ACLP How To Guide: Suicide Risk Assessment

Evaluation and Management of Suicide Risk in the General Hospital

Learning Objectives
1. Recognize the risk and protective factors pertinent to suicide assessment
2. Learn how to conduct a suicide risk assessment in a general hospital setting
3. Become familiar with the management of the suicidal patient
4. Plan a safe discharge

Step 1: Learn important definitions regarding suicidality and suicide intent
- Suicidal behavior exists on a spectrum and includes behaviors WITH the intent to kill oneself (see Table 1) and behaviors WITHOUT the intent to kill oneself (ie: parasuicidal acts, suicide gestures, self-injurious behaviors, and manipulative or reactive acts).

Table 1. Suicide Terminology

Terminology	Description	Evidence that…
Suicidal act	Potentially self-injurious behavior	…person intended to die; may have resulted in death, injuries, or no injuries
Suicide attempt	Potentially self-injurious behavior with nonfatal outcome	…person intended to die; may or may not have resulted in injuries
Suicide attempt with injuries	Action resulting in a nonfatal injury	…person intended to die; did not die but did suffer injuries
Completed suicide	Death from injury, poisoning, suffocation or some other means	…injury was self-inflicted, intent was to die, and the patient did die

Step 2: Perform an evaluation of suicide risk

Step 2A: Assess Suicidal Ideation/Behavior and Intent
- Patients should be approached in a nonjudgmental, supportive, and empathic fashion and questioned about suicidal ideation and intent in an open and direct manner.
- The clinician should elicit details such as when, where, and how an attempt has been made or would be made, potential means, etc.
- Evaluate suicidal ideation and intent: presence of suicidal thoughts, details of suicide plan, seriousness of intent (or attempt), social supports, risk/rescue ratio, degree of impulsivity
- Clinical assessment of intent accounts for the following items:
  - Knowledge of lethality of method
    - Extent to which patient understands that suicide attempt could result in death
  - Use of high lethality method
  - Planned, organized, persistent
    - Extent to which a specific and well-thought-out plan was carried out
  - Active measures of non-discovery/prevention or rescue
    - Likelihood of being rescued and brought to medical attention
    - Extent to which patient made sure that he/she would or would not be found

- The risk of acting on suicidal thoughts increases with the frequency, intent, preparatory behavior, and content (presence of a plan, levels of ambivalence or hopelessness, etc.) of suicidal ideation.

Step 2B: Assess Risk Factors and Protective Factors

- Identify risk and protective factors, especially those that may be modifiable targets for intervention (see Table 2).
- Treatment settings
  - Status as medical inpatient increases suicide risk relative to being an outpatient
  - The last clinical contact for the majority of individuals who die by suicide is either in an emergency department (ED) or in a primary care clinic. Screening for suicide risk in EDs is justified because as many as one in five individuals who die by suicide have visited the ED within 4 weeks of their death; similarly, a visit to the ED for a mental health reason is a predictor of suicidal behavior. Other reasons for visiting the ED (trauma, substance intoxication) can increase the risk for suicide and nearly half of individuals who screen + for suicide risk in the ED do not spontaneously communicate suicidal ideation.
- The circumstances and risk factors of an individual patient should be placed in the context of known risk factors for suicide.
- Interview family and friends to corroborate gathered information and obtain other pertinent information.

Table 2: Risk factors for Suicide

Nonmodifiable	Potentially modifiable	Modifiable
Gender M > F **Race** White > non-white **Age** Old > young	**Medical illness** Delirium Dementia HIV/AIDS Cancer Multiple sclerosis Peptic ulcer disease Spinal cord injuries ESRD Huntington's disease Pain Insomnia Physical dependence Disfigurement Loss of autonomy	**Psychiatric syndromes and states** Depression Psychotic disorders (delusions, perceptual disturbances) Hopelessness, helplessness
Familial Family history of psychiatric illness and completed suicide Early life adversity	**Marital status** Single > widowed, separated, divorced > married	**Substance misuse** Substance use disorder, intoxication, withdrawal
Previous suicide attempts Severity of previous attempts may be more important than number of previous attempts	**Social** Isolation Financial difficulties Housing Limited resources Lower socioeconomic status	

	Unemployment Access to high lethality means Recent loss/setback	

- Psychiatric (modifiable)
  - 90% of individuals who die by suicide have a psychiatric diagnosis. Depression is common. 30 – 60% have a substance use disorder. 25 – 50% of adults who die by suicide are intoxicated at the time of death. Alcohol and drugs are associated with suicidal ideation, more serious intent, more lethal attempts, and greater number of suicide attempts. Intoxicated states can be disinhibiting and lead to suicide attempts/completions. Impulsivity is a key mediator of substance use associated with suicidal ideation and suicidal behavior.
- Medical (modifiable vs non-modifiable)
  - Medical illness, especially severe or chronic, may be a risk factor for completed suicide. Medical disorders are associated with as many as 35 – 40% of suicides. Physical comorbidity, sleep and pain issues, and cognitive impairment are substantial contributors to suicidal behavior in older people. Chronic pain is a predictor of suicide and suicidal behavior, both independently as well as via the co-occurring difficulties of disability, sleep problems, reduced well-being and depression.
- Social (potentially modifiable)
  - Financial difficulties (housing availability, limited access to treatment resources, lower socioeconomic status (SES)
- Familial (non-modifiable)
  - Family history of psychiatric illness and completed suicide
    - As many as 7 – 14% of persons who attempt suicide have a family history of suicide. Relatives of individuals who died by suicide are more likely to have increased impulsivity and aggression and have an increased risk of suicidal behavior.
  - Early parental death or separation/history of emotional, physical, or sexual abuse
- Past and present suicidality
  - Previous suicide attempts (non-modifiable)
    - Those who have made previous attempts are more likely to succeed. Second attempts commonly occur within 3 months of the 1st attempt.
    - Nonfatal suicidal behavior is among the most robust predictors of future suicidal behavior and suicide death. ~40% of people dying by suicide have previously attempted suicide. The risk of suicide among people who survived a suicide attempt is 1.6% within 12 months and ~4% at 5 years.
    - Approximately 10% of patients who make a medically serious suicide attempt ultimately die.
  - Suicidal ideation (potentially modifiable)
  - Suicidal intent (potentially modifiable)
  - Hopelessness (potentially modifiable)
- Protective Factors for Suicide
  - Restricted access to lethal means
  - Skills in problem solving and conflict resolution

- Cultural/religious beliefs that discourage suicide
- Social support
- Reasons for living
- Dependent children in the home

Step 3: Management of Suicide Risk

- The management of suicide risk in the general hospital includes stabilization of medical conditions, treatment of psychiatric symptoms, protection from self-harm, removal of dangerous objects, serial assessments, addressing modifiable medical and social risk factors, communicating clearly with consultants, and determining appropriate disposition and setting for management following discharge from the medical unit
- Psychopharmacological Treatment of Suicidal Ideations
    - Decreasing suicide risk
        - Scheduled medications to treat underlying mood disorders, psychosis, or acute distress
        - PRN medications to treat acute anxiety, dysphoria, insomnia, withdrawal
        - Lithium in unipolar and bipolar depression
        - Clozapine in individuals with schizophrenia or schizoaffective disorder
        - Ketamine and Esketamine
        - Low-dose buprenorphine in opioid use disorder with comorbid depression
        - ECT
    - May increase suicide risk
        - Black box warning for SSRIs in pediatric populations and ages 18 – 24 yo but this warning is controversial with conflicting evidence
- Clear and effective documentation of suicide risk assessment is essential
- Document individual risk and protective factors, clarify intent (e.g., intent to die vs parasuicidal/gestural/manipulative), mental status examination (expressed suicidal ideations, observed low-risk and high-risk behaviors), clinical reasoning and decision making, mitigating interventions and follow-up.

References

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