capacities for self-regulation?
 - a. Does the patient have a history of impulsive behavior?
 - b. Does the patient need, and can he or she use external sustaining resources to regulate self-esteem?
3. Is the patient able to participate in treatment?
 - a. Does the patient verbalize a willingness to comply with treatment plan?
 - b. Does the patient possess the capacity for making an alliance?



Guidelines for Suicidality: Appendix 3

The following risk factors provide explicit criteria for identifying the presence of factors correlated with a greater likelihood of suicide risk. They can be used as a screen, to heighten risk awareness. With any individual patient, they assume greater or lesser importance. The list of factors most relevant to adults over age 30 differs from that for individuals younger than 30.

(Adapted from Klerman GL. Clinical Epidemiology of Suicide. *Journal of Clinical Psychiatry*. 1987; 48:33-38.)

Under 30 (Adolescents and Young Adults)

1. Family history of suicide
2. Males > females
3. History of previous attempts
4. Native American
5. Psychiatric diagnosis: mood disorders and substance abuse
6. White > black
7. Mini-epidemic in community
8. History of delinquent or semi-delinquent behavior even without depression in current mental state.
9. Presence of firearms (*when other factors are present*)

Over 30

1. Family history of suicide
2. Males > females
3. History of previous attempts
4. Native American
5. Psychiatric diagnosis: mood disorder, schizophrenia, alcoholism
6. Single: especially separated, widowed, or divorced
7. Lack of social supports
8. Concurrent medical illness(es)
9. Unemployment
10. Decline in socioeconomic status
11. Psychological turmoil



Guidelines for Suicidality

Developed by the Suicide Risk Advisory Committee of the
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