A Clinician's Guide to Suicide Risk Assessment and Management

Joseph Sadek

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Joseph Sadek
Department of Psychiatry
Dalhousie University Department of Psychiatry
Halifax, Nova Scotia
Canada

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I want to give my sincere thanks and gratitude to my wife Irene and my two children who were extremely supportive during the journey of producing the book. I want to thank Maryanne Sadek (University of Ottawa) for her work in generating the case studies and suicide instruments and for her work on assisting in the production of the book.

Foreword

Suicide is an enduring, endemic issue in mental health. Despite advances in the treatment and management of mental illness, suicide rates in the general population have remained stubbornly consistent over the years. There remains an urgent need to identify individuals at risk for suicide at the earliest opportunity so that appropriate interventions can be undertaken to manage and reduce risk at the personal level and to advocate for positive change in the social determinates of health that may underlie illness and illness behavior, including suicidal behavior.

Dr. Sadek, who is a psychiatrist and associate professor in the Department of Psychiatry at Dalhousie University in Halifax, Nova Scotia, has produced a valuable concise guide for clinicians on the assessment and management of suicide risk.

Dr. Sadek has been instrumental in his clinical work and, organizationally, in the development and dissemination of suicide risk assessment tools at the local and provincial level in Canada as required by Accreditation Canada to forward the goal of reducing death by suicide. His work in suicide prevention in the province of Nova Scotia has been replicated by another Canadian province, and several others are interested in adopting his work.

The book covers a range of topics, such as the epidemiology of suicide and parasuicide, clinical populations and their relationship to suicide and suicidal ideation, a practical approach to suicide assessment, and the benefits and limitations of structured assessments. Once identified, it covers interventions, both at the community and inpatient level, and is richly referenced to steer the reader to therapies for specific populations and has links to a wide array of guidelines, risk assessment tools, and other resources in the field of suicide prevention.

The language used throughout the text is accessible, jargon free, and geared toward a general readership. Each chapter begins with a general overview or introduction to the topic and then develops the topic in more detail, often using bullet points or charts to clarify and enhance understanding.

Dr. Sadek has written a text that covers an important area in mental health, one that we ignore at our peril. It should be a valuable resource for the beginning clinician or trainee and a very useful reference for the experienced clinician.

Scott Theriault
Dalhousie University
Halifax, NS, Canada

About the Reviewer

Dr. Theriault is the deputy head of the Department of Psychiatry, Dalhousie University, and the clinical director for mental health and addictions for the Nova Scotia Health Authority, in Halifax, NS. He is an internationally recognized forensic psychiatrist and a founder of Forensic Psychiatry as recognized by the Royal College of Physicians and Surgeons of Canada and has extensive experience in the field of suicide risk assessment and management. An experienced clinician/administrator with over 25 years in practice, Dr. Theriault has a broad understanding of suicide at the personal, clinical, and systemic level.

Disclaimer

The text in this book and its references are for education, guidance, and information purposes only. Responsibility remains in the hands of the clinician diagnosing and treating their own patient to determine the correct course for their patient. No one who took part in creating this text can be held legally responsible for any of the information contained in the text.

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About the Author

Dr. Sadek is an associate professor of psychiatry at Dalhousie University and the medical director of the Atlantic ADHD Center in Dartmouth, Nova Scotia. He is also the clinical and academic leader, Nova Scotia Hospital, Mayflower Unit, Dartmouth, NS, Canada.

Dr. Sadek is a diplomat of the American Board of Psychiatry and Neurology (DABPN) and fellow of the Royal College of Physicians and Surgeons of Canada (FRCPC). In addition to his medical degree (1990), Dr. Sadek also holds a pharmacy degree (B.Sc. Pharm 1986) and an M.B.A. from St. Mary's University. He also completed a one-year research training program at Harvard Medical School and obtained the certification of the Global Clinical Scholars Research Program (GCSRP) with commendation. He completed his psychiatry residency training at Dalhousie University, Nova Scotia, Canada.

Dr. Sadek served as the head of the Neurosciences professional competency unit for the Dalhousie Medical School. He started the first public adult ADHD clinic in Nova Scotia in 2007. He is very involved in both the undergraduate and postgraduate teaching and has published a book called *Clinician's Guide to ADHD*, second edition, in 2013. A second book called *Clinician's Guide to Adult ADHD Comorbidities* was published in 2016. His third book *Clinician's Guide to ADHD Comorbidities in Children and Adolescents* was released in 2018. Dr. Sadek has several peer-reviewed articles and received several quality awards for his work. He served as the vice president of the Canadian ADHD

Resource Alliance (CADDRA) and created the CADDRA ADHD Institute in 2012.

Dr. Sadek was the chair of the Suicide Prevention Task Force for the Province of Nova Scotia. He was also a member of the Dalhousie University Senate.

Dr. Sadek received the Mental Health Program Quality Council Certificate of Excellence Award for commitment to quality review (2012) and Mental Health Program Quality Council Certificate of Excellence Award for development and implementation of suicide risk assessment form (2012). In 2017, he received the Saint Mary's University MBA 25th Anniversary Alumni Impact Award.

joseph.sadek@nshealth.ca

Purpose and Background

1

Purpose
This document is developed to provide clinicians with a comprehensive guide to expand their clinical understanding of suicide risk assessment and management. Clinicians are encouraged to update their knowledge and continue to review the new literature and study other educational or competency enriching materials to improve their clinical understanding of suicide risk assessment and management.

1.1 Introduction

Suicide is viewed as a multidimensional determined outcome, which results from a complex interaction of biological, genetic, psychological, sociological and environmental factors. Not all of these factors are present nor are they equally weighted in all suicides. Thus, the outcome of any one suicide may be the result of factors or weighting of factors that can be different from those related to any other suicide.

Suicide is a highly emotional topic, and while suicide is a rare event (current Canadian rates are about 10–12/100,000), the experience of suicide can touch almost every person, family, and community. There exists a stigma related to suicide, and this stigma may be a barrier to help-seeking for individuals who are contemplating suicide (Ref: Health Canada www.hc-sc.gc.ca).

It is important to note that people with mental disorders have higher mortality rates than the general population, and researchers suggest that more detailed estimates of mortality differences are needed to address this public health issue (Erlangsen et al. 2017).

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1.2 Epidemiology

1.2.1 Worldwide

According to the World Health Organization (WHO), suicide is globally among the top 10 causes of death and the second leading cause of death in people aged 15–29 years. In 2012, about 804,000 people died by suicide globally, accounting for 1.4% of deaths worldwide. The average population annual rate of death by suicide is estimated to be 11.4/100,000 (15.0 per 100,000 people per year in men and 8.0 per 100,000 in women) (WHO).

There are wide variations of suicide rates reported across different countries, and suicide risk factors are not the same in every location. In high-income Western countries (e.g., Europe, Scandinavia, Australia, New Zealand, Canada, the USA), suicide rates are about three times higher in males than in females, and individuals who have a mental illness are at much higher risk for suicide. Risk factors that appear to be universal include youth or old age, a mental disorder, low socioeconomic status, substance use, and previous suicide attempts. Mental disorders occupy a primary position in the matrix of causation, although their relative contribution to suicide differs across countries (Patel et al. 2015).

The World Health Organization has estimated suicide rates among those aged 75 and to be 50/100,000 for men and 16/100,000 for women **(WHO)**.

1.2.2 The USA

In the USA, suicide is the 10th leading cause of death for all ages. There were 41,149 suicides in 2013 in the USA—a rate of 12.6 per 100,000 is equal to 113 suicides each day or 1 every 13 min **(Centre for Disease Control-CDC)**.

In 2011, over eight million adults reported having serious thoughts about suicide, and over one million reported a suicide attempt. An estimated 2.7 million people (1.1%) made a plan about how they would attempt suicide in the past year **(Substance Abuse and Mental Health Administration-SAMSHA, NSDUH Report 2011)**.

In 2015, a total of 2,712,630 resident deaths (all causes) were registered in the USA—86,212 more deaths than in 2014. The crude death rate for 2015 (844.0 deaths per 100,000 population) was 2.5% higher than the 2014 rate (823.7) **(National Vital Statistics Reports, Vol. 66, No. 6, November 27, 2017, CDC).**

In 2015, suicide is the 3rd leading cause of death among persons aged 10–14, the 2nd among persons aged 15–34 years, the 4th among persons aged 35–44 years, and the 17th among persons 65 years and older **(Centre for Disease Control-CDC)**.

1.2.3 Canada

In Canada suicide is a major cause of premature and preventable death. Close to 4000 people die by suicide each year in Canada. According to a Public Health

Agency of Canada report in 2006, suicide accounts for the cause of 1.7% of all deaths in Canada. The reporting of death by suicide is assigned by coroner deliberation. However, this statistic does not take into consideration those suicides wrongly reported as accidental deaths or cases where it is difficult for a coroner to appropriately assess whether or not the death was intentional.

(Ref: Health Canada www.hc-sc.gc.ca)

Suicide across the life span
Children and youth (10–19 years)
Suicide is the second leading cause of death For males ages 10–14, the rate is 41% For males ages 15–19, the rate is 70% For females the rate of self-harm hospitalization is 72%
Young adults (20–29)
Suicide is the second leading cause of death Males account for 75% of suicides For females the rate of self-harm hospitalization is 58%
Adults (30–44 years)
Suicide is the third leading cause of death Males account for 75% of suicides For females the rate of self-harm hospitalization is 56%
Adults (45–64 years)
Suicide is the seventh leading cause of death Males account for 73% of suicides (highest suicide rate is observed among males ages 45–59) For females the rate of self-harm hospitalization is 56%
Seniors 65+
Suicide is the 12th leading cause of death Males account for 80% of suicides (highest suicide rate is observed among males above age 85) For females the rate of self-harm hospitalization is 52% Canada, 2016, Public Health Agency of Canada Report

For every 1 suicide death, there are 7–10 people profoundly affected by suicide loss.

It is estimated that in 2009 alone, there were about 100,000 years of potential life lost to Canadians under the age of 75 as a result of suicide (Statistics Canada).

In 2012, approximately 3900 death in Canada were attributed to suicide. This resulted in suicide rate of 11.3 deaths per 100,000 people (2972 male compared to 954 females or rate of 17.3/100,000 for males versus 5.4/100,000 for females).

Suicide rates in adolescents (ages 15–19) have risen from a low of about 7/100,000 in 2005 to 10/100,000 in 2012.

There are provincial differences in suicide rates, for example, in 2009: Ontario rate was 9/100,000, Quebec 12.5/100,000, and British Columbia 10.2/100,000.

Rates of suicide and suicidal ideation are high in some First Nations communities and even higher in some Inuit communities. Among First Nations communities, suicide rates are twice the national average and show no signs of decreasing. Suicide rates among Inuit are even higher than among First Nations, at 6 to 11 times the Canadian average.

In Nunavut, rates are so high that 27% of all deaths since 1999 have been suicides. Nunavut's suicide rate—already one of the highest in the world—continues to rise, especially among youth.

There are significant differences in suicide rates within aboriginal/First Nations communities with some demonstrating high rates and some with rates well below the Canadian rate.

Another group of Canadians, LGBTQT, have higher suicide rates than the national average (www.publichealth.gc.ca).

1.3 The Burden and Cost of Suicide

The psychological and social impact of suicide on the family and society is immeasurable. On average, a single suicide intimately affects at least 7–10 other people. If a suicide occurs in a school or workplace, it can have an impact on many of those who are present or on site in those locations. Some high-profile suicides can have substantial impact on communities as well.

The burden of suicide can be estimated in terms of DALYs (disability-adjusted life years) and years of life lost (YLLs) to premature mortality or years of productive life lost (YPLL).

According to this indicator, suicide was responsible for 39 million disability-adjusted life years in 2012.

Mental and substance use disorders accounted for 183.9 million DALYs or 7.4% (6.2%–8.6%) of all DALYs worldwide in 2010 (Whiteford et al. 2013).

1.3.1 The Cost of Suicide

1.3.1.1 The USA

The national cost of suicide and suicide attempts in 2013 was $58.4 billion. Based on reported numbers alone costs and the average suicide costs **$1,164,499 (Centre for Disease Control-CDC).**

1.3.1.2 Canada

The estimated financial cost of a suicide ranges from $433,000 to $4,131,000 per individual, depending on potential years of life lost, income level, and effects on survivors **(Mental Health Commission Report, 2016. Mentalhealthcommission.ca).**

1.3.1.3 Australia

The average cost per youth suicide is valued at $2,884,426, including $9721 in direct costs, $2,788,245 as the value of lost productivity, and $86,460 as the cost of bereavement. The total economic loss of youth suicide in Australia is estimated at $22 billion a year (equivalent to US$ 17 billion), ranging from $20 to $25 billion (Kinchin and Doran 2018).

1.3.2 Estimating the Cost of Suicide

Total cost of suicide is the combination of direct and indirect costs. Examples of direct costs include services for ambulance, police investigation, hospital, physician, autopsy, funeral, and cremation. If it is attempted suicide, but not completed, other costs may include psychotherapy, rehabilitation, and drug treatments.

Indirect costs: Indirect costs are lost economic productivity that society must bear over time; they can be thought of as discounted future earnings due to potential years of life lost. In case of suicide attempts, costs can also include informal care, social welfare costs, and costs due to homelessness or unemployment (Kinchin and Doran 2018).

Example of estimating suicide cost in Australia (Kinchin and Doran 2018)

Direct cost
Funeral $4000
Autopsy and administrative cost $2595
Ambulance $805
Police $2595
Total Direct cost $9995
Bereavement and postvention cost $14,410 per person × 6 = $86,460
Indirect cost
Productivity loss = $2,788,245

1.4 Understanding Suicide Risk Assessment and Suicide Risk Management

Suicide risk assessment and suicide risk management are clinical competencies that are applied by mental health and healthcare providers throughout the period of patient care. Suicide risk assessment refers to the health provider's evaluation of suicide probability for a patient that occurs at every point of patient contact. This assessment can be applied with various degrees of intensity and can be assisted by the use of certain assessment tools that can be applied in specific situations. Not every point of patient contact requires the same degree of risk evaluation, but every point of patient contact requires a degree of risk evaluation. The degree of evaluation is based on clinical judgment, knowledge of the patient, and knowledge of the patient's circumstances. It can include information obtained directly from the patient or from collateral sources.

Over the course of clinical contact with a patient, suicide risk may change. For example, the emergence of specific symptoms (such as command hallucinations telling the person to take his/her life or the emergence of hopelessness within the context of a depressive episode), worsening of the clinical condition (such as increasing severity of a depressive episode or increased substance use), emergence

of significant life events (such as loss of a loved one or the suicide of a friend or admired person), and changes in clinical care situations (such as discharge from hospital or post emergency room visit care) can all increase suicide risk during the time course of clinical care. Thus, suicide risk assessment is an ongoing process.

The use of suicide assessment tools can assist a clinician in suicide risk assessment and when applied can also provide documentation of what the suicide risk assessment consisted of. This type of documentation may be preferred to clinical notes that make little or no mention of suicide risk assessment details. However, there are no suicide risk assessment tools that can accurately predict whether a person will or will not die by suicide and over what period of time.

A suicide risk assessment may enable a trained healthcare provider to determine the probability of death by suicide in the short term (usually over a period of hours to a few days). Long-term predictions are not reliable; thus suicide risk assessment is a continuous process. For some patients, increased risk for suicide can be an acute phenomenon, while for others it can be a chronic phenomenon. For some patients who are at chronically elevated risk for suicide, acute exacerbations of that risk can occur.

Suicide risk assessment requires training; a good understanding of the patient, their condition, and their circumstances; and clinician awareness that risk is not a static phenomenon and that risk can change over time. It is the responsibility of the healthcare provider to conduct the most appropriate degree of suicide risk assessment at every patient contact and if information on patient status is received in periods between patient contact points.

Suicide risk assessment leads to suicide risk management. Suicide risk management is also a continuous process and is based on the clinician's determination of the probability of suicide as an outcome—both acute and chronic. It involves application of both general and specific interventions. For example, some general interventions include provision of evidence-based treatments to individuals who have a mental illness or collaborative care approaches to the ongoing treatment of individuals with chronic and persistent mental illness. Some specific interventions may include tailored frequent posthospital or emergency room discharge contact, the advice to limit access to lethal means (such as removing guns from the home), or hospitalization (voluntary or involuntary) as the location in which treatment is provided.

Suicide risk assessment and suicide risk management are both the individual responsibility of every healthcare provider and the collective responsibility of the entire healthcare team involved with any specific patient. Communication among members of the healthcare team about patient suicide risk is an important part of ongoing care. Some researchers suggested that there may be gaps in the implementation of evidence-based suicide assessment and management due to mental health professionals' comfort working with suicidal patients (Roush et al. 2018).

1.5 Does Asking About Suicide Make a Patient More Likely to Act On It?

In the clinical setting, asking about suicide ideation or plans does not increase the risk of suicide. On the contrary, it decreases the risk of suicide as it identifies individuals who are at higher probability of immanent death by suicide and thus is part of ongoing suicide risk assessment. However, there is no substantial data available to provide the answer to the question if outside of the clinical setting, asking people about suicide ideation or plans either decreases or increases risk of death by suicide. According to Bolton and his colleagues (2015), a barrier to assessment is the belief held by some clinicians that asking about suicidal thoughts will induce such thoughts in patients. A nonsystematic review published in 2014 examined 13 studies published between 2001 and 2013 that investigated this question and found that none reported a significant increase in suicidal ideation in patients who were asked about suicide (Bolton et al. 2015).

References

American Foundation for Suicide Prevention. Facts and figures: suicide deaths. http://www.afsp.org/understanding-suicide/facts-and-figures. Accessed Jan 2017.

Bolton JM, Gunnell D, Turecki G. Suicide risk assessment and intervention in people with mental illness. BMJ. 2015;351:h4978.

Canada. Health Canada 2016. https://www.canada.ca/en/public-health/services/publications/healthy-living/suicide-canada-infographic.html.

Centers for Disease Control and Prevention. FASTSTATS: suicide and self-inflicted injury. http://www.cdc.gov/nchs/fastats/suicide.htm. Accessed July 2017.

Erlangsen A, Andersen PK, Toender A, Laursen TM, Nordentoft M, Canudas-Romo V. Cause-specific life-years lost in people with mental disorders: a nationwide, register-based cohort study. Lancet Psychiatry. 2017;4(12):937–45.

Kinchin I, Doran CM. The cost of youth suicide in Australia. Int J Environ Res Public Health. 2018;15(4):E672.

Patel V, et al. Disease control priorities. Mental, neurological, and substance use disorders. 3rd ed. Washington, DC: World Bank Group; 2015.

Public Health Agency of Canada analysis of Statistics Canada Vital Statistics Death Database and Canadian Institute for Health Information Hospital Morbidity Database; 2006.

Roush JF, Brown SL, Jahn DR, Mitchell SM, Taylor NJ, Quinnett P, Ries R. Mental health professionals' suicide risk assessment and management practices. Crisis. 2018;39(1):55–64.

Whiteford HA, Degenhardt L, Rehm J, Baxter AJ, Ferrari AJ, et al. Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. Lancet. 2013;382(9904):1575–86.

WHO. Preventing suicide: a global imperative. Geneva: World Health Organisation; 2014.

World Health Organization. Distribution of suicide rates (per 100,000) by gender and age. Geneva. http://www.who.int/mental_health/prevention/suicide/suicide_rates_charte/en/index.html. Accessed May 2014.

World Health Organization. Preventing suicide: a global imperative. http://www.who.int/mental_health/suicide-prevention/world_report_2014/en/.

Understanding Suicide and Self-Harm

2

2.1 Difference Between Suicide and Self-Harm

Researchers and clinicians have struggled with inconsistent terms in describing suicide-related thoughts and behaviors. However, there is some agreement that the term non-suicidal self-injury (NSSI) refers to behaviors engaged in with the purposeful intention of hurting oneself without intentionally trying to kill oneself. Several terms are used in the literature, including self-injurious behavior, non-suicidal self-injury, self-mutilation, cutting, deliberate self-harm, delicate self-cutting, self-inflicted violence, parasuicide, and autoaggression. However, many of these terms encompass more than NSSI (Jacobson and Gould 2007).

NSSI is expressed in various forms from relatively mild, such as scratching, plucking hair, or interfering with wound healing, to relatively severe forms, such as cutting, burning, or hitting (Gratz et al. 2002).

There is suggestion that suicide attempts and NSSI are distinct behaviors. Those who engage in NSSI typically have thoughts of temporary relief, while those who engage in suicidal behaviors have thoughts of permanent relief through death. NSSI is more common than completed suicide and attempts.

A review that included approximately 22 empirical studies that addressed NSSI in adolescents suggested that lifetime prevalence rate of NSSI ranges between 13% and 23% and that the typical reported age of onset of NSSI falls between 12 and 14 years of age (Cooper et al. 2006; Jacobson and Gould 2007).

Some studies found that NSSI is more often undertaken for reasons such as tension reduction, emotion regulation, anger expression, self-punishment, and a decrease in dissociation, whereas suicide attempts were more often reported as intended to make others better off (Nock and Prinstein 2005). A history of sexual abuse appears to be a specific risk factor for engaging in NSSI (Hamdullahpur et al. 2018). Sexual abuse and parental/other family member's mental illness were associated with increased odds of having attempted suicide among both

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genders, and emotional neglect was also a factor for men. Population attributable risk fractions for sexual abuse were 25.75% for women and 8.56% for men. Sexual abuse and a higher number of ACEs were also related to repeated suicide attempts (Choi et al. 2017).

Adverse childhood events in childhood (physical or sexual abuse, domestic violence) were found to account for a substantial proportion of variance in predicting suicidal ideation and attempts among women (16% and 50%, respectively) and men (21% and 33%, respectively) (Afifi et al. 2008)

Several psychosocial correlates of NSSI have been identified in the literature including depression, anxiety, eating disorders, alexithymia, hostility, negative self-esteem, antisocial behavior, anger, smoking, and emotional reactivity. Suicidal ideation is predictive of later suicide attempts, but not NSSI.

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), qualifies NSSI as a separate entity, among the disorders requiring further research.

The proposed criteria for DSM5 include the following: intentional self-inflicted injury performed with the expectation of physical harm, but without suicidal intent, on 5 or more days in the past year; and the behavior is performed for at least one of the following reasons: to relieve negative thoughts or feelings; to resolve an interpersonal problem; and to cause a positive feeling or emotion.

The behavior is associated with at least one of the following: negative thoughts or feelings or interpersonal problems that occur immediately prior to engaging in NSSI, preoccupation with NSSI that is difficult to resist, and frequent urge to engage in NSSI (APA 2013).

Suicide attempts and NSSI are correlated with each other. Those who engage in NSSI are at increased risk for suicide compared to individuals who do not self-injure, but the risk remains very low (i.e., about 3–7% of individuals who self-injure eventually die by their self-injury). The risk of death is higher for those with previous suicide attempts. It has been found that approximately half of patients who died by suicide had made at least one previous suicide attempt.

Engagement in NSSI is very common among adults with borderline personality disorder (BPD) (Goodman et al. 2012). One of the criteria for a diagnosis of BPD is engagement in self-injurious behaviors or threats, including both suicide attempts and self-mutilation (APA 2013).

2.2 Suicidal Behavior and Borderline Personality Disorder (BPD)

Suicidal behavior (defined as any action that could potentially cause one to die) is found in approximately 80% of borderline personality disorder (BPD) patients, a substantial increase from the general population, with 60–70% of patients engaging in suicide attempts. A history of self-injurious behavior doubles the risk for suicide among BPD patients, but affective instability is also associated with increased suicide attempts.

The risk of suicide for persons diagnosed with BPD is estimated at 8–10%. This suicide rate is 50 times higher than that of the general population. Although much of the suicidal behavior in BPD does not lead to completed suicide, suicide remains a major cause of death for this population (Dubovsky and Kiefer 2014). WHO has declared that reducing suicide-related mortality is a global imperative (Turecki and Brent 2016).

2.3 What are the Diagnostic Symptom Criteria of Borderline Personality Disorder?

According to DSM V (APA 2013), patient has to have a long-standing pattern that started in early adulthood that causes significant impairment in function and meets five of the following criteria:

- An intense fear of abandonment, even going to extreme measures to avoid real or imagined rejection or abandonment.
- A pattern of unstable intense relationships, sometimes seeing things as black and white or using splitting as a defense.
- Rapid changes in self-identity or self-image that include shifting goals and values.
- Periods of stress-related paranoia and loss of contact with reality, lasting from a few minutes to a few hours. It can be described as micro psychotic or dissociative experience.
- Engagement in impulsive and risky behavior in at least two areas such as reckless driving, sex, spending sprees, binge eating, or drug abuse or gambling.
- Suicidal threats or behavior, gestures, or self-injury, often in response to fear of separation or rejection.
- Significant and wide mood changes or swings that can happen within the same day, lasting from a few hours to a few days, which can include intense happiness, irritability, or anxiety.
- Long-standing feelings of emptiness.
- Inappropriate, severe anger episodes or difficulty controlling anger, such as frequently losing temper, being sarcastic or bitter, or having physical fights.

2.4 What are Some of the Helpful Tips for Managing Borderline Patients in Primary Care Setting?

- Learn about common clinical presentations and causes of undesirable behavior.
- Validate the patient's feelings by naming the emotion you suspect, such as fear of abandonment, anger, shame, and so on, before addressing the "facts" of the situation, and acknowledge the real stresses in the patient's situation.
- Avoid responding to provocative behavior.

- Schedule regular, time-limited visits that are not contingent on the patient being "sick."
- Set clear boundaries at the beginning of the treatment relationship, and do not respond to attempts to operate outside of these boundaries unless it is a true emergency.
- Make open communication with all other providers a condition of treatment.
- Avoid polypharmacy and large-volume prescriptions of potentially toxic medications (including tricyclic antidepressants, cardiac medications, and benzodiazepines).
- Avoid prescribing potentially addicting medications such as benzodiazepines or opiates. Inform patients of your policies regarding these medications early in the treatment relationship so they are aware of your limits.
- Set firm limits on manipulative behavior while avoiding being judgmental.
- Do not reward difficult behavior with more contact and attention. Provide attention based on a regular schedule rather than being contingent on behavior (Dubovsky and Kiefer 2014).

2.5 Examples of Psychotherapeutic Approaches for Patients with BPD

Examples of empirically studied treatments for BPD include dialectic behavior therapy (DBT), mentalization-based therapy, transference-focused psychotherapy, and general psychiatric management.

Several types of these psychotherapies have a manual and require therapists to undergo extensive training, to be self-aware and have access to therapy or consultation by other colleagues to avoid burnout.

DBT is an outpatient treatment involving group and individual therapy and considered as an effective treatment for BPD. DBT focuses on teaching the patient how to regulate emotions, manage self-destructive feelings and behaviors, tolerate distress, and develop interpersonal effectiveness and ability for reality testing. It uses different techniques over at least 1 year, including acceptance and mindfulness.

It has been found to reduce self-harm and suicidality in addition to lowering healthcare costs and utilization of emergency department and inpatient admission. Mentalization-based therapy is another group and individual psychotherapy.

The goal of treatment is focused on helping the patient to "mentalize" or understand the mental state of oneself and others and to think before reacting.

Transference-focused psychotherapy is an individual, twice-weekly therapy derived from psychoanalysis. It is focused on transference (feelings of the patient projected onto the therapist) and is among the more difficult techniques to learn.

General psychiatric management is a once-weekly psychodynamic therapy. It focuses on the patient's interpersonal relationships and can also include pharmacotherapy and family therapy. This is the most available and easiest to learn. In general, effective treatment requires the patient's active involvement and commitment (Dubovsky and Kiefer 2014).

Other examples include cognitive behavioral therapy (CBT), dynamic deconstructive psychotherapy (DDP), and interpersonal therapy for BPD (IPT-BPD) (Stoffers et al. 2012).

References

Afifi TO, Enns MW, Cox BJ, Asmundson GJ, Stein MB, Sareen J. Population attributable fractions of psychiatric disorders and suicide ideation and attempts associated with adverse childhood experiences. Am J Public Health. 2008;98(5):946952.

American Psychiatric Association, editor. Diagnostic and statistical manual of mental disorders. 5th ed. Washington, DC: American Psychiatric Association; 2013.

Choi NG, DiNitto DM, Marti CN, Segal SP. Adverse childhood experiences and suicide attempts among those with mental and substance use disorders. Child Abuse Negl. 2017;69:252–62.

Cooper J, Biddle L, Owen-Smith A, et al. Suicide after deliberate selfharm: a 4-year cohort study. Am J Psychiatry. 2006;162(2):297–30.

Dubovsky AN, Kiefer MM. Borderline personality disorder in the primary care setting. Med Clin North Am. 2014;98(5):1049–64.

Goodman M, Roiff T, Oakes AH, Paris J. Suicidal risk and management in borderline personality disorder. Curr Psychiatry Rep. 2012;14(1):79–85.

Gratz KL, Conrad SD, Roemer L. Risk factors for deliberate self-harm among college students. Am J Orthopsychiatry. 2002;72:128–40.

Hamdullahpur K, Jacobs KWJ, Gill KJ. Mental health among help-seeking urban women: the relationships between adverse childhood experiences, sexual abuse, and suicidality. Violence Against Women. 2018:1077801218761602.

Jacobson CM, Gould M. The epidemiology and phenomenology of non-suicidal self-injurious behavior among adolescents: a critical review of the literature. Arch Suicide Res. 2007;11(2):129–47.

Nock MK, Prinstein MJ. Contextual features and behavioral functions of self-mutilation among adolescents. J Abnorm Psychol. 2005;114(1):140–6.

Stoffers JM, Völlm BA, Rücker G, Timmer A, Huband N, Lieb K. Psychological therapies for people with borderline personality disorder. Cochrane Database Syst Rev. 2012;8:CD005652.

Turecki G, Brent DA. Suicide and suicidal behaviour. Lancet. 2016;387(10024):1227–39.

The Content of the Suicide Risk Assessment

3

Objectives
By the end of the chapter, clinicians will be able to:

- Understand the requirement for suicide risk assessment.
- List some required organizational practice (ROP) standards in certain countries.
- List common challenges in suicide risk assessment.
- Describe the process of building a therapeutic relationship and alliance with the patient.
- Describe the process of asking questions about suicidal plan, intent, and behavior.
- List and identify risk factors, noting those that can be modified to reduce suicide risk.
- Understand the limitations of protective or resiliency factors when conducting suicide risk assessment.

3.1 Overview on the Requirement for Suicide Risk Assessment

Good clinical care includes ongoing suicide risk assessment and management.

The World Health Organization recommends that all people over the age of 10 years with a mental disorder or other risk factor should be asked about thoughts or plans of self-harm within the past month.

Most guidelines encourage the use of standardized process for SRA (see Appendix G).

One observational UK study found that the process of assessment itself correlated with a lower likelihood of future suicidal Behavior (Olfson et al. 2013). This speaks to an often overlooked aspect in risk assessment: that clinician-patient contact can provide an important therapeutic effect (Bolton et al. 2015).

J. Sadek, *A Clinician's Guide to Suicide Risk Assessment and Management*,
https://doi.org/10.1007/978-3-319-77773-3_3

Psychological autopsy, involving interviews with key informants and examination of official records, has shown that psychiatric disorders are present in about 90% of people who kill themselves and contribute to 47–74% of population risk of suicide (Cavanagh et al. 2003).

Risk assessments include gathering history and conducting a clinical mental status examination, which are important for baseline information. Risk factors such as history of prior attempts and substance use would be encompassed in the generalized history gathering. Any collateral sources of information may shed additional light on risk factors and recent activities, patterns of escalation, as well as planned or impulsive violence toward self or others (Pinals and Anacker 2016).

3.2 Required Organizational Practice (ROP) Standards

In Canada, accreditation standards require the following organizational practices for suicide prevention (2015):

- Clients at risk of suicide are identified.
- The risk of suicide for each client is assessed at regular intervals or as needs change. The immediate safety needs of clients identified as being at risk of suicide are addressed.
- Treatment and monitoring strategies are identified for clients assessed as being at risk of suicide.
- Implementation of the treatment and monitoring strategies is documented in the client record.

3.3 Common Challenges in Suicide Risk Assessment

Suicide risk assessment can be challenging. Many people who are considered to be at high risk for suicide never die by suicide, and some who are not so considered do. There are several challenges in conducting a suicide risk assessment:

- Clinicians may have difficulty identifying patient at high imminent risk of suicide.
- Clinicians commonly rely on subjectively reported information, which does not always provide a full picture of the risk. Collateral information can provide a more complete picture of risk.
- Suicide risk assessment scales do not accurately predict death by suicide. They may be useful as a clinical tool or as documentation of the type of suicide risk assessment that was done but cannot be used for suicide risk assessment by individuals not trained in suicide risk assessment.
- There is a lack of consistency in the education and training of health care providers in the competencies needed to conduct a suicide risk assessment.

- Suicidal behavior can produce anxiety or intense emotional responses in clinicians. When these emotions are unrecognized, they can create negative reactions on the part of the clinician that limit their ability to work effectively with people who are acutely suicidal.
- Some clinicians may have negative attitude toward suicidal patients.
- Some system issues can be challenging such as limited resources, crowded spaces, multiple priorities, and lack of time.

(Betz et al. 2016; Kene et al. 2018)

3.4 The Suicide Risk Assessment Process

3.4.1 Step 1: Building a Therapeutic Relationship and Alliance with the Patient and Asking About Suicidal Ideation and Plan

A positive therapeutic alliance is considered to be a very important foundation for suicide risk assessment. It is a conscious collaboration between the clinician and the patient for the purpose of a mutual exploration of the patient's problems. Developing a therapeutic alliance involves:

- Empathy
- Active listening
- Respect
- Trust
- Support
- A non-adversarial and collaborative stance
- Nonjudgmental acceptance
- Transparency
- A strong interest in understanding the person and the nature and cause of their pain/distress (Bryan et al. 2012)

Clinicians should also be aware of their own reactions to suicide or the patient that they are conducting a suicide risk assessment with and attempt to manage those reactions effectively.

The therapeutic alliance has been proposed to be important for a number of reasons:

1. It reduces patient anxiety during suicide risk assessments, thereby increasing honesty and accuracy in the patient self-disclosure.
2. It leads to clinical improvement because the answers to the suicidal patient's struggles lie within him or her, and better alternatives to suicide for coping with problems and life distress can be identified together with the clinician (Jobes 2012).

3. It has been argued that a strong therapeutic alliance enables the clinician to deliver the interventions and teach the skills that enact the change required for suicide risk to resolve (Bryan et al. 2012).
4. Therapeutic alliance may serve as a protective factor by encouraging a sense of hopefulness and connectedness.

3.4.1.1 Examples of Approaches to Develop Therapeutic Alliance

The therapeutic alliance is built from the time that the clinician first makes contact with the patient. Additionally, specific questions can be used by the clinician to move from the development of the therapeutic alliance to the determination of suicide risk. The first step in that process includes confirming the challenges that the patient is having and laying the groundwork for more detailed questions about suicidal ideation and suicide plans.

For example, the clinician may say:

> I can see that things have been very challenging for you lately.
> or
> It seems that you have been having a difficult time lately.
> or
> It must be frustrating/difficult to be going through what you are experiencing.

These types of questions provide the link between the patient's experiences and the clinician's consideration of that experience and concurrently identify a supportive and caring concern.

Once that has been established, it is appropriate to move on to more detailed questioning, depending on the clinician's appreciation of risk factors as they are described below.

3.4.2 Step 2: Identify Risk Factors, Noting Those That Can Be Modified to Reduce Risk

A risk factor is something that increases the probability of a specific outcome. Risk factors are generally not causal, nor are they all modifiable nor are they all of equal weight in creating the determination of probability. Taken together however they can help provide the clinician with a weighted consideration as to their determination of the probability of the outcome—death by suicide. Risk factors help the clinician arrive at a risk determination.

Risk factors can be identified from information received from the patient and from collateral sources (such as family, friends, police, other health providers, medical records, etc.). These sources of information should be used when conducting a suicide risk assessment.

The following table provides some useful risk factors to consider when conducting a suicide risk assessment.

Examples of risk factors for suicide

Interview risk profile	**Individual risk profile**
☐ Suicidal thinking or ideation ☐ Access to lethal means ☐ Suicide intent or lethal plan or plan for after death (note) ☐ Hopelessness ☐ Intense emotions: rage, anger, agitation, humiliation, revenge, panic, severe anxiety ☐ Current alcohol or substance intoxication/ problematic use ☐ Withdrawing from family, friends ☐ Poor reasoning/judgment ☐ Clinical Intuition: assessor concerned ☐ Recent dramatic change in mood ☐ Recent crisis/conflict/loss	☐ Ethnic, cultural risk group or refugee ☐ Family history of suicide ☐ Trauma: as domestic violence/ sexual abuse/neglect ☐ Poor self-control: impulsive/ violent/aggression ☐ Recent suicide attempt ☐ Other past suicide attempts, esp. with low rescue potential ☐ Mental illness or addiction ☐ Depression/anhedonia ☐ Psychotic ☐ Command hallucinations ☐ Recent admission/discharge/ED visits ☐ Chronic medical illness/ pain ☐ Disability or impairment ☐ Collateral information supports suicide intent
Illness management	**Circle of support**
☐ Lack of clinical support ☐ Non-compliance or poor response to treatment	☐ Lack of family/friend support ☐ Caregiver unavailable ☐ Frequent change of home

The table of risk factors is useful to assist the clinician in her/his assessment, but the clinician must apply a variety of different methods to obtain the necessary information. Each clinician must create a series of questions that will allow them to comfortably consider that they have evaluated the risk factor under consideration.

A. Ask about suicidal thinking (ideation), and understand the frequency, intensity, duration, plans, and behaviors, and then ask about suicidal ideation in the last 48 h, past month, and worst ever.

B. Ask about suicidal plan, intent, and behavior (e.g., loading gun).

"Whether or not a plan is present, if a patient has acknowledged suicidal ideation, there should be a specific inquiry about the presence or absence of a firearm in the home. It is also helpful to ask whether there have been recent changes in access to firearms or other weapons, including recent purchases or altered arrangements for storage. If the patient has access to a firearm, the clinician is advised to discuss with and recommend to the patient or a significant other the importance of restricting access to, securing, or removing this and other weapons. Such discussions should be documented in the medical record, including any instructions that have been given to patient and significant others about firearms or other weapons."

(Excerpted from the American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors, Jacobs D, Baldessarini R et al. 2010)

Some researchers suggested that **two levels of inquiry about firearms** may be useful to guide their clinical decision.

Level 1 clinician inquire about:

- Firearm access
- Firearm storage
- Firearm ammunition availability
- Social support network to assist with firearms

Level 2 inquiry can be pursued if issues of concern are identified in the earlier questioning:

- Time spent with guns
- Violent fantasies about guns
- Psychodynamic attachment to guns
- How family and peers view guns
- Intentions of use (hobby, others)
- Acculturation with guns (new behavior or interest)
- (Pinals and Anacker 2016)

3.4.2.1 Examples of Questions About Suicidal Ideation

The next set of questions can be relatively general, exploring the possibility of suicidal ideation. For example, the clinician can say:

> Given what you are experiencing, I wonder if you have had any thoughts that you would be better off dead or that you would consider taking your own life?
> OR
> Sometimes in such circumstances, people may think or feel that they would be better off dead or that they may consider taking their own life. What about you?

3.4.2.2 Examples of Questions About Suicidal Intent and Plan

If the patient provides a positive response to any question about suicidal ideation, the clinician must explore in some detail that condition. The purpose of this exploration is to determine how intense and how persistent the suicidal ideation is, to determine if there has been an attempt and to determine how and how well the patient is coping with those thoughts. For example, the clinician could say:

You say that you have thought about dying, can you tell me more about that?
Can you tell me more about the thoughts of taking your life that you are having? How often do you have those thoughts? How strong are they? How do you deal with them when they come? Can you overcome those thoughts or are you concerned that they may overcome you?
When you are having those thoughts, what do you do? Do you feel safe?
What have you done to act on those thoughts? Have you done anything that might have caused you harm or lead to death? Can you tell me about what happened?

3.4.2.3 Examples of Questions About Suicidal Plan

If it is established that the patient has persistent and strong suicidal ideation, the next step is to determine if the patient has a plan. The presence of a plan immediately puts the patient into a higher risk category. For example, the clinician could say:

You have shared with me your thoughts about dying or taking your life, what are you planning to do?
OR
Can you tell me what you have thought about doing to take your own life?

Once the presence of a plan has been established, the clinician should ensure that they understand all the details. When is this to happen? How lethal is the plan? How committed is the patient to carrying out the plan? What are the facilitating factors (e.g., they have a gun in the house, they have obtained numerous bottles of pills, etc.)?

If a plan is identified, evaluate steps taken to enact the plan (practice CO emission from the car), preparations for dying, and the patient's expectations of lethality.

Timing, location of plan, lethality of method, and availability are keys to evaluating level of risk. Ask about a plan for afterdeath like writing a suicide note or plan to give away the belongings.

At each step in the suicide risk assessment, the clinician both continues to maintain the therapeutic alliance and applies a risk evaluation strategy that includes the patient's answers to the questions posed and a list of risk factors that should be considered in addition to the information collected from the interview.

3.4.2.4 Important Additional Inquiries

1. Past attempts

   If there is a history of past attempts, ask for when, method, what the patient understood to be the lethality of the method, and outcome. A history of suicide attempts or self-harm was strongly associated with increased risk of suicide (OR = 4.84, 95% CI 3.26–7.20) (Bolton et al. 2015).
2. Stressors

   If there are recent life stressors, ask about impact on the person, impact on significant others, and impact on financial situation.
3. Alcohol or substance use
4. Homicidal ideation

   Assess for homicidal ideation, particularly in postpartum women and in patients with cluster B personality disorders or who are psychotic or paranoid.
5. Social support

   Ask about social support, and obtain collateral information from family about withdrawal and isolation from them and/or from friends.
6. Understand the psychiatric diagnosis and comorbidity (both psychiatric and physical)

   Affective disorder is the most common psychiatric disorder, followed by substance (especially alcohol) misuse and schizophrenia. Comorbidity of these disorders greatly increases risk of suicide.

   Cluster B personality disorders or traits, eating disorders, and anxiety disorders also increase risk of suicide (Cavanagh et al. 2003).

   Key symptoms: anhedonia, impulsivity, hopelessness or despair, anxiety/panic, anger, agitation, insomnia, and command hallucinations

6.1 Affective disorders

Particularly depression (unipolar or bipolar depression) is a strong risk factor for suicide. More severe depressive psychopathology was associated with suicide risk (OR = 2.20, 95% CI 1.05–4.60), and severe degree of impairment was also associated with increased risk of suicide (Mattisson et al. 2007).

Risk was also substantially increased where individuals had expressed feelings of hopelessness (OR = 2.20. 95% CI 1.49–3.23).

Researchers identified the following risk factors for suicide in people with depression: male gender, family history of psychiatric disorder, previous attempted suicide, more severe depression, hopelessness, and comorbid disorders, including anxiety and misuse of alcohol and drugs (Hawton and Casanas 2013).

The proportion of completed suicides to attempts in affective disorders is higher than in the general population, which suggests the high lethality of suicidal behavior in that population (Undurraga et al. 2012). Psychological autopsy studies showed that more than half of all people who die by suicide meet criteria for current depressive disorder (Cavanagh et al. 2003).

10–15% of patients with bipolar disorder die by suicide, commonly early in the illness course (Goodwin and Jamison 2007).

6.2 Schizophrenia

Can contribute to an elevated risk for suicide, particularly during the initial years of the illness. Command hallucinations increase risk. National Institute of Mental Health (NIMH) longitudinal study of chronic schizophrenia found that, over a mean of 6 years, 38% of the patients made at least one suicide attempt and 57% admitted to substantial suicidal ideation. Some researchers suggested that 10 to 13% of schizophrenia patients die by suicide (Roy and Pompili 2009). It is also important to recognize that the risk of suicide in patients with first-episode psychosis (FEP) is high and high rates of premature mortality, particularly from suicide, may occur in the early phases of schizophrenia (Pompili et al. 2011).

In some studies, risk of suicide in schizophrenia was associated less with the core symptoms of schizophrenia, such as delusions, but more with depression and specific affective symptoms (e.g., agitation, sense of worthlessness, and hopelessness). Other factors include previous suicide attempts, drug misuse, fear of mental disintegration, recent loss, and poor adherence to treatment (Hawton et al. 2005).

6.3 Alcohol or substance use

Inquire about alcohol or substance use. If there is a suggestion of substance or alcohol use, ask about problematic use or a recent increase in use.

Assess for current intoxication or withdrawal.

Suicide was significantly increased in the presence of current substance misuse (i.e., alcohol and/or drug, OR = 2.17, 95% CI 1.77–2.66). This also applied in the two studies in which alcohol (OR = 2.47, 95% CI 1.40–4.36) or drug (OR = 2.66, 95% CI 1.37–5.20) misuse was examined separately.

Rates of suicidal behavior in alcohol use disorder (AUD) are high in several studies, with 16–29% of individuals seeking treatment for AUD reporting at least one lifetime suicide attempt, and rates of suicide completion range between 2.4% and 7% and alcoholism contributed to about 25% of the suicides (Murphy and Wetzel 1990; Oquendo et al. 2010).

The severity of the alcohol use disorder, aggression, impulsivity, and hopelessness seems to predispose to suicide. Key precipitating factors are depression and stressful life events, particularly disruption of personal relationships (Conner and Duberstein 2004).

A meta-analysis found a strong significant association between SUD and suicidal ideation: OR 2.04 (95% CI: 1.59, 2.50; I2 = 88.8%, 16 studies); suicide attempt OR 2.49 (95% CI: 2.00, 2.98; I2 = 94.3%, 24 studies), and suicide death OR 1.49 (95% CI: 0.97, 2.00; I2 = 82.7%, 7 studies).

Further evidence is required to assess and compare the association between suicide outcomes and different types of illicit drugs, dose-response relationship, and the way they are used (Poorolajal et al. 2016).

Use of multiple substances can trigger suicidal behavior. Withdrawal from cocaine, amphetamines, and other addictive drugs can increase suicidal ideation and attempts. Extended use of sedatives, hypnotics, and anxiolytics can increase suicidal ideation and attempts.

Systematic review of global burden disease found that illicit drug use is an important contributor to the global burden of disease and that opioid and amphetamine dependence were the two most common forms of illicit drug dependence worldwide, although millions of people were also dependent on cannabis or cocaine. Most individuals dependent on drugs were male (64% each for cannabis and amphetamines and 70% each for opioids and cocaine). Suicide was a significant contributor to illicit drug burden because it is a common cause of death in regular users of opioids, cocaine, or amphetamines.

Suicide as a risk of amphetamine dependence accounted for 854,000 disability-adjusted life years (DALYs) (291,000–1,791,000), as a risk of opioid dependence for 671,000 DALYs (329,000–1,730,000), and as a risk of cocaine dependence for 324,000 DALYs (109,000–682,000). Countries with the highest rate of burden (>650 DALYs per 100,000 population) included the USA, UK, Russia, and Australia (Whiteford et al. 2013).

6.4 Anxiety

The presence of symptoms of anxiety was also associated with increased risk of suicide (OR = 1.59, 95% CI 1.03–2.45).

6.5 Personality disorders

Risk of suicide was strongly associated with the presence of an Axis II (i.e., borderline or antisocial personality) disorder (OR 4.95, 95% CI 1.99–12.33). 30–40% of people who die by suicide have personality disorders.

6.6 Medical (physical) illness

Comorbid chronic physical illness in a single-study suicide risk was associated with the presence of physical illness such as malignant neoplasms, HIV/AIDS, peptic ulcer disease, hemodialysis, systemic lupus erythematosus (SLE), Huntington's disease, multiple sclerosis, epilepsy, renal disease, pain syndromes, functional impairment, and diseases of nervous system (Hawton and van Heeringen 2009).

Other disorders (e.g., undiagnosed diabetes, iron/thyroid deficiency) were also associated with individuals over 60 years old who died by suicide (Brådvik et al. 2008).

See Appendix B for Relative risk of Suicide in Specific Psychiatric Disorders and Medical conditions.

6.7 A. Other factors

Suicide is a common cause of death in people with eating disorders, in particular anorexia nervosa. The risk of suicide is increased in adjustment disorder, attention deficit hyperactivity disorder (ADHD), anxiety disorders, and panic disorder.

6.7 B. Suicide during inpatient admission

The risk of suicide while admitted as an inpatient is high. It happens particularly early during the admission (40% in the first 3 days). The rate of suicide has been reported at five per 1000 occupied beds each year in some studies and up to 860 suicides per 100,000 (Bolton et al. 2015).

Meta-analysis of 27 studies on inpatient suicide suggested that the rates of suicide per 100,000 inpatient years increased steeply in the periods after 1980. Studies from the USA reported the highest number of suicides per 100,000 inpatient years followed by the UK and Ireland, Continental Europe, Australasia, and the Nordic countries.

They noted that the pooled estimate of suicides per 100,000 inpatient years was 147 (95% CI 138–156). Studies from the USA reported the highest number of suicides per 100,000 inpatient years followed by the UK and Ireland, Continental Europe, Australasia, and the Nordic countries (Walsh et al. 2015).

An increase in the suicide rate of admitted and discharged patients might be attributable to multiple factors, including changing legal and other criteria for admission, shorter lengths of inpatient treatment, increased prevalence of substance use, and a greater acuity of illness among those admitted in the era of deinstitutionalization (Walsh et al. 2015).

6.8 Suicide after recent hospital discharge

The risk of suicide is high in the first week after discharge from a psychiatric hospital admission, remains high for the first few months after discharge, and then slowly decreases. The risk of suicide after discharge is especially high for psychiatric patients who were admitted to hospital with a suicide attempt (Bolton et al. 2015).

Recent research on post discharge suicide rate found a pooled rate of 484 per 100,000 person-years. The rate is 44 times the global suicide rate of 11.4 per 100,000 patients per year in 2012.

Studies with follow-up periods of 3–12 months had almost 60 times the global suicide rates, and the suicide rate among discharged patients was more than 30 times that in the general population even for periods of follow-up of 5–10 years (Chung et al. 2017).

6.9 Suicide among patients presenting to the emergency department

Rates of future suicide among people presenting to the emergency department with self-harm are high: 2% of these people will kill themselves within 1 year, and the 5-year estimate of suicide is 4%. This risk is more than 50 times greater than that seen in the general population and is associated with a 40-year reduction in average life expectancy. Rates of repeat self-harm after contact with the emergency department are 10% at 1 month and as high as 27% at 6 months (Bolton et al. 2015).

6.10 Past psychiatric hospital admissions

Higher risk in those with a history of previous psychiatric hospital admissions (OR = 2.37, 95% CI 0.86–6.55) (Bolton et al. 2015)

Danish study concluded that there are two sharp peaks of risk for suicide around psychiatric hospitalization, one in the first week after admission and another in the first week after discharge; suicide risk is significantly higher in patients receiving a shorter than median length of hospital treatment; affective disorders impacted suicide at the strongest in terms of its effect size and population attributable risk (PAR); and suicide risk associated with affective and schizophrenia spectrum disorders declined quickly after treatment and recovery, while the risk associated with substance abuse disorders declined relatively slower.

History of admission increases the risk relatively more in women than in men (Qin and Nordentoft 2005).

6.11 Suicide after visiting healthcare professional

A systematic review and meta-analysis of mental health service contact prior to suicide published in 2018 found that within the prior year, 18.3% of persons who died by suicide had contact with inpatient mental health services, 26.1% had contact with outpatient mental health services, and 25.7% had contact with inpatient or outpatient mental health services (Walby et al. 2018).

A review published by the *American Journal of Psychiatry* in 2002 reported that approximately 32% of people who died by suicide were in contact with mental health services in the year before death, across all age groups. They also reported that contact with primary care providers in the month before suicide averaged approximately 45% (range = 20–76%). The rate of contact with primary care providers within 1 year of suicide averaged approximately 77% (range = 57–90%) (Luoma et al. 2002).

Earlier studies had shown that up to 41% of persons who died by suicide were in contact with inpatient services in the year before death (Pirkis and Burgess 1998).

In countries where the mental health services are not well developed, the proportion of people in suicidal crisis consulting a general physician is likely to be higher (WHO).

6.12 Understand the social and demographic risk factors for suicide

Suicide risk was significantly greater in males (OR = 1.76, 95% CI 1.08–2.86).

Risk increases with age; rates of suicide increase after puberty and in adults over the age of 65.

Marital status: Widowed, divorced, and single

Suicide seems to be much higher in certain cultural and ethnic groups.

Indigenous populations in several countries have high suicide rates compared with the rest of the population, for example, Native American people in the USA, Métis and Inuit in Canada, Australian Aborigines, and Maori in New Zealand all have high rates of suicide (Fortune and Hawton 2007).

Some researchers suggest that LGBTQ youth often face considerable stress over the course of their lives because of bullying, victimization, and overt/covert discrimination, and they have higher rates of depression, suicide, anxiety, posttraumatic stress disorder, and alcohol and drug use (Rodgers 2017).

Some researchers suggested that suicide rates are higher when patient's caregiver is unavailable or when patients are not responding to treatment.

Frequent changes of residence had been identified as a risk of suicide in adolescence.

6.13 Family history of suicide or mental illness

Suicide risk was increased where there was a family history of mental disorder (OR = 1.41, 95% CI 1.0–1.97), while risk was increased where there was a family history of suicide (OR = 1.83, 95% CI 0.96–3.47) (Bolton et al. 2015).

Family history of suicide increases the risk at least twofold, particularly in girls and women, independently of family psychiatric history (Qin et al. 2003; Hawton and van Heeringen 2009).

6.14 Childhood trauma

Physical and, in particular, sexual abuse during childhood is strongly associated with suicide. The effects of childhood maltreatment and its relation to suicide are compounded by intergenerational transmission of abuse.

Familial transmission of suicidal behavior is most likely if the person attempting suicide had been sexually abused as a child. Abuse is, thus, not only a risk factor for suicidal behavior for individuals abused as children but also for their offspring (Bridge et al. 2006).

3.4.3 Protective Factors

In addition to risk factors, and sometimes overlooked, suicide risk assessment should identify protective factors that may reduce suicide risk. Although patients who exhibit protective factors do attempt and complete suicide, multiple protective factors generally contribute to patient resiliency in the face of stress and adversity.

Protective factors may be considered in each of the domains of the individual, family, work, and community. Important factors may include:

Internal: Ability to cope with stress, religious beliefs, frustration tolerance
External: Responsibility to children except among those with postpartum psychosis or beloved pets, positive therapeutic relationships, supportive relationships (Hawton and van Heeringen 2009)

Although the above listed factors may only provide a certain degree of protection, it is essential that clinicians recognize the poor predictive power and limitations of reliance on presence or absence of these factors (Large et al. 2011; National Collaborating Centre for Mental Health 2011).

3.4.4 Step 3: Formulating Risk: Make a Clinical Judgment of the Risk that a Patient/Client May Attempt or Complete Suicide in the Short or Long Term

- Integrate and prioritize all the information regarding risk and protective factors.
- Assess if the patient is minimizing or escalating their stated risk.
- Assess acute and imminent suicidality.
- Assess chronic and ongoing suicidality.
- Assess acute exacerbation of a patient with chronic risk.

In terms of acute risk, determine if the risk level is:

- *Low acute risk*

When there are no specific risk factors requiring intervention and there are few active concerns about suicide. The current suicidal intent, plan, and preparatory acts are absent. The person has the willingness and ability to utilize a safety plan in the case of increase in suicidal thoughts or change in intent. Family and clinician feel confident of patient's ability and willingness to maintain his or her own safety.

In cases of previously established suicidal gestures or behaviors, low risk implies that there are no new, treatable risk factors to target; the patient/client is at "their baseline risk."

The patient/client may require follow-up monitoring of clinical status and suicide risk if (but not limited to):

– Changes in life situation and/or mental status occur that may be reasonably expected to change suicide risk.
– Changes in care pathways or continuity occur (e.g., transition from a day-hospital to a community clinic setting).

- *Medium acute risk*

When there are some identified risk factors that may impact risk and there is a need for a suicide plan to address risk factors. Suicide risk is present but not imminent; patient has no intent, and in the opinion of the health provider, suicide risk can be managed through current supports and ongoing clinical care. Preparatory acts are usually absent, and the clinician believes that patient can maintain safety independently and follow the safety plan.

In this circumstance the patient requires ongoing monitoring of suicide risk, and the following shall be implemented:

– Suicide risk is formally assessed and the assessment outcome is appropriately documented.
– A suicide risk monitoring and management plan is developed, documented, communicated, implemented, and reviewed as clinically indicated.
– A change in suicide risk status is documented and appropriately communicated.
– The suicide risk level is documented and appropriately communicated, as per policy.

- *High acute risk*

When in the opinion of the health provider, suicide risk is high (imminent). There are multiple risk factors that convey a strong degree of risk, and patient has intent to die by suicide and inability to maintain safety independently of external support or help. A high level of intervention or monitoring is required such as hospitalization. Often this suggests that there is a subjective sense of urgency to address the risk factors as quickly as possible. In this case the patient requires increased monitoring of suicide risk, and the following shall be implemented:

– The high level of suicide risk shall be appropriately documented and communicated to all relevant providers and as clinically determined within the patient's circle of care.
– A suicide risk assessment, intervention, and monitoring protocol shall be documented in the patient's individual care plan and other locations as deemed appropriate by the clinical care team. This may require application of constant, close, or other monitoring frameworks as clinically determined.
– The suicide risk assessment and monitoring plan shall be appropriately communicated to all relevant care providers and such members of the patient's circle of care as deemed appropriate by the responsible clinician.
– The responsible clinician shall determine the appropriate level and location of care based on their best clinical judgment.

Ongoing formal review of the patient's suicide risk status shall be undertaken as deemed appropriate by the clinical care team.

In terms of chronic risk, determine if the risk level is:

- *Low chronic risk*

For example, patients with personality disorders with ability to manage their stressors without resorting to suicidal ideation or behavior.

- *Medium chronic risk*

Individuals with major mental illnesses and/or personality disorders, substance abuse/ dependence, and/or chronic medical conditions or pain. However, in these individuals, the relative balance of protective factors, coping skills, reasons for living, and psychosocial stability suggests an enhanced ability to endure future crises without resorting to self-directed violence and/or suicidal behaviors.

- *High chronic risk*

Patients with chronic major mental illness and/or personality disorder, history of prior suicide attempt(s), history of substance abuse/dependence, chronic pain, chronic suicidal ideation, chronic medical illness, and limited coping skills who usually self-harm but when faced new stressful situation such as loss of partner or a job, they are at chronic risk for becoming acutely suicidal.

It is the combination of the information obtained from the patient and the determination of additional risk factors that are used to conduct a suicide risk assessment. For example, a patient may say that they have persistent ideation but that they have no plan and that they can push the thoughts about suicide away from their mind

and can control their behavior. However, that same patient is known to have made two suicide attempts in the past year, is suffering from depression, is feeling hopeless, and has recently lost their job. It is this combination of interview information and additional risk factors that the clinician uses to determine risk for suicide.

Some researchers argued that the clinical formulation of risk is based on a cognitive understanding of data gathered about risk, ideation, and protective factors and an intuitive process that takes into account such factors as the clinician's familiarity with the patient and the patient's character structure (Berman and Silverman 2014; Wortzel et al. 2014).

References

Berman AL, Silverman MM. Suicide risk assessment and risk formulation part II: suicide risk formulation and the determination of levels of risk. Suicide Life Threat Behav. 2014;44(4):432–43.

Betz ME, Wintersteen M, Boudreaux ED, et al. Suicide risk: challenges and opportunities in the emergency department. Ann Emerg Med. 2016;68(6):758–65.

Bolton JM, Gunnell D, Turecki G. Suicide risk assessment and intervention in people with mental illness. BMJ. 2015;351:h4978.

Brådvik L, Mattisson C, Bogren M, Nettelbladt P. Long-term suicide risk of depression in the Lundby cohort 1947–1997—severity and gender. Acta Psychiatr Scand. 2008;117:185–91.

Bridge JA, et al. Adolescent suicide and suicidal behavior. J Child Psychol Psychiatry. 2006;47:372–94.

Bryan CJ, Corso KA, et al. Therapeutic alliance and change in suicidal ideation during treatment in integrated primary care settings. Arch Suicide Res. 2012;16(4):316–23.

Cavanagh JTO, Carson AJ, Sharpe M, Lawrie SM. Psychological autopsy studies of suicide: a systematic review. Psychol Med. 2003;33:395–405.

Chung DT, Ryan CJ, Hadzi-Pavlovic D, Singh SP, Stanton C, Large MM. Suicide rates after discharge from psychiatric facilities: a systematic review and meta-analysis. JAMA Psychiatry. 2017;74(7):694–702. Review. https://doi.org/10.1001/jamapsychiatry.2017.1044.

Conner KR, Duberstein PR. Predisposing and precipitating factors for suicide among alcoholics: empirical review and conceptual integration. Alcohol Clin Exp Res. 2004;28:6S–17S.

Fortune SA, Hawton K. Culture and mental disorders: suicidal behaviour. In: Bhugra D, Bhui K, editors. Textbook of cultural psychiatry. Cambridge: Cambridge University Press; 2007. p. 255–71.

Goodwin FK, Jamison KR. Manic-depressive illness: bipolar disorders and recurrent depression. 2nd ed. New York: Oxford University Press; 2007.

Hawton K, Casañas I, et al. Risk factors for suicide in individuals with depression: a systematic review. J Affect Disord. 2013;147(1–3):17–28.

Hawton K, van Heeringen K. Suicide Lancet. 2009;373(9672):1372–81.

Hawton K, Sutton L, Haw C, et al. Schizophrenia and suicide: a systematic review of risk factors. Br J Psychiatry. 2005;187:9–20.

Jacobs D, Baldessarini R et al. Practice guideline for the assessment and treatment of patients with suicidal behaviors. 2010.

Jobes DA. The Collaborative Assessment and Management of Suicidality (CAMS): an evolving evidence-based clinical approach to suicidal risk. Suicide Life Threat Behav. 2012;42(6):640–53.

Kene P, Yee ET, Gimmestad KD. Suicide assessment and treatment: gaps between theory, research, and practice. Death Stud. 2018:1–9.

Large M, Smith G, Sharma S, Nielssen O, Singh SP. Systematic review and meta-analysis of the clinical factors associated with the suicide of psychiatric in-patients. Acta Psychiatr Scand. 2011;124:18–29.

Luoma JB, Martin CE, Pearson J. Contact with mental health and primary care providers before suicide: a review of the evidence. Am J Psychiatry. 2002;159:909–16.
Mattisson C, Bogren M, Horstmann V, Munk-Jorgensen P, Nettelbladt P. The long-term course of depressive disorders in the Lundby Study. Psychol Med. 2007;37:883–91.
Murphy GE, Wetzel RD. The lifetime risk of suicide in alcoholism. Arch Gen Psychiatry. 1990;47(4):383–92.
National Collaborating Centre for Mental Health. Self-harm: The NICE guideline on longer-term management. London: National Collaborating Centre for Mental Health; 2011.
Olfson M, Marcus SC, Bridge JA. Emergency department recognition of mental disorders and short-term outcome of deliberate self-harm. Am J Psychiatry. 2013;170:1142–50.
Oquendo MA, Currier D, Liu SM, Hasin DS, Grant BF, Blanco C. Increased risk for suicidal behavior in comorbid bipolar disorder and alcohol use disorders: results from the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC). J Clin Psychiatry. 2010;71(7):902–9.
Pinals DA, Anacker L. Mental illness and firearms: legal context and clinical approaches. Psychiatr Clin North Am. 2016;39(4):611–21.
Pirkis J, Burgess P. Suicide and recency of health care contacts: a systematic review. Br J Psychiatry. 1998;173:462–74.
Pompili M, Serafini G, Innamorati M, Lester D, et al. 2011. Suicide risk in first episode psychosis: a selective review of the current literature. Schizophr Res. 2011;129(1):1–11.
Poorolajal J, Haghtalab T, Farhadi M, Darvishi N. Substance use disorder and risk of suicidal ideation, suicide attempt and suicide death: a meta-analysis. J Public Health (Oxf). 2016;38(3):e282–91.
Qin P, Nordentoft M. Suicide risk in relation to psychiatric hospitalization: evidence based on longitudinal registers. Arch Gen Psychiatry. 2005;62(4):427–32.
Qin P, Agerbo E, et al. Suicide risk in relation to socioeconomic, demographic, psychiatric and familiar factors: a national register based study of all suicides in Denmark, 1981-1997. Am J Psychiatry. 2003;160:765–72.
Rodgers SM. Transitional age lesbian, gay, bisexual, transgender, and questioning youth: issues of diversity, integrated identities, and mental health. Child Adolesc Psychiatr Clin N Am. 2017;26(2):297–309.
Roy A, Pompili M. Management of schizophrenia with suicide risk. Psychiatr Clin North Am. 2009;32(4):863–83.
Undurraga J, Baldessarini RJ, Valenti M, Pacchiarotti I, Vieta E. Suicidal risk factors in bipolar I and II disorder patients. J Clin Psychiatry. 2012;73:778–82.
Walby FA, Myhre MØ, Kildahl AT. Contact with mental health services prior to suicide: a systematic review and meta-analysis. Psychiatr Serv. 2018:appips201700475.
Walsh G, Sara G, Ryan CJ, Large M. Meta-analysis of suicide rates among psychiatric in-patients. Acta Psychiatr Scand. 2015;131(3):174–84. https://doi.org/10.1111/acps.12383.
Whiteford HA, Degenhardt L, Rehm J, Baxter AJ, Ferrari AJ, Erskine HE, Charlson FJ, Norman RE, Flaxman AD, Johns N, Burstein R, Murray CJ, Vos T. Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. Lancet. 2013;382(9904):1575–86.
Wortzel H, et al. Therapeutic risk management of the suicidal patient: stratifying risk in terms of severity and temporality. J Psychiatr Pract. 2014;20(1):63–7.

4 Suicide Risk Assessment Tools and Instruments

4.1 Challenges in Evaluation of Suicide Risk Assessment Tools

- The ability to predict suicide based on the score (or scores) on a risk assessment tool is low.
- Predictive validity is hard to evaluate because suicide is relatively a rare event.
- Research on the predictive value suicide risk assessment tools is forced rely on proxy outcome measures such as increase in risk factors or warning signs of suicide.
- There is no evidence to support the use of summary scores as the sole basis for decision-making on acute risk.

4.2 Reasons for Using Suicide Risk Assessment Tools

- To gather additional information that can shed light on the person's degree of risk of suicide.
- To corroborate findings from clinical interviews.
- To identify discrepancy in risk, if any. For example, in some instances, a person may not disclose indicators of risk in a clinical interview but may report indicators on a self-report tool.
- To standardize the assessment and improve the overall quality of the suicide risk assessment process.

4.3 Suicide Screening and Risk Assessment Instruments

The following are some of the suicide screening and assessment instruments. This is not an exhaustive list, so clinicians are encouraged to review the literature to get a complete list of the different instruments.

J. Sadek, *A Clinician's Guide to Suicide Risk Assessment and Management*,
https://doi.org/10.1007/978-3-319-77773-3_4

4.4 Screening Tools

Ask Suicide-Screening Questions (ASQ) National Institute of Mental Health: ASQ is a four-item suicide-screening tool designed to be used for people ages 10–24 in emergency departments, inpatient units, and primary care facilities. A Brief Suicide Safety Assessment is available to be used when patients screen positive for suicide risk on the ASQ.

https://www.nimh.nih.gov/news/science-news/ask-suicide-screening-questions-asq.shtml

Behavioral Health Measure-10® (BHM-10®): The BHM-10 is a ten-item tool that assesses patient depression, anxiety, and overall life functioning. The instruments can be administered electronically, although these require a licensing fee. https://www.pointnclick.com/sites/default/files/files/CelestHealth%20Behavioral%20Health%20Measure-10%2001-29-2010.pdf

Behavioral Health Screen (BHS): The BHS is the screening tool delivered by the BH-Works browser-based web software. The BHS screens across 16 domains of mental health and psychosocial risk factors. Several versions are available: child (ages 6–11), adolescent primary care (ages 12–24), primary care (ages 24 and up), and emergency department (ages 12 and up). There is a licensing fee for this instrument. https://bh-works.com/

Brief Symptom Inventory 18® (BSI 18®): The BSI 18 is an 18-item instrument designed to measure psychological distress and psychiatric disorders in individuals age 18 and older. It includes one suicide-specific question. The BSI 18 can be administered with paper and pencil, via computer, or online and takes approximately 4 min to complete. Manuals and trainings are available. There is a licensing fee for this instrument. http://www.pearsonclinical.com/psychology/products/100000638/brief-symptom-inventory-18-bsi18.html

Columbia-Suicide Severity Rating Scale (C-SSRS): The C-SSRS features questions that help determine whether an individual is at risk for suicide. It is available in 114 country-specific languages. There are brief versions of the C-SSRS often used as a screening tool that, based on patient response, can lead to the administration of the longer C-SSRS to triage patients. http://www.cssrs.columbia.edu/

Outcome Questionnaire-45.2® (OQ-45.2®): The OQ-45.2 helps mental health professionals assess symptom distress (depression and anxiety), interpersonal relationships (loneliness, conflicts with others, and marriage and family difficulties), and social role (difficulties in the workplace, school, or home). It includes explicit questions about suicide and is for use with adults. There is a licensing fee for this instrument. http://www.oqmeasures.com/

4.5 Patient Health Questionnaire-9 (PHQ-9) Depression Scale

The PHQ-9 is a widely used nine-item tool used to diagnose and monitor the severity of depression. Question 9 screens for the presence and duration of suicide

ideation. This screening tool and an instruction manual are available at no cost. http://www.phqscreeners.com

Suicide Behavior Questionnaire-Revised (SBQ-R): The SBQ-R is four-item self-report questionnaire that asks about future anticipation of suicidal thoughts or behaviors as well as past and present ones and includes a question about lifetime suicidal ideation, plans to commit suicide, and actual attempts. https://www.integration.samhsa.gov/images/res/SBQ.pdf

4.6 SAFE-T

SAFE-T (Suicide Assessment Five-Step Evaluation and Triage) was developed in collaboration with the Suicide Prevention Resource Center and Screening for Mental Health.

4.6.1 Assessment Tools

Columbia-Suicide Severity Rating Scale (C-SSRS): The C-SSRS is frequently used as a secondary suicide assessment tool following the use of one of the available screening tools. Three versions of the C-SSRS are used in clinical practice to assess patient safety and management and monitor improvements or worsening of suicidality.

- The Lifetime/Recent version gathers lifetime history of suicidality, as well as recent suicide-related ideation and/or behavior. This version is appropriate for use as part of the person's first interview.
- The Since Last Visit version prospectively monitors suicide-related behavior since the person's last visit or the last time the C-SSRS was administered.
- The Risk Assessment version is intended for use in acute care settings as it establishes a person's immediate risk of suicide. Suicide-related ideation and behavior is assessed over the past week and lifetime through a checklist of protective and risk factors for suicidality. http://www.cssrs.columbia.edu/

Reasons for Living (RFL; Linehan et al. 1983): The RFL is a self-report questionnaire that measures clients' expectancies about the consequences of living versus killing oneself and assesses the importance of various reasons for living. It may be used to explore differences in the reasons for living among individuals who engage in suicide-related behavior and those who do not (e.g., "I believe that I could cope with anything life has to offer").

The measure has six subscales: Survival and Coping Beliefs, Responsibility to Family, Child-Related Concerns, Fear of Suicide, Fear of Social Disapproval, and Moral Objections. http://depts.washington.edu/uwbrtc/resources/assessment-instruments

http://depts.washington.edu/uwbrtc/wp-content/uploads/LSSN-LRAMP-v1.0.pdf

The Beck Hopelessness Scale (BHS; Beck et al. 1988) was designed to measure negative attitudes about one's future and perceived inability to avert negative life events. It has 20 true/false statements to measure three aspects of hopelessness:

- Negative feelings about the future
- Loss of motivation
- Pessimistic expectations

Each of the 20 statements is scored 0 or 1. The published cutoff score for the BHS is greater than 9 (Beck et al. 1985).

The BHS is not supported for use in identifying individuals at high risk of repetitive, non-suicidal self-injury nor is it supported for use in emergency settings (Cochrane-Brink et al. 2000).

The Beck Scale for Suicide Ideation (BSS ®; Beck et al. 1979) measures the current and immediate intensity of attitudes, behaviors, and plans for suicide-related behavior with the intent to end life among psychiatric patients.

The scale consists of 21 items that are rated on a 3-point scale of suicidal intensity (e.g., 0–2).

In a 20-year prospective study, patients considered at high risk were seven times more likely to die by suicide than those patients considered at lower risk (Brown et al. 2000). Predictive validity of the BSS® for acute suicide was not found in the literature.

It is one of the most widely used measures of suicide-related ideation and has been extensively studied. It has been shown to differentiate between adults and adolescents with and without a history of suicide attempts (Holi et al. 2005).

A two-factor model of motivation (e.g., wishes, reasons, desires) and preparation (e.g., planning and acting) was established among a sample of female suicide attempters.

The Geriatric Suicide Ideation Scale (GSIS; Heisel and Flett 2006) is a multidimensional measure of suicide-related ideation developed for use with older adults.

It is composed of 31 questions with scores ranging from 31 to 165.

The GSIS has four factors:

- Suicide ideation (e.g., "I want to end my life")
- Perceived meaning in life (e.g., "Life is extremely valuable to me," reverse keyed)
- Loss of personal and social worth (e.g., "I generally feel pretty worthless")
- Death ideation (e.g., "I often wish I would pass away in my sleep") and one additional item (e.g., "I have tried ending my life in the past")

The interRAI Severity of Self-harm (SOS Scale) measures risk of harm to self (suicide and self-harm) based on historical and current suicide ideation, plans, and behaviors as well as indicators of depression, hopelessness, positive symptoms, cognitive functioning, and family concern over the person's safety. The SOS Scale uses hierarchical scoring algorithm producing scores ranging from 0 (no risk) to 6 (extreme or imminent risk).

In Ontario and other jurisdictions (e.g., Finland, Iceland), the interRAI MH is used to assess all persons admitted to an inpatient mental health bed.

The Modified Scale for Suicide Ideation (SSI-M; Miller et al. 1986) is a revised version of Beck's Scale for Suicidal Ideation (BSS®: Beck et al. 1979). An advantage of the SSI-M is its ability to effectively discriminate between suicide ideators and attempters at intake.

The Nurses' Global Assessment of Suicide Risk (NGASR) is a nursing assessment tool used to identify psychosocial stressors that are reported to be strongly linked with suicide.

4.7 SAD PERSONS

The SAD PERSONS Scale (Patterson et al. 1983) is a simple mnemonic to assess major suicide-related risk factors (Patterson et al. 1983).

Format

The letters in SAD PERSONS are associated with demographic, behavioral, and psychosocial risk factors. A positive endorsement of each letter is weighted with 1 point, to a maximum of 10 points. A cutoff score of greater than 5 is the suggested risk level when hospitalization (either voluntary or involuntary) of the at-risk patient is necessary. However, limited evidence is available to support the validity of this cutoff. The items include:

- S = Sex (male) 1 point
- A = Age (25–34); (35–44); (65+) 1 point
- D = Depression 1 point
- P = Previous attempt 1 point
- E = Ethanol abuse 1 point
- R = Rational thinking loss (psychosis) 1 point
- S = Social support lacking 1 point
- O = Organized suicide plan 1 point
- N = No spouse (for males) 1 point
- S = Sickness (chronic/severe) 1 point

Each item is scored as present/not present to a maximum of 10 points. Patterson et al. (1983) recommend that for scores of 3–4, clinicians should closely monitor status, for 5 and 6 clinicians should "strongly consider hospitalization," and scores of 7–10 should hospitalize for further assessment. The scale has a false-positive rate of 87%.

A *modified version* of the SAD PERSONS, the *SAD PERSONAS*, was developed to incorporate a weighting system and modify several items:

- S = Sex (male) 1 point
- A = Age (<19 or >45 years) 1 point
- D = Depression or hopelessness 2 points
- P = Previous suicide attempts or psychiatric care 1 point
- E = Excessive alcohol or drug use 1 point

- R = Rational thinking loss 2 points
- S = Separated, divorced or widowed 1 point
- O = Organized or serious attempt 2 points
- N = No social supports 1 point
- A = Availability of lethal means 2 points
- S = Stated future intent 2 points

It is still lacking predictive validity for clinical decision-making.

The Scale for Impact of Suicidality Management: Assessment and Planning of Care (SIS-MAP; Nelson et al. 2010) is composed of 108 items to aid in the prediction of suicide risk, as well as the development of a management plan.

The items in the SIS-MAP are balanced between risk and resilience (protective) factors, in addition to factors that contribute to suicide from a wide variety of domains. Current level of suicide risk is measured from eight domains: (1) demographics, (2) psychological, (3) comorbidities, (4) family history, (5) biological, (6) protective factors, (7) clinical ratings/observations, and (8) psychosocial/environmental problems.

The Suicidal Behaviors Questionnaire (SBQ) is a self-report assessment for suicidal thoughts and behaviors in adults.

It measures the frequency and intensity of suicidal ideation, past and future suicidal threats, past and future suicide attempts, and nonfatal self-harming behavior.

Items are rated according to the past several days, the last month, the last 4 months, the last year, and over a lifetime.

Behaviors are scored using a weighted summary score across each time interval.

It can be completed using a 14-item version (SBQ-14; Linehan et al. 2006) and a 4-item version (SBQ-4).

The self-report format of the SBQ allows opportunity to obtain information from individuals who may have difficulty revealing suicidal thoughts or previous suicide-related behavior during an interview situation (Osman et al. 2001).

The Suicide Intent Scale (SIS; Beck et al. 1974) is largely used as a research instrument to assess circumstantial and subjective feelings of intent following a specific attempt to die by suicide.

It includes 15 items scored for severity from 0 to 2 with a total score ranging from 0 to 30, with higher scores indicating a greater degree of intent.

The SIS is typically administered as an interview. The first part of the SIS (items 1–8) assesses objective circumstances surrounding the suicide attempt including items on preparation and manner of execution of the attempt, the setting, as well as prior cues given by the patient that could facilitate or hamper the discovery of the attempt. The second part of the SIS (items 9–15) covers the attempter's perceptions of the method's lethality, expectations about the possibility of rescue and intervention, the extent of premeditation, and the alleged purpose of the attempt.

A four-factor structure has been identified among adults that include conception (e.g., purpose and seriousness of attempt), preparation (e.g., degree of planning), precautions against discovery (e.g., isolation), and communication (e.g., act to gain help).

The Suicide Probability Scale (SPS) measures current suicide ideation, hopelessness, negative self-evaluation, and hostility.

Format:

The SPS includes 36 self-report items. Questions are answered on a 4-point scale ranging from 1 ("None or a little of the time") to 4 ("Most or all of the time"). The SPS scale takes approximately 10–20 min to complete and requires a fourth grade reading level.

The SPS is based on six factors:

- Suicide ideation (6 items)
- Hopelessness (12 items)
- Positive outlook (6 items)
- Interpersonal closeness (3 items)
- Hostility (7 items)
- Angry Impulsivity (2 items)

Can be used for adolescents and adults

The Tool for Assessment of Suicide Risk (TASR; Chehil and Kutcher 2007) was designed to assess imminent suicide risk. The TASR is a short and succinct tool intended for use as part of regular mental health assessment. It was designed to assist in clinical decision-making regarding the "burden of risk" for suicide (Chehil and Kutcher 2007) by ensuring that the most pertinent individual, symptom, and acute risk factors have been addressed by the clinician.

Although not routinely used in clinical care, standardized suicide risk factor components of clinical and research scales are crucial to clinical assessment; however, these scales cannot be used alone or as a substitute for a full clinical assessment for the reasons previously mentioned.

The Beck Depression Inventory-Revised (BDI-II) was constructed to measure the severity of self-reported depression according to DSM-IV. It consists of 21 items. Each item is rated on a 4-point Likert scale with 0 indicating no reported symptoms and 3 indicating extreme symptoms. Total scores range from 0 to 63 with the following breakdown: 0–13, minimal depression; 14–19, mild depression; 20–28, moderate depression; and 29–63, severe depression.

The BDI-II is generally completed in approximately 5 min and can be scored by any trained mental health professional (TMHP). This inventory is designed to assess feelings and behaviors over the previous 2 weeks and can be used to track depressive symptom severity over the course of treatment. The BDI-II has been validated for use in adolescents and adults and in an outpatient or inpatient setting and has become one of the most widely used instruments for depression assessment.

The Beck Hopelessness Scale (BHS) was developed based on the known association between pessimism, hopelessness, and suicide. The BHS is a 20-item, true-false, self-report inventory and scale that takes 5 min to complete. Total scores range from 0 to 20. The BHS measures three major aspects of hopelessness: feelings about the future, loss of motivation, and expectations. It has been studied for use in children, adolescents, and adults. A score of 10 or greater correctly identified 91% of suicides within a 10-year follow-up in an inpatient psychiatric setting of patients with reported SI. In addition, a score of 9 or more accurately identified outpatients who eventually committed suicide. Beck's studies of this particular scale suggest that hopelessness is an even stronger predictor of suicidal intention than the severity of the patient's depression. Scores obtained on the BHS have been more strongly related to suicidal behavior as compared to BDI-II scores, but it is recommended that both be used in combination when assessing suicide risk (Beck et al. 1985, 1990).

The Minnesota Multiphasic Personality Inventory-2 (MMPI-2) is a 567 true/false-item inventory that consists of 10 basic clinical scales and 14 content scales. Interpretation is based upon a code type, consisting of the two highest scores on the clinical scales. Research has shown that individuals preoccupied with suicide and death may yield a profile with the highest elevations on the Depression Scale (Scale 2) and the Psychasthenia Scale (Scale 7). Although a 2-7/7-2 code type is the most correlated with suicidality, there are several other code types that have been associated with a high risk for suicide. Furthermore, the MMPI-2 contains content component scales that have also been associated with suicidal thinking. The Suicidal Ideation (DEP4) and the Suicide/Death Ideation (SUI) subscales have been particularly useful in identifying individuals considering suicide. Finally, inspection of the validity scales found on the MMPI-2 has been cited as useful in identifying and categorizing individuals who present as high risk for suicide. In particular, individuals with elevated L scores (Lie Scale) should alert clinicians to the tendency of an individual to minimize or outright deny any symptoms, including SI, indicating a need to be more thorough and careful when conducting a risk assessment. The MMPI-2 must be administered by a clinical psychologist and generally takes 90 min to administer and score. The results provide important subjective information from the patient's perspective that is often not gathered during the course of a clinical interview (Simon and Hales 2012; Gottfried et al. 2014).

The Rorschach Inkblot Test was, at one time, the most commonly used method for estimating suicide risk. The Rorschach contains ten stimulus cards that are presented to patients with the directive to share what the inkblot might represent. The idea behind the use of this test is that patients will project their inner world onto the ambiguous shapes seen on the cards. A patients' interpretations of the innocuous inkblots can provide a glimpse into the patient's way of thinking and interpreting the world. Examples of responses to Rorschach cards that might be indicative of suicidal thinking include the following: "It looks like staring into a well … so black and deep … disgusting … can't get out of there." Such statements can be interpreted

as painful self-reflections and may be indicative of shame, despair, or an inability to find alternatives to current circumstances, all of which can be considered characteristics of patients at higher risk for suicide. The Suicide Constellation is now included among the Rorschach special indices and consists of 12 variables that highlight certain features common in Rorschach protocols of individuals ($N = 101$) who completed suicide within 60 days of testing. Patients who endorse six or more Suicide Constellation variables should prompt the clinician to rescore the protocol because there may be a possibility of self-destructive preoccupation present, and scores of 7 or more Suicide Constellation variables have been utilized to predict near-lethal suicide attempts. This test can only be administered by a clinical psychologist, can take an hour or more to administer, and is only recommended for use in individuals 15 and older.[1] The Rorschach is considered to be helpful in that it is a relatively nonthreatening task without any right or wrong answers. Although its use has declined in recent years, it remains a potent tool in evaluating SI (Simon and Hales 2012; Fowler et al. 2001).

Other scales:

- BIS, Barratt Impulsivity Scale
- ERRS, Edinburgh Risk of Repetition
- GSI, Global Severity Index
- MSHR, Manchester Self-Harm Rule
- RESH, Repeated Episodes of Self-Ham score
- SSHR, Söderjukuset Self-harm Rule
- SUAS, Suicide Assessment Scale

Motto's Risk Estimator and the Firestone Assessment for Self-Destructive

4.7.1 Suggested New Suicide Risk Assessment Tool

The tool below could be helpful in the following areas:

- Support and inform the clinical decision of risk level.
- Understanding the reason for the assessment.
- Documenting the risk factors for suicide.
- Documenting the protective factors.
- Communicating SRA results to other clinicians working with the patient.
- Having a solid management plan.
- Documenting the level of the suicide risk (high, moderate, low).
- Inform clinical decision-making of management.
- Having a space to do analysis of the findings.

Sadek Suicide Prevention Assessment (SSPA) Tool

Patient Information

Suicide Risk Assessment and Intervention Tool

Date **Time** **Assessor** **Diagnosis**

Reason: ○ MH Assessment ○ Admission/Transfer/Discharge ○ Acute deterioration _____

Interview Risk Profile

- ▫ Suicidal thinking or Ideation
- ▫ Access to lethal means
- ▫ Suicide intent or lethal plan or plan for after death (note)
- ▫ Hopelessness
- ▫ Intense Emotions: rage, anger, agitation, humiliation, revenge, panic, severe anxiety
- ▫ Current Alcohol or Substance intoxication / problematic use
- ▫ Withdrawing from family, friends
- ▫ Poor Reasoning/Judgment
- ▫ Clinical Intuition: assessor concerned
- ▫ Recent Dramatic Change in mood
- ▫ Recent Crisis/Conflict/ Loss

Illness Management

- ▫ Lack of clinical support
- ▫ Noncompliance or poor response to treatment

Individual Risk Profile

- ▫ Ethnic, cultural risk group or refugee
- ▫ Family history of suicide
- ▫ Trauma:as domestic violence / sexual abuse/neglect
- ▫ Poor self-control: impulsive / violent/aggression
- ▫ Recent suicide attempt
- ▫ Other past suicide attempts, esp. with low rescue potential
- ▫ Mental illness or addiction
- ▫ Depression/anhedonia
- ▫ Psychotic
- ▫ Command hallucinations
- ▫ Recent admission / discharge / ED visits
- ▫ Chronic medical illness/ pain
- ▫ Disability or impairment
- ▫ Collateral information supports suicide intent

Circle of support

- ▫ Lack of family/
- ▫ friends support
- ▫ Caregiver unavailable
- ▫ Frequent change of home

Risk Buffers – Not to be used to determine degree of risk.

- ▫ Has reason to live/hope
- ▫ Social support
- ▫ Responsibility for family/kids/pets
- ▫ Capacity to cope/resilience
- ▫ Religion/faith
- ▫ Strength for managing risk

Communication Plan

Verbal (V) Written/fax(W)

- ▫ Nurse:
- ▫ Physician:
- ▫ SDM/Family:
- ▫ Mobile Crisis:
- ▫ Others:
- ▫ Documentation in chart

Management Plan

- ▫ Follow patient care plan for chronic risk
- ▫ Regular outpatient follow-up
- ▫ Removal of lethal means
- ▫ Urgent outpatient follow-up
- ▫ Admit to a psychiatric unit
  - o Routine observation
  - o Close observation q 15 m
  - o Constant observation

Suicide Risk Level: Risk assessment is based on clinical judgment and not based on number of item schecked. The checklist is intended toguide the clinical decision only.

RISK LEVEL: ☐ **High** ☐ **Moderate** ☐ **Low** Signature:_____

Analysis of Risk, Comments and Collateral Information:_____

For information about this form contact Dr. Joseph Sadek at joseph.sadek@nshealth.ca

Suicide risk monitoring level

Level	Suicide risk monitoring level	Risk level
1	**When there are no specific risk factors requiring intervention and there are few active concerns about suicide. In cases of previously established suicidal gestures or behaviors, low risk implies that there are no new, treatable risk factors to target; the patient/client is at "their baseline risk"** **The patient/client may require follow-up monitoring of clinical status and suicide risk if (but not limited to):** • Changes in life situation and/or mental status occur that may be reasonably expected to change suicide risk • Changes in care pathways or continuity occur (e.g., transition from a day hospital to a community clinic setting)	**Low**
2	**When there are some identified risk factors that may impact risk and there is a need for a suicide plan to address risk factors. Suicide risk is present but not imminent and, in the opinion of the health provider, can be managed through current supports and ongoing clinical care. In this circumstance the patient requires ongoing monitoring of suicide risk, and the following shall be implemented:** • Suicide risk is formally assessed, and the assessment outcome is appropriately documented • A suicide risk monitoring and management plan is developed, documented, communicated, implemented, and reviewed as clinically indicated • A change in suicide risk status is documented and appropriately communicated • The suicide risk level is documented and appropriately communicated, as per policy	**Moderate**
3	**When in the opinion of the health provider, suicide risk is high (imminent). There are multiple risk factors that convey a strong degree of risk and that a high level of intervention or monitoring is required. Often this suggests that there is a subjective sense of urgency to address the risk factors as quickly as possible. In this case the patient requires increased monitoring of suicide risk, and the following shall be implemented:** • The high level of suicide risk shall be appropriately documented and communicated to all relevant providers and as clinically determined within the patient's circle of care • A suicide risk assessment, intervention, and monitoring protocol shall be documented in the patient's individual care plan and other locations as deemed appropriate by the clinical care team. This may require application of constant, close, or other monitoring frameworks as clinically determined • The suicide risk assessment and monitoring plan shall be appropriately communicated to all relevant care providers and such members of the patient's circle of care as deemed appropriate by the responsible clinician • The responsible clinician shall determine the appropriate **level and location of care** based on their best clinical judgment • Ongoing formal review of the patient's suicide risk status shall be undertaken as deemed appropriate by the clinical care team	**High**

References

Beck RW, Morris JB, Beck AT. Cross-validation of the Suicidal Intent Scale. Psychol Rep. 1974;34:445–6.

Beck AT, Kovacs M, Weissman A. Assessment of suicidal intention: the scale for suicide ideation. J Consult Clin Psychol. 1979;47(2):343–52.

Beck AT, Steer RA, Kovacs M, Garrison B. Hopelessness and eventual suicide: a 10-year prospective study of patients hospitalized with suicidal ideation. Am J Psychiatry. 1985;142(5):559–63.

Beck AT, Steer RA, Ranieri WF. Scale for suicide ideation: psychometric properties of a self-report version. J Clin Psychol. 1988;44(4):499–505.

Beck AT, Brown G, Berchick RJ, Stewart BL, Steer RA. Relationship between hopelessness and ultimate suicide: a replication with psychiatric outpatients. Am J Psychiatry. 1990;147(2):190–5.

Berman AL. Risk management with suicidal patients. J Clin Psychol. 2006;62(2):171–84.

Brown GK, Beck AT, Steer RA, Grisham JR. Risk factors for suicide in psychiatric outpatients: a 20-year prospective study. J Consult Clin Psychol. 2000;68(3):371–7.

Chehil S, Kutcher SP. Suicide risk management: a manual for health professionals. Carlton: Blackwell; 2012.

Cochrane-Brink KA, et al. Clinical rating scales in suicide risk assessment. Gen Hosp Psychiatry. 2000;22(6):445–51.

Fowler JC, Piers C, Hilsenroth MJ, Holdwick DJ, Padawer JR. The Rorschach suicide constellation: assessing various degrees of lethality. J Pers Assess. 2001;76(2):333–51.

Gottfried E, Bodell L, Carbonell J, Joiner T. The clinical utility of the MMPI-2-RF suicide/death ideation scale [abstract]. Psychol Assess. 2014;26(4):1205–11.

Heisel MJ, Flett GL. The development and initial validation of the geriatric suicide ideation scale. Am J Geriatr Psychiatry. 2006;14(9):742–51.

Holi MM, Pelkonen M, Karlsson L, Kiviruusu O, Ruuttu T, Heila H, et al. Psychometric properties and clinical utility of the scale for suicidal ideation (SSI) in adolescents. BMC Psychiatry. 2005;3(5):8.

Linehan MM, Goodstein JL, Nielsen SL, Chiles JA. Reasons for staying alive when you are thinking of killing yourself: the reasons for living inventory. J Consult Clin Psychol. 1983;51(2):276–86.

Linehan MM, Comtois KA, Brown MZ, Heard HL, Wagner A. Suicide Attempt Self-Injury Interview (SASII): development, reliability, and validity of a scale to assess suicide attempts and intentional self-injury. Psychol Assess. 2006;18(3):303–12.

Miller IW, Norman WH, Bishop SB, Dow MG. The modified scale for suicidal ideation: reliability and validity. J Consult Clin Psychol. 1986;54(5):724–5.

Nelson C, Johnston M, Shrivastava A. Improving risk assessment with suicidal patients: a preliminary evaluation of the clinical utility of the scale for impact of suicidality–management, assessment and planning of care (SIS-MAP). Crisis. 2010;31(5):231–7.

Osman A, et al. The Suicidal Behaviors Questionnaire-Revised (SBQ-R): validation with clinical and nonclinical samples. Assessment. 2001;8(4):443–54.

Patterson WM, Dohn HH, Bird J, Patterson GA. Evaluation of suicidal patients: the SAD PERSONS scale. Psychosomatics. 1983;24(4):343–5, 348–9

Simon RI, Hales RE. Textbook of suicide assessment and management. 2nd ed. Arlington, VA: American Psychiatric Publishing; 2012.

Management of Patients with Acute Suicidality

5

5.1 Medicolegal View

For a physician to be liable to a patient for malpractice, the following four elements are as follows:

Duty: The clinician must have assumed a duty to care for the patient.
Negligence: The clinician was negligent based on the standards of care or the standards of physicians of similar orientation and training.
Harm: The patient must prove that there was a harm (either physical or emotional).
Causation: The patient should prove that the negligent act in question caused the harm.

The most common malpractice issue related to suicide is failure to provide protection to patients from killing themselves.

The law recognizes that suicide is a complex issue and cannot be attributed to a single cause. The law also recognizes that there are no standards for its prediction; however, the law would consider the "foreseeability" concept. That means that when the court makes a decision in many cases, consideration is given to the clinician's ability to take an accurate history, recognize the relevant risk factors, and prepare a treatment plan that is implemented to guard against completed suicide (Sher 2015).

J. Sadek, *A Clinician's Guide to Suicide Risk Assessment and Management*,
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5.2 Management of Suicidal Patients

1. Maintain the therapeutic alliance with the patient (see previous chapter).
2. Consider immediate safety needs during and after SRA assessment.
3. Select a treatment setting and protocol based on your SRA risk level.
4. Select other specific measures to manage the suicidal patient based on your clinical judgment.

5.2.1 Safety Needs to Consider in the Physical Environment (E.g., Emergency Room or Inpatient)

5.2.1.1 The Following Measures Should Improve Safety in the Physical Facility

- Having elopement precaution measures such as security staff in the unit and locked doors or locked area.
- Ensuring that agitated or aggressive patients are well controlled with medications.
- Eliminating access to means of hanging, suffocation, and strangulation: Are there fixtures (shower heads, light fixtures, curtain rods, closet doors, door knobs) from which something heavy could be suspended? Do closets and showers have breakaway rods?
- Ensuring that patients who require medical equipment (e.g., beds, intravenous lines, oxygen) after a suicide attempt are properly and adequately observed.
  - Ensuring that the circumstances of taking shoelaces and belts from patients (and returning them back) are well described and documented
- Locking linen closets.
- If guitars and other string instruments are allowed in inpatient units, then their use and storage should be supervised.

5.2.1.2 Access to Jumping as a Method of Suicide

- Do patients have access to windows, balconies, fire escapes, and places from which they could jump?
- Could they open or break the windows?

5.2.1.3 Access to Other Potentially Harmful Items

- Is a body/belongings search done on admission?
- Could visitors bring harmful items to patients?
- Is the unit locked?
- Are items brought in by visitors searched?
- Are items such as belts/glass bottles/cigarette lighters taken from patients?
- Are cleaning supplies closely monitored by staff?

- Are there electrical outlets in the bathrooms?
- Are there blow-dryers or other electrical appliances?
- How are razors for shaving monitored?

5.2.1.4 Consider Safety If There Is a Need to Transport the Suicidal Patient

The increased risk associated with the transport should be considered:

– Consider where the patient is going. Is that facility safe? Any access to places from which to jump or hang?
– Consider a higher level of observation for the duration when patient is not in a secure unit, e.g., if the patient is on 15 min checks, consider a 1:1 for the transport.
– Staff responsible for the observations must be informed of the status of the patient and aware of their options and level of responsibility for intervening during crisis.

5.2.2 Select a Treatment Setting and Protocol Based on Your SRA Risk Level

5.2.2.1 Hospital Admission is Generally Indicated for High Risk Patients

High-risk patients include but not limited to those with:

- Increased intensity of suicidal thoughts, a plan, or intent.
- After a serious suicide attempt or aborted suicide attempt.
- Attempt was violent, near-lethal, or premeditated.
- Precautions were taken to avoid rescue or discovery.
- Persistent plan and/or intent is present.
- Distress is increased or patient regrets surviving.
- Patient is male, older than 45 years of age, especially with new onset of psychiatric illness or suicidal thinking.
- Patient is psychotic or responding to command hallucinations to kill self.
- Patient has limited family and/or social support, including lack of stable living situation.
- Current impulsive behavior, severe agitation, poor judgment, or refusal of help is evident.
- Patient has demonstrated a change in mental status with a metabolic, toxic, infectious, or other etiology requiring further workup in a structured setting in the presence of suicidal ideation with:

  Specific plan with high lethality (e.g., plans to shoot self and has a gun)

  High suicidal intent (e.g., "I can't take this any longer; I must find a way to make it stop; my family would be better off without me.")
- Severe anxiety, agitation, or perturbation.

Hospital admission is also generally indicated in the following circumstances:

- Lack of response to or inability to cooperate with outpatient treatment
- Need for supervised setting for medication trial or ECT
- Need for skilled observation, clinical tests, or diagnostic assessments that require a structured setting
- Limited family and/or social support, including lack of stable living arrangements
- Lack of an ongoing clinician-patient relationship
- Lack of access to timely outpatient follow-up
- In the absence of suicide attempts or reported suicidal ideation/plan/intent but evidence from the psychiatric evaluation and/or history from others suggests a high level of suicide risk.

Monitoring and observation levels of high-risk patients in hospital

The monitoring of the suicidal patient includes a range of frequency of observations from 1:1 (constant observation), to 15 min checks, to 30 min checks.

Different categories of restrictions can also be used.

Examples of restrictions include:

- Supervised bathroom
- Restricted to being on the unit
- Restriction to public areas
- Placement in hospital clothing

The determination of the level of observations and restrictions depends upon the acuity and suicide risk level.

Clinical staff should be familiar with indications, policies for appropriate pharmacologic intervention, seclusion, restraints, and body and belongings searches.

5.2.2.2 Release from Emergency Department

Release from the emergency department with follow-up recommendations may be possible after a suicide attempt or in the presence of suicidal ideation/plan when:

- Suicidality is a reaction to precipitating events (e.g., exam failure, relationship difficulties), particularly if the patient's view of the situation has changed since coming to the emergency department.
- Plan/method and intent have low lethality.
- Patient has stable and supportive living situation.
- Patient is able to cooperate with recommendations for follow-up, with treatment provider contacted, if possible, if applicable.
- Patient is provided with instructions on the available emergency response services, and they are able to contract for safety.

Steps required prior to leaving the hospital or facility:

- Before the person leaves the hospital or other facility, he/she should be given a management plan including the level of support to be provided by the service and written information about how to seek further help, including a 24-h telephone number and the name of a contact person.
- The management plan should include the date and in some cases even the time that a reassessment of risk will be undertaken.
- The management plan should be negotiated with the person and family/support person. Information concerning the management of the person should also be conveyed when possible to the referring source, treating psychiatrist, general practitioner, and other relevant health providers in contact with the person.

5.2.2.3 Outpatient Suicide Management

Outpatient treatment may be beneficial in the following circumstances:

- Patients with borderline personality disorder with chronic suicidal behavior but with no acute exacerbation.
- Patient has chronic suicidal ideation with no intent.
- Self-injury without prior attempts.
- Having a safe and supportive circle of care and living situation and an ongoing outpatient psychiatric care.
- If patient is determined to have no intent to die from their self-injury and their behavior is determined to be of low lethality (e.g., superficial cutting or burning) and does not require medical attention.

Developing a management plan for a person in the community (outpatient)

When the patient is being managed in the community, the following information should be provided to the patient and the circle of support:

- The name of the clinician that patient should contact first and their phone contact should be provided.
- Time and place for the reassessment interview according to the suicide risk level.
- Detailed information about the 24-h number of mobile crisis or emergency services.

If concern increases because suicide risk increases or the person's situation changes and earlier reassessment is required, the following information should be provided:

1. How the outpatient team will respond
2. The scope and limitations of the outpatient services
3. Name and contact of the clinician who should be contacted first:
   (a) Name and contact of the next service that should assess the patient if the outpatient team cannot be reached such as mobile crisis, emergency services, 911, police, or going to the emergency department (use that order when possible).

(b) Information on how to manage a person with suicidal behavior. The most important instructions are maintaining appropriate supervision, knowing where the person is at all times and who they are with, and how to contact the team for an urgent reassessment.
(c) Information on the next steps if a patient who has been assessed as at a medium or high risk of suicide does not attend a follow-up appointment.

(Contact mobile crisis, or emergency services, or 911, or police, or go directly to the emergency department.)

Contingency planning and safety planning require the clinician and the person at risk and/or their family or career to anticipate likely escalations of risk such as:

- Deterioration of family relationships
- Increase in symptoms (depression, insomnia, hallucinations, intensity of suicidal thoughts)
- Initial difficulty accessing the acute care service

Contingency planning is framed, communicated, and documented in the following manner:

If…, then the person will…,
The family will…,
The service will…

Example of safety plan

Step 1: My own warning signs
Intense fight with people
Drinking heavily, start planning an overdose, etc.
Step 2: Internal coping strategies—things I can do to distract myself without contacting anyone:
Go for a walk, call my friends, and play music
Step 3: Social situations and people that can help to distract me:
AA meeting
Group therapy meeting
Local coffee shop…
Step 4: People who I can ask for help
My pastor
My family member
My friend
Step 5: Professionals or agencies I can contact during a crisis
My clinician
Mobile mental crisis line or local help line
Local hospital emergency department

Step 6: Making the environment safe
– Locking my guns outside the home
– Keeping only 1 week of medications at home
– Do not keep alcohol at home
(Matarazzo et al. 2014)

Suicide prevention contracts (known as "no-harm contracts" or "contracts for safety")

- Potential utility needs to be weighed against potential limitations.
- Have been used clinically in either verbal or written form to assess or manage suicide risk.
- Sometimes viewed as helpful in judging the strength of the therapeutic alliance or the extent of the patient's ambivalence about seeking help if suicidal impulses occur.
- May provide an opportunity to educate patients about staff availability or coping with suicidal impulses.
- However, use of suicide prevention contracts is often overvalued.
- They do not act as legally binding contracts, and the evidence is not clear about their effectiveness.
- May inappropriately reduce clinical vigilance particularly if substituted for more detailed assessments of suicide risk.
- Characteristics of the individual patient, nature of the therapeutic alliance, and treatment setting must also be considered
- (Matarazzo et al. 2014; Puskar and Urda 2011; Edwards and Sachmann 2010; Stanley and Brown 2012).
- "Suicide prevention contracts are only as reliable as the state of the therapeutic alliance…As a result, the use of suicide prevention contracts in emergency settings or with newly admitted and unknown inpatients is not recommended. Furthermore, patients in crisis may not be able to adhere to a contract because of the severity of their illness. Suicide prevention contracts are also ill-advised with agitated, psychotic, or impulsive patients or when the patient is under the influence of an intoxicating substance."
- *Excerpted from the American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors* (APA 2013).

Low-risk patients include those who:

- Have modifiable risk factors and strong protective factors
- Have thoughts of death, but do not have a plan, intent, or behavior

Interventions for low-risk patients include:

- Outpatient referral
- Symptom reduction
- Providing emergency information, including both local phone numbers mobile crisis and provincial mobile crisis number

5.2.3 Select Other Specific Measures to Manage the Suicidal Patient Based on Your Clinical Judgment

5.2.3.1 Assessment and Management of Chronically Suicidal Patients

- Detailed management plans that list both chronic and acute symptoms should be developed with the person. This assists clinicians in determining whether a person is presenting with new/greater risk than their ongoing risk. All services working with this person should have a copy of these plans, and they should be regularly reviewed and updated.
- Emergency departments should contact mental health services (even if only by phone) when a chronically suicidal person presents. Care must be taken not to downplay the seriousness of attempts.
- When a person who is well-known to the service arrives at the emergency department, it is important that their file is obtained, their management plan consulted, and ideally their case manager or therapist contacted in case they are now experiencing from additional stressors or a significant change in their mental illness(es).
- Inpatient admission or referral to high support services (such as crisis respite) may be necessary when the person's suicidality is exacerbated by an acute life stressor or if they also develop an Axis I disorder.

5.2.3.2 What Are Some of the Helpful Tips for Managing Patients with Borderline Personality Disorder in Primary Care Setting?

- Learn about common clinical presentations and causes of undesirable behavior.
- Validate the patient's feelings by naming the emotion you suspect, such as fear of abandonment, anger, shame, and so on, before addressing the "facts" of the situation, and acknowledge the real stresses in the patient's situation.
- Avoid responding to provocative behavior.
- Schedule regular, time-limited visits that are not contingent on the patient being "sick."
- Set clear boundaries at the beginning of the treatment relationship, and do not respond to attempts to operate outside of these boundaries unless it is a true emergency.
- Make open communication with all other providers a condition of treatment.
- Avoid polypharmacy and large-volume prescriptions of potentially toxic medications in overdose (including tricyclic antidepressants, cardiac medications, and benzodiazepines).
- Avoid prescribing potentially addicting medications such as benzodiazepines or opiates. Inform patients of your policies regarding these medications early in the treatment relationship, so they are aware of your limits.

- Set firm limits on manipulative behavior while avoiding being judgmental.
- Do not reward difficult behavior with more contact and attention. Provide attention based on a regular schedule rather than being contingent on behavior.
- During crisis, have a written consistent plan across providers, and be ready to implement the plan.
- DBT psychotherapy is a helpful modality in managing patients with BPD (Dubovsky 2014).

5.3 Hospitalization of Patients with Borderline Personality Disorder (BPD)

If BPD patients require admission to hospital, then brief admissions to hospital are recommended. Prolonged psychiatric hospitalization should be avoided because this is typically counter-therapeutic and may foster and increase dependency needs and cause behavior regression. Brief admission can be used to reduce repeated self-harm and suicidal crisis along with the prevention of death. It can also be used to facilitate outpatient treatment through lowering rates of treatment disruption.

A quick return to the community and facilitating community-based treatment should be one of the goals of the brief admission.

Literature suggested that the duration of a brief admission ranged from 3 nights to a maximum of 14 nights depending on the study.

The interventions used during hospital admission:

- Provide active cognitive and affective support to integrate/move away from present stressor.
- Facilitate therapeutic alliance and develop a working alliance.
- Help give expression to overwhelming experiences of rage, helplessness, or deception.
- Promote insight into repetitive patterns of behavior, perception, and attachment.
- Address life events involving separation and loss with impaired mourning of significant affective relationships as main target of treatment.
- Interpersonal intervention with family, close friends, and especially partners to clarify communication processes and decrease acute conflicts.
- Teaching of coping behaviors to patient and family.
- Psychoeducation with respect to illness, treatment, and problems to be expected following discharge and how to respond to them.
- Help with organization of acute outpatient treatment following hospital discharge.

References

APA. American Psychiatric Association Practice Guidelines for the assessment and treatment of patients with suicidal behaviors. Washington, DC: APA; 2013.

Dubovsky AN, Kiefer MM. Borderline personality disorder in the primary caresetting. Med Clin North Am. 2014;98(5):1049–64.

Edwards SJ, Sachmann MD. No-suicide contracts, no-suicide agreements, and no-suicide assurances: a study of their nature, utilization, perceived effectiveness, and potential to cause harm. Crisis. 2010;31(6):290–302.

Matarazzo BB, Homaifar BY, Wortzel HS. Therapeutic risk management of the suicidal patient: safety planning. J Psychiatr Pract. 2014;20(3):220–4.

Puskar K, Urda B. Examining the efficacy of no-suicide contracts in inpatient psychiatric settings: implications for psychiatric nursing. Issues Ment Health Nurs. 2011;32(12):785–8.

Sher L. Suicide medical malpractice: an educational overview. Int J Adolesc Med Health. 2015;27(2):203–6.

Stanley B, Brown GK. The case against no-suicide contracts: the commitment to treatment statement as a practice alternative. J Clin Psychol. 2012;62(2):243–51.

Documentation and Communication

6

6.1 Overview on Malpractice and Documentation

An educational review published by L Sher in 2015 stated that for a physician to be found liable to a patient for malpractice, four essential elements must be proved to sustain an assertion of malpractice: duty, negligence, harm, and causation.

The review mentions that the incidence of malpractice litigation in the field of psychiatry is increasing and that the most common malpractice claim related to psychiatric practice is the failure to provide reasonable protection to patients from killing themselves.

It is imperative for clinicians to have a good documentation. Careful documentation of evaluations and treatment interventions with a description of changes related to the patient's clinical condition indicates clinically and legally appropriate care. The failure to document suicide risk assessments and interventions may give the court reason to conclude they were not done (Sher 2015).

6.1.1 The Importance of Documentation

Careful documentation of assessment and management with a description of changes related to the patient's illness indicates clinically and legally appropriate psychiatric care.

Some researchers suggest that taking more time to appropriately document a suicide risk assessment can have a significant benefit in reducing clinician stress and financial burden defending a lawsuit or professional body complaint.

Sometimes the complaints are filed years after the suicide. Relying on memory can be very difficult months or years later.

Sometimes medical records are reviewed prior to initiating lawsuit; therefore, the quality of documentation can decide whether a malpractice lawyer accepts or declines a suicide case.

J. Sadek, *A Clinician's Guide to Suicide Risk Assessment and Management*,
https://doi.org/10.1007/978-3-319-77773-3_6

> Defendant physicians and their attorneys often argue that it's impossible and/or too time-consuming to document everything. While there is some truth to that position, one thing is clear: vital information must be documented, and it is difficult to come up with something more vital for a psychiatric patient than suicide risk. Documenting properly will take some extra time, but this intelligent use of time can pay huge dividends. In the big picture, taking an extra 5 minutes to properly document a suicide assessment can save years of stress and hundreds of hours dedicated to defending a lawsuit. Quote (Simpson and Stacy 2004)

6.2 Documentation Requirement of SRA

- Date of the assessment (included in the NS tool).
- Reasons of the assessment (included in the NS tool).
- Risk factor (included in the NS tool).
- Actions taken regarding firearms and other means of suicide.
- Protective factors (included in the NS tool).
- Risk level (included in the NS tool).
- Basis for the risk level and plan (space is available at the NS tool to document).
- The others that receive communication and consultation about patient's risk (included in the tool).
- Management plan (included in the tool).
- Plan for patients with chronic risk particularly patients with borderline personality disorder (space is available at the tool to document).
- For patients who are hospitalized, it is also important to document basis of involuntary treatment (must be recorded in the involuntary treatment (IPT) forms).
- Contact details for the person, relatives, and treating professionals.
- Sources of corroborative history and outcome from contact with each source (with consent).

6.3 Documentation on Inpatient Units for Patients Admitted for Suicide-Related Issues

In addition to the above issues, important points of documentation include:

- Level of observation on admission (one-to-one versus every-15-minute checks, etc.)
- Changes in the level of observations, progress, and outcome
- Observation level during transitions between treatment units
- The issuance of passes
- Marked changes in the clinical condition of the patient
- Discharge evaluation
- Response to clinical interventions
- Outpatient plan for follow-up and monitoring

6.4 Continuity of Care for Suicidal Patients

A common factor identified by research is the failure or breakdown in the continuity of care for mental health problems.

A summary issued by the US Center for Military Health Policy Research summarized the problem:

Having a "chain of care" and "warm transfers" would prevent individuals from "falling through the cracks of the care system" and is seen as particularly important for individuals suffering from a mental health problem or experiencing suicidal ideation or intent.

The center recommended smooth transitions between providers during transition times so that there is always care available. Increased occurrences of suicidal ideation or behavior appear to be associated with disruptions in patient medication access and continuity.

The documentation of continuity of care includes the following:

- Transition from emergency room to inpatient or outpatient or home
- Move to a different area
- Transition from hospital to the community
- Transition from child and adolescent system to an adult mental health system
- Other areas of transition such as military deployments and redeployment

Communication to other treatment team members and circle of care should be documented. Exact names should be documented, and the method of communication whether verbal or written should be documented.

6.5 Documentation in Emergency Room

Recent research suggested that documentation of suicide risk assessment is particularly challenging in emergency room. Some emergency medicine physicians felt a pressure to complete assessments quickly and treat multiple patients simultaneously in an area of high noise and activity. As a result, over 50% of the time, physicians failed to document many of the social (e.g., presence of a support system), psychological (e.g., mood and substance use disorders), and suicide-specific (e.g., preparation for and rehearsal of suicide) risk factors when conducting suicide risk assessments within the ED, despite having been indicated as important by the same physicians and by the suicidology literature (Reshetukha et al. 2018).

A retrospective chart review of psychiatric evaluations performed by psychiatry residents during a 1-year period in the psychiatric emergency services of a large, urban, academic medical center found that documentation was deficient in multiple areas, with even the presence/absence of suicidal ideations not being documented in all evaluations.

The study suggested that emphasis on documentation of assessments is paramount while training residents in suicide risk assessment. It also indicated that using built-in "clickable" options selectively improved documentation especially regarding risk and protective factors (Tanguturi et al. 2017).

The author of this book invites clinicians to use of the Sadek Suicide Prevention Assessment (SSPA) Tool to cover the different areas required for documentation of suicide risk assessment and intervention.

References

Reshetukha TR, Alavi N, Prost E, Kirkpatrick RH, Sajid S, Patel C, Groll DL. Improving suicide risk assessment in the emergency department through physician education and a suicide risk assessment prompt. Gen Hosp Psychiatry. 2018;52:34–40.

Simpson S, Stacy M. Avoiding the malpractice snare: documenting suicide risk assessment. J Psychiatr Pract. 2004;10(3):185–9.

Sher L. Suicide medical malpractice: an educational overview. Int J Adolesc Med Health. 2015;27(2):203–6.

Tanguturi Y, Bodic M, Taub A, Homel P, Jacob T. Suicide risk assessment by residents: deficiencies of documentation. Acad Psychiatry. 2017;41(4):513–9.

7 Suicide Risk Assessment Quality Monitoring

7.1 Audit Process

- Clinical audit will facilitate quality improvement by ensuring adherence to the standards required around suicide risk assessment. It will also inform the system on future training needs.
- Random charts are selected from each area for the scheduled audit (outpatient, emergency room, and inpatient).
- An audit should be conducted at least once a year.
- Results of the audit should remain confidential and not directed to put blame on specific individuals. It is helpful to inform the system on areas of quality improvement.

7.2 Emergency Department Audit Checklist

- Date and time of assessment documented and signed on the tool
- Reason for the assessment documented on the tool
- Risk and protective factors identified on the tool
- Risk level identified and documented on the tool
- Rationale for formulating the risk and management plan explained on the tool
- Communication plan documented on the tool
- Management plan documented on the tool
- When the patient is discharged from ED, there should be documentation of:
  - The date and time of the follow-up appointment
  - Key contacts to call for emergency purposes
- Information given to family and/or circle of care about key contacts such as mobile crisis number or responsible clinician when there is a concern about the patient

J. Sadek, *A Clinician's Guide to Suicide Risk Assessment and Management*,
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7.3 Psychiatric Inpatient Audit Checklist

- Date and time of assessment documented on the tool
- Reason for the assessment documented on the tool
- Risk and protective factors identified on the tool
- Risk level identified and documented on the tool
- Rationale for formulating the risk and management plan explained on the tool
- Communication plan documented on the tool
- Management plan documented on the tool
- When the patient is discharged from the inpatient unit, there is documentation of:
  - The date and time of the follow-up appointment
  - Key contacts to call for emergency purposes
- Information given to family and/or circle of care about key contacts such as mobile crisis number or responsible clinician when there is a concern about the patient

7.4 Mental Health Outpatient Audit Checklist

- Date and time of assessment documented on the tool
- Reason for the assessment documented on the tool
- Risk and protective factors identified on the tool
- Risk level identified and documented on the tool
- Rationale for formulating the risk and management plan explained on the tool
- Communication plan documented on the tool
- Management plan documented on the tool
- When the patient is discharged from ED, there is documentation of:
  - The date and time of the follow-up appointment
  - Key contacts to call for emergency purposes
- Information given to family and/or circle of care about key contacts such as mobile crisis number or responsible clinician when there is a concern about the patient
- If the patient did not attend the appointment, documentation of the next follow-up appointment or safety plan should be present in the chart.

7.4.1 Examples of Audit Findings

7.4.1.1 Example 1

Setting: Emergency Department

Purpose: To determine the quality of psychiatric risk assessments conducted by Mental Health and Addiction Services clinicians for patients presenting to the emergency department following an attempted suicide

Audit method: Retrospective audit. Randomized audit of 376 files

Audit period: 12-month period from 1 July 2015 to 30 June 2016

Main findings:

- Interactions with family members were recorded in less than half of the cases.
- Clinicians failed to record judgements about future suicidal behaviors.
- Clinical guidelines regarding cultural issues were not followed in majority of cases (De Beer et al. 2018).

7.4.1.2 Example 2

A de-identified retrospective audit examined the demographics of Indigenous Australians dying by suicide in the Kimberley region of Western Australia during the period 2005–2014 found that:

- Indigenous suicide rates in that region have dramatically increased in the last decade.
- An overall trend upwards in Indigenous youth suicide and Indigenous female suicides (Campbell et al. 2016a, b).

References

Campbell A, Balaratnasingam S, McHugh C, Janca A, Chapman M. Alarming increase of suicide in a remote Indigenous Australian population: an audit of data from 2005 to 2014. World Psychiatry. 2016a;15(3):296–7.

Campbell A, Chapman M, McHugh C, Sng A, Balaratnasingam S. Rising Indigenous suicide rates in Kimberley and implications for suicide prevention. Australas Psychiatry. 2016b;24(6):561–4.

De Beer W, DeWitt B, Schofield J, Clark H, Gibbons V. An audit of risk assessments for suicide and attempted suicide in ED: a retrospective review of quality. N Z Med J. 2018;131(1470):14–21.

Case Studies

8

8.1 Case 1: Anna

Identifying information: Anna O is a 21-year-old female who lives alone and works at a restaurant.

Circumstances of referral and chief complaints: The patient was brought by a friend to ER. Anna told her friend that she was cutting her wrists. Her friend found some blood on the floor and took her to ER.

Stressors: Her boyfriend left her 2 days prior to this ER visit.

Suicide-related questions: The patient said that she has been cutting since she was 13 years old. She does not wish to die. The cutting was impulsive. Anna called her friend asking for help. She does not feel like cutting now and says that she wants to go home and go to work that evening.

History of present illness: The patient reported a fluctuating mood every day. Now her mood is good. She reported poor concentration and attention. Her sleep has been poor for years. She has good appetite and denies feelings of guilt. She loves yoga and soccer. She plays in two leagues. She also loves her job. From time to time, she finds herself crying for no reason. She worries about everything and cannot control her anxiety. Her energy is good. She becomes irritable and angry very easily. She had significant anger episodes that contributed to why her boyfriend left.

Alcohol and drug use: Bing drinks on weekends and smokes 1 g of weed daily

Past psychiatric history: No previous contact with mental health

Medical history: Allergic to penicillin. Healthy

Family history: The patient has one half-brother and one half-sister. Parents were 15 and 16 years old when they had her. Positive family history of depression, anxiety, and ADHD. She has great relationship with her parents.

Personal history: Her mother smoked during the pregnancy. She dropped out after grade 11 and was not attending classes. She was sexually abused by her grandfather at age 6. She failed grade 7 and 8 and had several academic and learning problems. She never kept partners for more than 6 months and had 23 boyfriends so

J. Sadek, *A Clinician's Guide to Suicide Risk Assessment and Management*,
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far. She identifies herself as bisexual. She has been working in restaurants after grade 11 and has been in her current job for 2 years. Anna has many friends, but she gets bored easily, stops talking to her old friends, and looks for new friends.

Collateral information: The patient agreed that clinician talk to her parents who confirmed the long-term nature of the suicidal behavior. They said that she is very impulsive when it comes to drug use and spending money.

What are the risk factors for suicide in this case?
What is the risk level in this case and how did you come up with this conclusion? Low
How are you going to manage this patient? Regular follow-up

Interview risk profile	**Individual risk profile**
☐ Suicidal thinking or ideation ☐ Access to lethal means ☐ Suicide intent or lethal plan or plan for after death (note) ☐ Hopelessness ☐ Intense emotions: rage, anger, agitation, humiliation, revenge, panic, and severe anxiety ☐ Current alcohol or substance intoxication/ problematic use ☐ Withdrawing from family and friends ☐ Poor reasoning and judgment ☐ Clinical intuition: assessor concerned ☐ Recent dramatic change in mood ☐ Recent crisis/conflict/loss	☐ Ethnic and cultural risk group or refugee, LGBT ☐ Family history of suicide ☐ Trauma: as domestic violence/ sexual abuse/neglect ☐ Poor self-control: impulsive/ violent/aggression ☐ Recent suicide attempt ☐ Past suicide attempts ☐ Mental illness or addiction ☐ Depression/anhedonia ☐ Psychotic ☐ Command hallucinations ☐ Recent admission/discharge/ED visits ☐ Chronic medical illness/pain ☐ Disability or impairment ☐ Collateral information supports suicide intent
Illness management	**Circle of support**
☐ Lack of clinical support ☐ Non-compliance or poor response to treatment	☐ Lack of family/friends support ☐ Caregiver unavailable ☐ Frequent change of home

Sadek Suicide Prevention Assessment (SSPA)Tool

Anna
Case #1

Suicide Risk Assessment and Intervention Tool

Date **Time** **Assessor** **Diagnosis**

Reason: MH assessment_____

Interview risk profile	**Individual risk profile**	**Risk buffers–not to be used to determine degree of risk**
Suicidal thinking or ideation	Ethnic and cultural risk group or refugee	✓ Has reason to live/hope
Access to lethal means	Family history of suicide	✓ Social support
Suicide intent or lethal plan or plan for after death (note)	Trauma: as domestic violence	✓ Responsibility for family/kids/pets
Hopelessness	✓ /sexual abuse/neglect	✓ Capacity to cope/resilience
✓ Intense emotions: rage, anger, agitation, humiliation, revenge, panic, and severe anxiety	✓ Poor self-control: impulsive/ violent/aggression	Religion/faith
Current alcohol or substance intoxication/ problematic use	Recent suicide attempt	Strength for managing risk
Withdrawing from family and friends	Other past suicide attempts, esp. with low rescue potential	**Communication plan**
Poor reasoning/judgment	✓ Mental illness or addiction	Verbal (V) Written/fax (W)
Clinical intuition: assessor concerned	Depression/anhedonia	Nurse: W
Recent dramatic Change in mood	Psychotic	Physician: W
✓ Recent crisis/conflict/ loss	Command hallucinations	SDM/family: V
	Recent admission/ discharge/ED visits	Mobile crisis: V
Illness management	Chronic medical illness/ pain	Others:
Lack of clinical support	Disability or impairment	✓ Documentation in chart
Non-compliance or poor response to treatment	Collateral information supports suicide intent	**Management plan**
		Follow patient care plan for chronic risk
	Circle of support	✓ Regular outpatient follow-up
	Lack of family/ friends support	Removal of lethal means
	Caregiver unavailable	Urgent outpatient follow-up
	Frequent change of home	Admit to a psychiatric unit
		Routine observation
		Close observation q15m
		Constant observation

Suicide risk level: Risk assessment is based on clinical judgment and not based on number of items checked. The checklist is intended to guide the clinical decision only.

Risk level: **High** **Moderate** **x Low** Signature: _____

Anna wants to live. She mentioned that she had been cutting for many years. She has no intent nor a plan to die. She has good family support. She will be referred to outpatient follow-up.

For information about this form, contact Dr. Joseph Sadek at joseph.sadek@nshealth.ca

8.2 Case 2: Shawn

Identifying information: He is a 41-year-old man who lives in Bridgewater with his brother. He works as a fisherman but was fired from his job 3 months ago.

Circumstances of referral and chief complaints: The patient was brought by ambulance to ER. His brother was away but decided to come back home 1 day early. He found his brother in the car, while the engine is running and fumes all over the garage. He opened the car door, got his brother out, and called 911.

Stressors: The patient was fired from his job after being humiliated by his manager 3 months ago. His wife left him and took his 9-year-old son with her 2 months ago. He moved in with his brother then. He discovered she was cheating on him for 2 years. He started having severe pain and difficulty breathing a year ago, and after several investigations, he was diagnosed with cancer lung.

Suicide-related questions: After spending 3 days in a medical unit, the patient was seen by the psychiatrist. He said he has no suicidal thoughts and he tried to elope from the medical unit. He informed the staff that his life is his own business and does not want to discuss anything. "I just want to be left alone," he said. He refused to answer questions and looked sad and tearful.

Past psychiatric history: The patient had two documented depressive episodes in the past. He was treated successfully with antidepressants. No previous suicide attempts.

Medical history: NKA, has been diagnosed with lung cancer 1 year ago, and is currently in remission

Family history: The patient has one healthy brother. Parents have been divorced for years. Father is alcoholic and grandfather had schizophrenia.

Personal history: The patient was born in Halifax. No abnormality documented about his development. He struggled in school but was able to finish grade 12 and then worked as a fisherman. He struggled in school and failed several grades but was pushed through until he completed grade 12.

Shawn had many friends as a child and continued to have friends as an adult. He was married for 11 years and had one previous long-term relationship prior to this marriage.

Collateral information: Brother said that he found a long suicide note at home. He also found a recent will in his room. He said his brother stopped eating and was isolating himself in the room. He stopped going out, and his alcohol consumption increased dramatically in the past few months. He was drinking 24 beers daily and was very sad and lonely. Two weeks before the attempt, he told his brother that he is grateful for everything he did for him. His brother was surprised at that comment but did not consider that his younger brother is planning to kill himself.

What are the risk factors for suicide in this case?
What is the risk level in this case and how did you come up with this conclusion? High
How are you going to manage this patient? Admit with constant observation

Interview risk profile	**Individual risk profile**
☐ Suicidal thinking or ideation ☐ Access to lethal means ☐ Suicide intent or lethal plan or plan for after death (note) ☐ Hopelessness ☐ Intense emotions: rage, anger, agitation, humiliation, revenge, panic, and severe anxiety ☐ Current alcohol or substance intoxication/ problematic use ☐ Withdrawing from family and friends ☐ Poor reasoning/judgment ☐ Clinical intuition: assessor concerned ☐ Recent dramatic change in mood ☐ Recent crisis/conflict/loss	☐ Ethnic and cultural risk group or refugee, LGBT ☐ Family history of suicide ☐ Trauma: as domestic violence/ sexual abuse/neglect ☐ Poor self-control: impulsive/ violent/aggression ☐ Recent suicide attempt ☐ Past suicide attempts ☐ Mental illness or addiction ☐ Depression/anhedonia ☐ Psychotic ☐ Command hallucinations ☐ Recent admission/discharge/ED visits ☐ Chronic medical illness/pain ☐ Disability or impairment ☐ Collateral information supports suicide intent
Illness management	**Circle of support**
☐ Lack of clinical support ☐ Non-compliance or poor response to treatment	☐ Lack of family/friends support ☐ Caregiver unavailable ☐ Frequent change of home

Sadek Suicide Prevention Assessment (SSPA)Tool

Shawn
Case #2

Suicide Risk Assessment and Intervention Tool

Date **Time** **Assessor** **Diagnosis** major depressive episode

Reason: MH assessment

Interview risk profile	**Individual risk profile**	**Risk buffers–not to be used to determine degree of risk**
✓ Suicidal thinking or ideation	Ethnic and cultural risk group or refugee	✓ Has reason to live/hope
Access to lethal means	Family history of suicide	Social support
✓ Suicide intent or lethal plan or plan for after death (note)	Trauma: as domestic violence /sexual abuse/neglect	Responsibility for family/kids/pets
✓ Hopelessness	Poor self-control: impulsive/ violent/aggression	Capacity to cope/resilience
✓ Intense emotions: rage, anger, agitation, humiliation, revenge, panic, and severe anxiety	Recent suicide attempt	Religion/faith
✓ Current alcohol or substance intoxication/ problematic use	Other past suicide attempts, esp. with low rescue potential	Strength for managing risk
✓ Withdrawing from family and friends	✓ Mental illness or addiction	**Communication plan**
✓ Poor reasoning/judgment	✓ Depression/anhedonia	Verbal (V) Written/fax (W)
✓ Clinical intuition: assessor concerned	Psychotic	✓ Nurse: W
Recent dramatic Change in mood	Command hallucinations	✓ Physician: W
✓ Recent crisis/conflict/ loss	Recent admission/ discharge/ED visits	✓ SDM/family: V
	✓ Chronic medical illness/ pain	Mobile crisis: V
Illness management	Disability or impairment	Others:
Lack of clinical support	✓ Collateral information supports suicide intent	Documentation in chart
Non-compliance or poor response to treatment		**Management plan**
	Circle of support	Follow patient care plan for chronic risk
	Lack of family/ friends support	Regular outpatient follow-up
	Caregiver unavailable	Removal of lethal means
	Frequent change of home	Urgent outpatient follow-up
		✓ Admit to a psychiatric unit
		Routine observation
		Close observation q15m
		✓ Constant observation

Suicide risk level: Risk assessment is based on clinical judgment and not based on number of items checked. The checklist is intended to guide the clinical decision only.

Risk level: X **High** ☐ **Moderate** ☐ **Low** Signature: _____

The patient is at very high risk of suicide. He was accidentally rescued by his brother. He has intent to die. He had a serious plan that he acted on. He is uncooperative and has multiple stressors. This patient will need involuntary admission and constant observation in hospital until reassessed.

For information about this form, contact Dr. Joseph Sadek at joseph.sadek@nshealth.ca

8.3 Case 3: Diane

Identifying information: A 29-year-old female who lives with her female partner and two children ages 2.5 and 7 months old

Circumstances of referral and chief complaints: The patient was brought to ER by her partner. The patient reported the following symptoms:

Depressed mood, poor attention, excessive guilt, anxiety attacks, forgetfulness, crying spells, excessive worry, hyperactivity and impulsivity, fatigue, and irritability

Alcohol and drug use: Drinks twice a month. No drug use

Review of symptoms: When asked about suicide, she was very vague and evasive. She said that her life has not been good. She is not a good mother. She started crying and said that she will be punished and deserves death penalty.

While waiting alone in the room, she was observed by the nursing staff attending to voices. When asked about these communication, she said that these voices know all her sins and they will "make it public" if she does not respond to their commands and requests. After long pause, she said that they want her to stab her children and then herself to end this miserable life.

Medications: Currently takes citalopram 40 mg AM. In the past she was prescribed Zoloft and Wellbutrin, and as a child she said she was given Adderall and Ritalin for ADHD that was diagnosed by her pediatrician at age 7.

Medical history: NKA. Had two bone fractures in the past after being gang raped

Family history: The patient has a half-sister and three half-brothers. Parents divorced when she was 3 years old. She has a positive family history of depression, anxiety, substance use disorder, and ADHD. Father had schizophrenia and he died by suicide 2 years ago.

Personal history: The patient was born in Alberta. She came to NS at age 4 with her father and his girlfriend.

She reported normal developmental milestones.

She did not do well in school because she hated school. Teachers did not like her. She was obese, and other kids called her fat kid.

She always had few friends. She had a boyfriend who left her then came with his friends and gang raped her. She started having female partners after that. She described herself as bisexual.

Her older daughter was from a one-night relationship and the young one was the product of rape. The patient was receiving social assistance after being fired from her last job as a cashier in a supermarket.

What are the risk factors for suicide in this case?
What is the risk level in this case and how did you come to this conclusion?
High-moderate
How are you going to manage this patient? Admission to hospital

Interview risk profile	**Individual risk profile**
☐ Suicidal thinking or ideation ☐ Access to lethal means ☐ Suicide intent or lethal plan or plan for after death (note) ☐ Hopelessness ☐ Intense emotions: rage, anger, agitation, humiliation, revenge, panic, and severe anxiety ☐ Current alcohol or substance intoxication/ problematic use ☐ Withdrawing from family and friends ☐ Poor reasoning/judgment ☐ Clinical intuition: assessor concerned ☐ Recent dramatic change in mood ☐ Recent crisis/conflict/loss	☐ Ethnic and cultural risk group or refugee, LGBT ☐ Family history of suicide ☐ Trauma: as domestic violence/ sexual abuse/neglect ☐ Poor self-control: impulsive/ violent/aggression ☐ Recent suicide attempt ☐ Past suicide attempts ☐ Mental illness or addiction ☐ Depression/anhedonia ☐ Psychotic ☐ Command hallucinations ☐ Recent admission/discharge/ED visits ☐ Chronic medical illness/pain ☐ Disability or impairment ☐ Collateral information supports suicide intent
Illness management	**Circle of support**
☐ Lack of clinical support ☐ Non-compliance or poor response to treatment	☐ Lack of family/friends support ☐ Caregiver unavailable ☐ Frequent change of home

Sadek Suicide Prevention Assessment (SSPA)Tool

Diane
Case #3

Suicide Risk Assessment and Intervention Tool

Date **Time** **Assessor** **Diagnosis**

Reason: MH assessment_____

Interview risk profile	**Individual risk profile**	**Risk buffers–not to be used to determine degree of risk**
✓ Suicidal thinking or ideation	✓ Ethnic and cultural risk group or refugee	✓ Has reason to live/hope
✓ Access to lethal means	✓ Family history of suicide	Social support
✓ Suicide intent or lethal plan or plan for after death (note)	Trauma: as domestic violence	Responsibility for family/kids/pets
Hopelessness	✓ /sexual abuse/neglect	Capacity to cope/resilience
✓ Intense emotions: rage, anger, agitation, humiliation, revenge, panic, and severe anxiety	✓ Poor self-control: impulsive/ violent/aggression	Religion/faith
Current alcohol or substance intoxication/ problematic use	Recent suicide attempt	Strength for managing risk
Withdrawing from family and friends	Other past suicide attempts, esp. with low rescue potential	**Communication plan**
✓ Poor reasoning/judgment	✓ Mental illness or addiction	Verbal (V) Written/fax (W)
✓ Clinical intuition: assessor concerned	Depression/anhedonia	✓ Nurse: W
Recent dramatic change in mood	✓ Psychotic	✓ Physician: W
Recent crisis/conflict/ loss	Command hallucinations	✓ SDM/family: V
	Recent admission/ discharge/ED visits	✓ Mobile crisis: V
Illness management	Chronic medical illness/ pain	Others:
Lack of clinical support	Disability or impairment	✓ Documentation in chart
Non-compliance or poor response to treatment	✓ Collateral information supports suicide intent	**Management plan**
		Follow patient care plan for chronic risk
	Circle of support	Regular outpatient follow-up
	Lack of family/ friends support	Removal of lethal means
	Caregiver unavailable	Urgent outpatient follow-up
	Frequent change of home	Admit to a psychiatric
		✓ unit
		Routine observation
		✓ Close observation q15m
		Constant observation

Suicide risk level: Risk assessment is based on clinical judgment and not based on number of items checked. The checklist is intended to guide the clinical decision only.

Risk level: X **High** □ **Moderate** □ **Low** Signature: _____

Analysis of risk, comments and collateral information: The patient is at high risk of suicide. She hears voices (command hallucinations) and she feels she needs to act on it. She is also at risk of harming her two children.

For information about this form, contact Dr. Joseph Sadek at joseph.sadek@nshealth.ca

8.4 Case 4: Christine C

Identifying information: She is a 26-year-old white single female.

Circumstances of referral and chief complaints: Who walked to ER on December 23. She complained that she cannot stand life anymore. She said "I will go ahead and end it all." She was living with a boyfriend who broke up with her that evening and asked her to leave his house. She has no place to go. Her mother lives approximately 5 h away and her father is deceased. She has no friends in town.

Review of symptoms: The patient said she has been stressed, anxious, and depressed the past month. She said "Christmas was very hard, remembering that dad used to drink a lot around that time." He physically and sexually abused her and her only sister as kids. She talked a lot about her traumatic memories of the abuse she suffered. She kept talking about the nights she spent crying after being hit by the built and pushed on the stairs. She remembered when she was taken to hospital after one of these episodes where her father kept hitting her until she lost consciousness. Her head was open and was taken to hospital. Her mother told the nurses in the hospital that she fell from her bike.

She has been experiencing frequent nightmares for the past 10 years.

Christine reported daily panic episodes, worrying about everything, and inability to relax. Her appetite and sleep did not change. Her mood has been low and frustrated. She enjoys watching Netflix but she stopped that a month ago. She has been feeling guilty for her sister's death a year ago. She did not talk to her sister and finally received a text message from her asking to meet. She ignored the text message, and the next day she learnt from the police that her sister jumped in front of the train in Toronto and died immediately.

Past psychiatric history: She was followed by her family doctor and never had any interaction with mental health. No previous admission and no history of receiving any type of psychotherapy.

Alcohol and drug use: She said she never used alcohol nor street drugs.

Medical history: She has no active medical problems other than Crohn's disease. NKA. One abortion at age 15

Medications: Her family doctor has kept her on venlafaxine 75 mg daily for the past 3 years, and she does not feel it is helping her.

Personal history: She is currently considering distant education or going to college full time to upgrade her education. She quit school in grade 11. Currently, she works part time at the Dollar Store.

What are the risk factors for suicide in this case?
What is the risk level in this case and how did you come to this conclusion?
How are you going to manage this patient?

Interview risk profile	**Individual risk profile**
☐ Suicidal thinking or ideation ☐ Access to lethal means ☐ Suicide intent or lethal plan or plan for after death (note) ☐ Hopelessness ☐ Intense emotions: rage, anger, agitation, humiliation, revenge, panic, and severe anxiety ☐ Current alcohol or substance intoxication/ problematic use ☐ Withdrawing from family and friends ☐ Poor reasoning/judgment ☐ Clinical intuition: assessor concerned ☐ Recent dramatic change in mood ☐ Recent crisis/conflict/loss	☐ Ethnic and cultural risk group or refugee, LGBT ☐ Family history of suicide ☐ Trauma: as domestic violence/ sexual abuse/neglect ☐ Poor self-control: impulsive/ violent/aggression ☐ Recent suicide attempt ☐ Past suicide attempts ☐ Mental illness or addiction ☐ Depression/anhedonia ☐ Psychotic ☐ Command hallucinations ☐ Recent admission/discharge/ ED visits ☐ Chronic medical illness/pain ☐ Disability or impairment ☐ Collateral information supports suicide intent
Illness management	**Circle of support**
☐ Lack of clinical support ☐ Non-compliance or poor response to treatment	☐ Lack of family/friends support ☐ Caregiver unavailable ☐ Frequent change of home

Sadek Suicide Prevention Assessment (SSPA)Tool

Christine
Case #4

Suicide Risk Assessment and Intervention Tool

Date **Time** **Assessor** **Diagnosis**

Reason: MH assessment_____

Interview risk profile	**Individual risk profile**	**Risk buffers–not to be used to determine degree of risk**
✓ Suicidal thinking or ideation	✓ Ethnic and cultural risk group or refugee	✓ Has reason to live/hope
Access to lethal means	✓ Family history of suicide	Social support
Suicide intent or lethal plan or plan for after death (note)	Trauma: as domestic violence	Responsibility for family/kids/pets
Hopelessness	✓ /sexual abuse/neglect	Capacity to cope/resilience
✓ Intense emotions: rage, anger, agitation, humiliation, revenge, panic, and severe anxiety	Poor self-control: impulsive/ violent/aggression	Religion/faith
Current alcohol or substance intoxication/ problematic use	Recent suicide attempt	Strength for managing risk
Withdrawing from family and friends	Other past suicide attempts, esp. with low rescue potential	**Communication plan**
Poor reasoning/judgment	✓ Mental illness or addiction	Verbal (V) Written/fax (W)
Clinical intuition: assessor concerned	✓ Depression/anhedonia	Nurse: W
Recent dramatic change in mood	Psychotic	✓ Physician: W
Recent crisis/conflict/ loss	Command hallucinations	✓ SDM/family: V
	Recent admission/ discharge/ED visits	Mobile crisis: V
Illness management	Chronic medical illness/ pain	Others:
Lack of clinical support	✓ Disability or impairment	✓ Documentation in chart
✓ Non-compliance or poor response to treatment	Collateral information supports suicide intent	**Management plan**
		Follow patient care plan for chronic risk
	Circle of support	Regular outpatient follow-up
	✓ Lack of family/ friends support	Removal of lethal means
	Caregiver unavailable	Urgent outpatient follow-up
	Frequent change of home	✓ Admit to a psychiatric unit
		✓ Routine observation
		Close observation q15m
		Constant observation

Suicide risk level: Risk assessment is based on clinical judgment and not based on number of items checked. The checklist is intended to guide the clinical decision only.

Risk level: **High** **X Moderate** **Low** Signature:_____

The patient may benefit from short-stay admission. She has suicidal thoughts after breakup and she has no place to go. The patient has a strong history of trauma and will benefit from adjustment in her medication. The hospital stay should be very short.

For information about this form, contact Dr. Joseph Sadek at joseph.sadek@nshealth.ca

Appendix A

Glossary

Circle of care: Circle of care may also be defined as "individuals and activities related to the care and treatment of a patient." Thus, it covers the healthcare providers who deliver care and services for the primary therapeutic benefit of the patient, and it covers related activities such as laboratory work and professional or case consultation with other healthcare providers.

Discharge from care: File closure or discharge from the system. Clinicians must document the level of risk before file is closed.

Entry into care: Entry into care is the first contact with a particular mental health and addiction service and varies depending on the structure of the particular service. Therefore, initial assessment could be an emergency department (ED) visit, preadmission assessment, admission to a new service, admission to an inpatient unit, or new patient to a community clinic.

Next step care provider: This can be a clinician, physician, or team, depending on who is involved in providing care and treatment at the point of transition.

Screening for suicide: Detecting patients/clients who require full suicide risk assessment and further evaluation by means of asking questions, obtaining history, and examining mental status.

Trauma informed: A trauma-informed context recognizes an approach to care that is sensitive to the impact of exposure to traumatic events on patients/clients and their families. It includes recognition of signs and symptoms of trauma in clients/patients and families along with responses that integrate knowledge about trauma into policies, procedures, and practices.

Suicidal ideation: Refers to thoughts, images, or fantasies of dying or killing oneself.

Suicide attempt: A purposeful self-inflicted act associated with the explicit or implicit intent to die.

Suicide (completed suicide): Death occurring as a result of a suicide attempt.

Self-harm (non-suicidal self-injury): Any self-inflicted destructive behavior that is not associated with the implicit or explicit attempt to die.

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Appendix B

Suicide Risk Assessment in Children and Adolescents

Some Warning Signs in Children and Adolescents

- Making suicidal statements
- Being preoccupied with death in conversation, writing, or drawing
- Giving away belongings
- Withdrawing from friends and family
- Having aggressive or hostile behavior
- Neglecting personal appearance
- Running away from home
- Risk-taking behavior, such as reckless driving or being sexually promiscuous
- A change in personality (such as from upbeat to quiet)

Common Risk Factors for Suicide in Children and Adolescents

- Depression or another mental disorder
- A parent with active mental health problems
- Previous suicide attempt
- A friend, peer, family member, or hero (such as a sports figure or musician) who recently attempted or died by suicide
- Disruptive or abusive family life
- History of sexual abuse
- History of being bullied

Other Risk Factors

- Possession or purchase of a weapon, pills, or other means of inflicting self-harm
- Drug or alcohol use problems
- Witnessing the suicide of a family member
- Problems at school, such as falling grades, disruptive behavior, or frequent absences

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- Loss of a parent or close family member through death or divorce
- Legal or discipline problems
- Stress caused by physical changes related to puberty, chronic illness, and/or sexually transmitted infections
- Withdrawing from others and keeping thoughts to themselves
- Uncertainty surrounding sexual orientation

Appendix C

References and Suggested Readings

Kutcher S, Chehil S. Suicide risk management: a manual for health professionals. Malden, MA: Blackwell Publishing Ltd.; 2007.

Palmer B, Pankratz V, Bostwick J. The lifetime risk of suicide in schizophrenia. Arch Gen Psychiatry. 2005;62:247–53.

Bostwick J, Pankratz V. Affective disorders and suicide risk: a reexamination. Am J Psychiatry 2000;157:1925–32.

Joiner T. Why people die by suicide. Cambridge, Harvard University Press; 2005.

Patel V, et al. Disease control priorities. Mental, neurological, and substance use disorders. 3rd ed. Washington, DC: World Bank Group; 2015.

Olfson M, Marcus SC, Bridge JA. Emergency department recognition of mental disorders and short-term outcome of deliberate self-harm. Am J Psychiatry. 2013;170:1142–50.

Hawton K, Casañas I, et al. Risk factors for suicide in individuals with depression: a systematic review. J Affect Disord. 2013;147(1–3):17–28.

Ronquillo L, Minassian A, Vilke GM, Wilson MP. Literature-based recommendations for suicide assessment in the emergency department: a review. J Emerg Med. 2012;43(5):836–42.

Bryan CJ, Corso KA, et al. Therapeutic alliance and change in suicidal ideation during treatment in integrated primary care settings. Arch Suicide Res. 2012;16(4):316–23.

Jobes DA. The Collaborative Assessment and Management of Suicidality (CAMS): an evolving evidence-based clinical approach to suicidal risk. Suicide Life Threat Behav. 2012;42(6):640–53.

Wortzel HS, Matarazzo B, Homaifar B. A model for therapeutic risk management of the suicidal patient. J Psychiatr Pract. 2013;19(4):323–6.

Wilcox HC, Wyman PA. Suicide Prevention Strategies for Improving Population Health. Child Adolesc Psychiatr Clin N Am. 2016;25(2):219–33.

Bolton JM, Gunnell D, Turecki G. Suicide risk assessment and intervention in people with mental illness. BMJ. 2015;351:4978.

J. Sadek, *A Clinician's Guide to Suicide Risk Assessment and Management*,
https://doi.org/10.1007/978-3-319-77773-3

Calear AL, Christensen H, Freeman A, et al. A systematic review of psychosocial suicide prevention interventions for youth. Eur Child Adolesc Psychiatry. 2016;25(5):467–82.

Turecki G, Brent DA. Suicide and suicidal behaviour. Lancet. 2016;387(10024):1227–39.

Chu C, Klein KM, Buchman-Schmitt JM, Hom MA, Hagan CR, Joiner TE. Routinized assessment of suicide risk in clinical practice: an empirically informed update. J Clin Psychol. 2015;71(12):1186–200.

Schaffer A, Isometsä ET, Azorin JM, et al. A review of factors associated with greater likelihood of suicide attempts and suicide deaths in bipolar disorder: part II of a report of the International Society for Bipolar Disorders Task Force on Suicide in Bipolar Disorder. Aust N Z J Psychiatry. 2015;49 (11):1006–20.

Bennett K, Rhodes AE, Duda S, Cheung AH, Manassis K, Links P, Mushquash C, Braunberger P, Newton AS, Kutcher S, Bridge JA, Santos RG, Manion IG, Mclennan JD, Bagnell A, Lipman E, Rice M, Szatmari P. A youth suicide prevention plan for canada: a systematic review of reviews. Can J Psychiatry. 2015;60(6):245–57.

Cheung G, Merry S, Sundram F. Medical examiner and coroner reports: uses and limitations in the epidemiology and prevention of late-life suicide. Int J Geriatr Psychiatry. 2015;30(8):781–92.

Inagaki M, Kawashima Y, Kawanishi C, et al. Interventions to prevent repeat suicidal behavior in patients admitted to an emergency department for a suicide attempt: a meta-analysis. J Affect Disord. 2015;175:66–78.

Dignam PT. Suicide prevention: let's start at the very beginning. Aust N Z J Psychiatry. 2015;49(1):16–7.

Fowler JC. Suicide risk assessment in clinical practice: Pragmatic guidelines for imperfect assessments. Psychotherapy. 2012;49(1):81–90.

Rimkeviciene J, O'Gorman J, De Leo D. Impulsive suicide attempts: a systematic literature review of definitions, characteristics and risk factors. J Affect Disord. 2015;171:93–104.

Sher L, Fisher AM, Kelliher CH, et al. Clinical features and psychiatric comorbidities of borderline personality disorder patients with versus without a history of suicide attempt. Psychiatry Res. 2016;246:261–266.

Russ MJ. Constant Observation of Suicidal Patients: The Intervention We Love to Hate. J Psychiatr Pract. 2016;22(5):382–8.

Dubovsky AN, Kiefer MM. Borderline personality disorder in the primary care setting. Med Clin North Am. 2014;98(5):1049–64.

Helleman M, Goossens PJ, Kaasenbrood A, van Achterberg T. Evidence base and components of Brief Admission as an intervention for patients with borderline personality disorder: a review of the literature. Perspect Psychiatr Care. 2014;50(1):65–75.

Turecki G, Brent DA. Suicide and suicidal behaviour. Lancet. 2016;387(10024):1227–39.

Jacobson CM, Gould M. The epidemiology and phenomenology of non-suicidal self-injurious behavior among adolescents: a critical review of the literature. Arch Suicide Res. 2007;11(2):129–47.

Cardell R, Bratcher KS, Quinnett P. Revisiting "suicide proofing" an inpatient unit through environmental safeguards: a review. Perspect Psychiatr Care. 2009;45(1):36–44.

Bowers L, Banda T, Nijman H. Suicide inside: a systematic review of inpatient suicides. J Nerv Ment Dis. 2010;198(5):315–28.

Sher L. Suicide medical malpractice: an educational overview. Int J Adolesc Med Health. 2015;27(2):203–6. doi: https://doi.org/10.1515/ijamh-2015-5012.

Belik SL, Stein MB, Asmundson GJ, Sareen J. Relation between traumatic events and suicide attempts in Canadian military personnel. Can J Psychiatry. 2009;54(2):93–104.

Conner KR, Bohnert AS, McCarthy JF, Valenstein M, Bossarte R, Ignacio R, Lu N, Ilgen MA. Mental disorder comorbidity and suicide among 2.96 million men receiving care in the Veterans Health Administration health system. J Abnorm Psychol. 2013;122:256–63.

Desai RA, Dausey DJ, Rosenheck RA. Mental health service delivery and suicide risk: the role of individual patient and facility factors. Am J Psychiatry. 2005;162(2):311–18.

Roy A, Carli V, Sarchiapone M. Resilience mitigates the suicide risk associated with childhood trauma. J Affect Disord. 2011;133(3):591–4

Schulberg HC, Bruce ML, Lee PW, Williams JWJ, Dietrich AJ. "Preventing suicide in primary care patients: the primary care physician's role. Gen Hosp Psychiatry. 2004;26(5):337–45.

Zamorski MA. Suicide prevention in military organizations. Int Rev. Psychiatry. 2011;23(2):173–80.

Suicide Risk Assessment and Management References

Bernstein SL, D'Onofrio G. A promising approach for emergency departments to care for patients with substance use and behavioral disorders. Health Aff. 2013;32(12):2122–28.

Kaplan MS, McFarland BH, Huguet N, Conner K, Caetano R, Giesbrecht N, Nolte KB. Acute alcohol intoxication and suicide: A gender-stratified analysis of the National Violent Death Reporting System. Injury Prevention. 2013;19(1):38–43.

Silverman MM, Berman AL, Sanddal ND, O'Carroll PW, Joiner TE. Rebuilding the tower of Babel: a revised nomenclature for the study of suicide and suicidal behaviors. Background, rationale, and methodology. Suicide Life Threat Behav. 2007;37(3):248–63.

Ahmedani BK, Simon GE, Stewart C, Beck A, Waitzfelder BE, Rossom R, et al. Health care contacts in the year before suicide death. J Gen Intern Med. 2014;29(6):870–77.

Mann JJ, Apter A, Bertolote J, Beautrais A, et al. Suicide prevention strategies: a systematic review. JAMA. 2005;294(16):2064–74.

Meyer RE, Salzman C, Youngstrom EA, Clayton PJ, Goodwin FK, Mann JJ, et al. Suicidality and risk of suicide—definition, drug safety concerns, and a

necessary target for drug development: a brief report. J Clin Psychiatry. 2010;71(8):1040–6.

American Academy of Child and Adolescent Psychiatry (AACAP). Practice parameter for the assessment and treatment of children and adolescents with suicidal behavior. J Am Acad Child Adolesc Psychiatry. 2001;40(7 Suppl): 24s–51.

American Psychiatric Association (APA). Practice guideline for the assessment and treatment of patients with suicidal behaviors. American Psychiatric Association; 2003.

The Assessment and Management of Risk for Suicide Working Group. VA/DOD Clinical Practice Guideline (CPG) for the assessment and management of patients at risk for suicide. 2013;Version 1.0:1–190.

Wasserman D, Rihmer Z, Rujescu D, SarchiaponeM, Sokolowski M, Titelman D, et al. The European Psychiatric Association (EPA) guidance on suicide treatment and prevention. Eur Psychiatry. 2012;27(2):129–41.

Registered Nurses' Association of Ontario (RNAO). Assessment and care of adults at risk for suicidal ideation and behaviour. Toronto, ON: Registered Nurses' Association of Ontario; 2009.

State of Victoria Department of Health. Working with the suicidal person: clinical practice guidelines for emergency departments and mental health services. Melbourne, Vic: Mental Health, Drugs, & Regions Branch, Victorian Government; 2010.

American Association for Suicidology (AAS). Core competencies for the assessment and management of individuals at risk for suicide. Assessing and Managing Suicide Risk (AMSR): Education Development Center, Inc. (EDC); 2004.

Clayton PJ. Suicide prevention: saving lives one community at a time. American Foundation for Suicide Prevention. http://www.afsp.org/index.php/content/download/9544/169597/file/Saving_Lives_One_Community_at_a_Time.pptx. Accessed 18 Apr 2014.

Clayton PJ. Suicide and the elderly. American Foundation for Suicide Prevention. http://www.afsp.org/index.php/content/download/3015/54627/file/Suicide_and_the_Elderly.pptx. Accessed 18 Apr 2014.

International Association for Suicide Prevention (IASP). IASP guidelines for suicide prevention. http://www.iasp.info/suicide_guidelines.php. Accessed 18 Apr 2014.

Substance Use and Mental Health Services Administration (SAMHSA). Promoting emotional health and preventing suicide: a toolkit for senior living communities. Rockville: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration; 2011.

Substance Use and Mental Health Services Administration (SAMHSA). Preventing suicide: a toolkit for high schools. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration; 2012.

Substance Use and Mental Health Services Administration (SAMHSA). Suicide Assessment Five-step Evaluation and Triage (SAFE-T). Substance Abuse and Mental Health Services Administration; 2009.

Priebe S, McCabe R, Bullenkamp J, Hansson L, Lauber C, Martinez-Leal, et al. Structured patient-clinician communication and 1-year outcome in community mental healthcare: cluster randomized controlled trial. Br J Psychiatry. 2007;191:420–26.

Riihimaki K, Vuorilehto M, Melartin T, Haukka J, Isometsa E. Incidence and predictors of suicide attempts among primary-care patients with depressive disorders: a 5-year prospective study. Psychological Medicine. 2014;44(2):291–302.

Coverdale JH, Roberts LW, Louie AK. Encountering patient suicide: emotional responses, ethics, and implications for training programs. Acad Psychiatry. 2007;31(5):329–32.

Brown GK. A Review of suicide assessment measures for intervention research with adults and older adults. Bethesda, MD: National Institute of Mental Health; 2002.

Bryan CJ, Rudd MD. Advances in the assessment of suicide risk. J Clin Psychol. 2006;62(2):185–200.

Stanley B, Brown GK, (with Karlin B, Kemp, JE, VonBergen, HA). Safety Plan treatment manual to reduce suicide risk: veteran version: U.S. Department of Veterans Affairs; 2008.

Brown GK, Ten Have T, Henriques GR, Xie SX, Hollander JE, Beck AT. Cognitive therapy for the prevention of suicide attempts: a randomized controlled trial. JAMA J Am Med Assoc. 2005;294(5), 563–570.

Currier GW, Litts D, Walsh P, Schneider S, Richardson T, Grant. Evaluation of an emergency department educational campaign for recognition of suicidal patients. West J Emerg Med. 2012;13(1):41–50.

Loh A, Simon D, Wills CE, Kriston L, Niebling W, Härter M. The effects of a shared decision-making intervention in primary care of depression: A cluster-randomized controlled trial. Patient Educ Couns. 2007;67(3):324–32.

Linehan MM, Comtois KA, Murray AM, Brown MZ, et al. Two-year randomized controlled trial and follow-up of dialectical behavior therapy vs therapy by experts for suicidal behaviors and borderline personality disorder. Archiv Gen Psychiatry. 2006;63(7):757–66.

Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Behavioral Health Statistics and Quality. Safety planning intervention: a brief intervention to mitigate suicide risk. Cogn Behav Pract. 2014;19(2):256–64.

Suicide Prevention Contracts

Matarazzo BB, Homaifar BY, Wortzel HS. Therapeutic risk management of the suicidal patient: safety planning. J Psychiatr Pract. 2014;20(3):220–4.

Puskar K, Urda B. Examining the efficacy of no-suicide contracts in inpatient psychiatric settings: implications for psychiatric nursing. Issues Ment Health Nurs. 2011;32(12):785–8.

Edwards SJ, Sachmann MD. No-suicide contracts, no-suicide agreements, and no-suicide assurances: a study of their nature, utilization, perceived effectiveness, and potential to cause harm. Crisis. 2010;31(6):290–302.

Stanley B, Brown GK. The case against no-suicide contracts: the commitment to treatment statement as a practice alternative. J Clin Psychol. 2012;62(2):243–51.

Appendix D

Guidelines

VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide

Department of Veterans Affairs, Department of Defense http://www.healthquality.va.gov/guidelines/MH/srb/VADODCP_SuicideRisk_Full.pdf

National Strategy for Suicide Prevention: Goals and Objectives for Action

U.S. Department of Health & Human Services

https://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/index.html

Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors

American Psychiatric Association

http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/suicide.pdf

Technical Report: Developing Caring for Adult Patients at Risk of Suicide: A Consensus Based Guide for Emergency Departments

Suicide Prevention Resource Center

http://www.sprc.org/resources-programs/caring-adult-patients-suicide-risk-consensus-guide-emergency-departments

A Resource Guide for Implementing the Joint Commission 2007 Patient Safety Goals on Suicide

Screening for Mental Health and Suicide Prevention Resource Center

http://www.sprc.org/sites/default/files/migrate/library/jcsafetygoals.pdf

Royal Australian and New Zealand College of Psychiatrists (RANZCP) Australian and New Zealand clinical practice guidelines for the management of adult deliberate self-harm. 2004

www.ranzcp.org/Files/Resources/Publications/CPG/Clinician/CPG_Clinician_Full_DSH-pdf.aspx

Substance Abuse and Mental Health Services Administration (SAMHSA) Suicide Assessment Five-step Evaluation and Triage. 2009

www.integration.samhsa.gov/clinical-practice/safe-t_card.pdf

WHO Self harm and suicide. 2015

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https://doi.org/10.1007/978-3-319-77773-3

www.who.int/mental_health/mhgap/evidence/suicide/en/

International Association for Suicide Prevention (IASP) IASP guidelines for suicide prevention. 2015. www.iasp.info/suicide_guidelines.php

National Institute for Health and Care Excellence (NICE) Self-harm: the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care. 2004. www.nice.org.uk/guidance/cg16/chapter/1-recommendations

New NICE guidance for the longer-term management of self-harm. 2011. www.nice.org.uk/guidance/cg133/resources/new-nice-guidance-for-the-longerterm-management-ofselfharm.

Appendix E

Other Web Resources

Children and Adolescent

- http://www.teenmentalhealth.org/
- Pediatric and Adolescent Mental Health Emergencies in the Emergency Medical Services System Committee of Pediatric Emergency Medicine, American Academy of Pediatrics (2011). http://pediatrics.aappublications.org/content/127/5/e1356.full.html
- Recommendations for School-Based Suicide Prevention Screening Lessons Learned Working Group, Substance Abuse and Mental Health Services Administration (2012). http://www.sprc.org/sites/sprc.org/files/library/Recommendations%20for%20School-Based%20Suicide%20Prevention%20Screening.pdf.

Adults: Primary Care

O'Connor E, Gaynes B, Burda BU, Williams C, Whitlock EP. Screening for suicide risk in primary care: a systematic evidence review for the U.S. Preventive Services Task Force. 2013. http://www.ncbi.nlm.nih.gov/pubmed/23678511

Seniors

A Review of Suicide Assessment Measures for Intervention Research with Adults and Older Adults G. Brown, National Institute of Mental Health (2003). http://www.sprc.org/sites/sprc.org/files/library/BrownReviewAssessmentMeasuresAdultsOlderAdults.pdf

This resource presents a systematic examination of assessment instruments for suicidal behaviors and behaviors closely associated with suicide risk in adults and older adults.

Other Resources

- http://www.suicideinfo.ca/csp/go.aspx?tabid=1
- Health Canada http://www.hc-sc.gc.ca/english/lifestyles/mental_health.html
- World Health http://www.who.int/mental_health/prevention/suicide/suicideprevent/en/

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- The Canadian Association for Suicide Prevention
  http://www.suicideprevention.ca/
- American foundation for suicide prevention
  http://www.afsp.org/
- Canadian mental Health Association
  http://www.cmha.ca/

Websites from Suicide Prevention Resource Centre (USA)

Evaluation

Screening for Suicide Risk in Adolescents, Adults, and Older Adults in Primary Care United States Preventive Services Task Force Recommendations (May 2014). http://www.uspreventiveservicestaskforce.org/uspstf/uspssuic.htm

Understanding Risk and Protective Factors for Suicide: A Primer for Preventing Suicide

Suicide Prevention Resource Center

http://www.sprc.org/library_resources/items/understanding-risk-and-protective-factors-suicide-primer-preventing-suicide

Suicide Risk Factors and Risk Assessment Tools: A Systematic Review

Department of Veterans Affairs

http://www.ncbi.nlm.nih.gov/books/NBK92671/pdf/TOC.pdf

Project BETA: Best Practices in Evaluation and Treatment of Agitation

American Academy of Emergency Psychiatry

http://escholarship.org/uc/item/4kz5387b

Safety Planning Guide: A Quick Guide for Clinicians

Suicide Prevention Resource Center

http://www.sprc.org/library_resources/items/safety-planning-guide-quick-guide-clinicians

Suicide Assessment Five-Step Evaluation and Triage (SAFE-T): Pocket Card for Clinicians

Substance Abuse and Mental Health Services Administration

http://store.samhsa.gov/product/Suicide-Assessment-Five-Step-Evaluation-and-Triage- SAFE-T-/SMA09-4432

Recognizing and Responding to Suicide Risk: Essential Skills for Clinicians

American Association of Suicidology

http://www.sprc.org/resources-programs/recognizing-and-responding-suicide-risk-essential-skills-clinicians

Screening, Brief Intervention, and Referral to Treatment

Substance Abuse and Mental Health Services Administration

http://www.integration.samhsa.gov/clinical-practice/sbirt

Post-Evaluation

SMART Discharge Protocol

The Picker Institute

http://www.ihi.org/resources/Pages/Tools/SMARTDischargeProtocol.aspx

Project RED (Re-engineered Discharge Planning) Toolkit
Agency for Healthcare Research and Quality
http://www.ahrq.gov/professionals/systems/hospital/red/toolkit/index.html

Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version
Department of Veterans Affairs
http://www.mentalhealth.va.gov/docs/VA_Safety_planning_manual.pdf

SPRC Emergency Department Consensus Panel
Suicide Prevention Resource Center
http://www.sprc.org/sites/sprc.org/files/consensuspanelroster.pdf

Patient Safety Plan template
Suicide Prevention Resource Center
http://www.sprc.org/sites/sprc.org/files/SafetyPlanTemplate.pdf

Transitions of Care Resources
American College of Emergency Physicians
http://www.acep.org/transitionsofcare/

Preventing Suicide: Following up After the Crisis
Substance Abuse and Mental Health Services Administration
http://beta.samhsa.gov/samhsaNewsLetter/Volume_22_Number_2/preventing_suicide/

General Resources
Attachment-Based Family Therapy (ABFT)
National Registry of Evidence-based Programs and Practices
http://www.sprc.org/resources-programs/attachment-based-family-therapy-abft

Brief Psychological Intervention after Deliberate Self-Poisoning
Suicide Prevention Resource Center and American Foundation for Suicide Prevention
http://www.sprc.org/bpr/section-I/brief-psychological-intervention-after-deliberate-self-poisoning

Now Matters
(Psychotherapy Using DBT for Suicidal Patients)
http://www.nowmattersnow.org/skills

NIMH Publications

National Institute of Mental Health
http://www.nimh.nih.gov/health/publications/index.shtml

Suicide Attempt Survivors
American Association of Suicidology
http://www.suicidology.org/suicide-survivors/suicide-attempt-survivors

The Way Forward: Pathways to hope, recovery, and wellness with insights from lived experience
Suicide Attempt Survivors Task Force of the National Action Alliance for Suicide Prevention

http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/The-Way-Forward-Final-2014-07-01.pdf

Suicide Safe Mobile App

Substance Abuse and Mental Health Services Administration

http://store.samhsa.gov/product/SAMHSA-Suicide-Safe-Mobile-App/PEP15-SAFEAPP1

Safety Plan Mobile App

New York State Office of Mental Heath

https://itunes.apple.com/us/app/safety-plan/id695122998?mt=8

American Association of Suicidology.

http://www.suicidology.org/

Emergency Department

Continuity of Care for Suicide Prevention: The Role of Emergency Departments. Suicide Prevention Resource Center.

http://www.sprc.org/sites/default/files/migrate/library/continuityofcare.pdf

Critical Issues in the Diagnosis and Management of the Adult Psychiatric Patient in the Emergency Department. American College of Emergency Physicians.

http://www.acep.org/content.aspx?id=48427

Caring for Adult Patients with Suicide Risk: A Consensus Guide for Emergency Departments — Quick Guide Version. Suicide Prevention Resource Center.

http://www.sprc.org/sites/sprc.org/files/EDGuide_quickversion.pdf

After an Attempt: A Guide for Taking Care of Your Family Member After Treatment in the Emergency Department. Substance Abuse and Mental Health Services Administration.

http://store.samhsa.gov/shin/content/SMA08-4357/SMA08-4357.pdf

Helpful resources regarding BPD patients most at risk of death by suicide

Helping Residents Cope with a Patient Suicide (http://www.psych.org/MainMenu/EducationCareerDevelopment/ResidentsMembersinTraining/index.aspx)
APA Practice Guidelines: Suicidal Behaviors (http://www.psychiatryonline.com.ezproxy.library.dal.ca/pracGuide/pracGuideChapToc_14.aspx)
APA Practice Guidelines: BPD (http://www.psychiatryonline.com.ezproxy.library.dal.ca/pracGuide/pracGuideChapToc_13.aspx)
APA Guideline Watch: BPD (http://www.psychiatryonline.com.ezproxy.library.dal.ca/content.aspx?aid=148718)
NICE Guideline: BPD (http://www.nice.org.uk/Guidance/CG78/NiceGuidance/pdf/English

Appendix F

Myth and Reality About Suicide

Examples

Myth: Asking about suicide would plant the idea in my patient's head.

Reality: Asking how your patient feels doesn't create suicidal thoughts. Would asking about chest pain cause angina?

Myth: There are talkers and there are doers. I cannot identify people who will die by suicide because they do not talk about it.

Reality: Most people who die by suicide have communicated some intent. Someone who talks about suicide gives the clinician an opportunity to intervene before suicidal act or behaviors occur.

Myth: If somebody really wants to die by suicide, there is nothing you can do about it.

Reality: Not true. Many patients with suicidal intent have underlying mental disorders. Providing a safe environment for treatment of the underlying cause can change the outcome. The acute risk for suicide is often time-limited. If you can help the person survive the immediate crisis and the strong intent to die by suicide, then you will have gone a long way toward promoting a positive outcome.

Myth: He/she really wouldn't kill themselves since _____.

- He just made plans for a vacation.
- She has young children at home.
- He signed a no-harm contract.
- He knows how dearly his family loves him.

Reality: The intent to die can override any rational thinking. In the presence of suicidal ideation or intent, the clinician should not be dissuaded from thinking that the patient is capable of acting on these thoughts and feelings.

Myth: Apparently manipulative self-injurious behaviors mean that the patient is just trying to get attention and are not really suicidal.

Reality: Suicide "gestures" require thoughtful assessment and treatment. Multiple prior suicide attempts increase the likelihood of eventually dying by suicide. The task is to empathically and nonjudgmentally engage the patient in understanding the behavior and finding safer and healthier ways of asking for help.

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Appendix G

Relative Risk of Suicide in Specific Disorders

(CAMH)

Relative risk (RR) is an epidemiological term that quantifies the risk of an event (or of developing a disease) relative to exposure. Relative risk is a ratio of the probability of the event occurring in the exposed group versus a nonexposed group. The following list contains the condition relative risk of suicide:

Prior suicide attempt 38.4
Eating disorders 23.1
Bipolar disorder 21.7
Major depression 20.4
Mixed drug abuse 19.2
Dysthymia 12.1
Obsessive-compulsive disorder 11.5
Panic disorder 10.0
Schizophrenia 8.45
Personality disorders 7.08
Alcohol abuse 5.86
Cancer 1.80
General population 1.00

- A relative risk of 1 means there is no difference in risk between the two groups.
- A relative risk of <1 means the event is less likely to occur in the experimental group than in the control group.
- A relative risk of >1 means the event is more likely to occur in the experimental group than in the control group. (Adapted from APA Guidelines, part A, p.16. From Jacobs, 2007)

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Appendix H

Suicide Risk Screening

This screening can be useful for staff who work with patients but have no professional designation to assess suicide risk.

What is the difference between suicide risk screening and suicide risk assessment?

Screening refers to a process used to identify individuals who may be at risk for suicide. It involves asking questions about suicidal thoughts/wishes to be dead, plans, or suicide intent.

In a sense, they serve as "triage" by screening in a small set of people who may be at risk of killing themselves. **The "screened-in" group then needs additional step which is standardized interview questions or consultation by a qualified mental health professional—in order to identify the seriousness of the suicide risk**. This next step is called suicide risk assessment.

Suicide risk assessment usually refers to a more comprehensive full evaluation done by a qualified clinician to confirm suspected suicide risk, estimate the immediate danger to the patient, and decide on a plan for intervention and a course of treatment.

How do I conduct the screening for suicide?

Use that opening statement:

Now I'm going to ask you some questions that we ask everyone. It helps us to make sure we are not missing anything important.

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Suicide Screening

Module 1

1. In the past few weeks, have you wished you were dead or go to sleep and not wake up or even your family is better off without you?
   _____ Yes
   _____ No
2. Have you attempted to kill yourself in the past?

_____ Yes_____ No**If the patient answers yes to any of the above...**

3. Are you having thoughts of killing yourself right now?
   _____ Yes
   _____ No

Module 2

Sometimes people who get upset or feel bad wish they were dead or feel they'd be better off dead. Have you ever had these type of thoughts?

When?

Do you feel that way now?

Was there ever another time you felt that way?

Do I ask everyone I meet about suicide?

Not in selective screening.

This is not a universal screening program where everyone is asked about suicide (e.g., asking all first-year university students about having suicidal thoughts).

This is a selective screening. The people you will ask about suicide are the people whom you interact with and articulate suicidal thoughts or wishes or any indication that they may harm themselves.

Remember that suicide has many risk factors (see Table H1 to see examples), but it is not your duty to determine if the person will do self-harm or not. Your responsibility is to pass your concerns to the next level of assessment. The duty of the assessor is to receive your concerns and formulate the suicide risk based on a full suicide risk assessment.

Table H1 Common risk factors for suicide

Interview risk profile	Individual risk profile
☐ Suicidal thinking or ideation	☐ Ethnic, cultural risk group or refugee
☐ Access to lethal means	☐ Family history of suicide
☐ Suicide intent or lethal plan or plan for after death (note)	☐ Trauma: as domestic violence/ sexual abuse/neglect
☐ Hopelessness	☐ Poor self-control: impulsive/ violent/aggression
☐ Intense emotions: rage, anger, agitation, humiliation, revenge, panic, severe anxiety	☐ Recent suicide attempt
☐ Current alcohol or substance intoxication / problematic use	☐ Other past suicide attempts, esp. with low rescue potential
☐ Withdrawing from family, friends	☐ Mental illness or addiction
☐ Poor reasoning/judgment	☐ Depression/anhedonia
☐ Clinical intuition: assessor concerned	☐ Psychotic
☐ Recent dramatic change in mood	☐ Command hallucinations
☐ Recent crisis/conflict/loss	☐ Recent admission/discharge/ ED visits
Illness management	☐ Chronic medical illness/pain
☐ Lack of clinical support	☐ Disability or impairment
☐ Non-compliance or poor response to treatment	☐ Collateral information supports suicide intent
	Circle of support
	☐ Lack of family/friends support
	☐ Caregiver unavailable
	☐ Frequent change of home

What is the next step if I feel that patient/client screens positive for suicide?

Your service will give you specific directions on the next step and whom to contact for conducting a suicide risk assessment depending on your location. Please talk to your direct supervisor about that next step. The options are:

– Contacting the treating clinician of the patient
– Assisting the transfer to the nearest emergency department
– Calling 911

Appendix I

Suicide Risk Assessment in the Elderly

Although suicide rates in the elderly are relatively high, their suicide risk is often overlooked.

Any elderly person who is expressing suicidal ideation or has presented following a suicide attempt should be treated very seriously because:

1. Elderly people who attempt suicide usually choose more lethal means.
2. Elderly people who attempt suicide often live alone; therefore the chances of being discovered are decreased.
3. Elderly people may be suffering from physical frailty; therefore they are less able to survive/recover from a physically serious suicide attempt.
4. Elderly people may not seek assistance after deliberately self-harm.
5. Elderly who attempt suicide usually have a strong intent to die and are more likely to make fatal attempts.
6. Older people may be uncomfortable talking about their feelings, especially their psychological distress, to younger clinicians.

Risk Factors for Suicide in the Elderly

The general risk factors for suicide among elderly people are very similar to those experienced by younger people. Important risk factors include the presence of psychiatric disorder, in particular depression, early stages of dementia, physical illness (particularly painful illness), and major losses, which may act as precipitating events, such as:

- loss of health
- loss of mobility, cognitive functioning, ability for self-care
- loss of role/job (e.g., retirement)
- loss of means for self-support
- loss of home or cherished possessions (e.g., going into a nursing home)
- loss of loved ones, including family/friends and pets

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https://doi.org/10.1007/978-3-319-77773-3

Appendix J

Sample of Questions During SRA

Laying the groundwork for more detailed questions about suicide, the clinician may say:

I can see that things have been very challenging for you lately.

OR

It seems that you have been having a difficult time lately.

OR

It must be frustrating /difficult to be going through what you are experiencing.

Given what you are experiencing, I wonder if you have had any thoughts that you would be better off dead or that you would consider taking your own life?

OR

Sometimes, in such circumstances, people may think or feel that they would be better off dead or that they may consider taking their own life. What about you?

Examples of Questions About Suicidal Intent and Plan

The clinician could say:

You say that you have thought about dying, can you tell me more about that?

Can you tell me more about the thoughts of taking your life that you are having? How often do you have those thoughts? How strong are they? How do you deal with them when they come? Can you overcome those thoughts or are you concerned that they may overcome you?

When you are having those thoughts, what do you do? Do you feel safe?

What have you done to act on those thoughts? Have you done anything that might have caused you harm or lead to death? Can you tell me about what happened?

Examples of Questions About Suicidal Plan

If it is established that the patient has persistent and strong suicidal ideation, the next step is to determine if the patient has a plan. The presence of a plan immediately puts the patient into a higher-risk category. For example, the clinician could say:

You have shared with me your thoughts about dying or taking your life, what are you planning to do?

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OR

Can you tell me what you have thought about doing to take your own life?

Once the presence of a plan has been established, the clinician should ensure that they understand all the details. When is this to happen? How lethal is the plan? How committed is the patient to carrying out the plan? What are the facilitating factors (e.g., they have a gun in the house, they have obtained numerous bottles of pills, etc.).

If a plan is identified, evaluate steps taken to enact the plan (practice CO emission from the car), preparations for dying, and the patient's expectations of lethality.

Questions About Past Suicide Attempts

Have you ever tried to kill yourself?

Questions About Mental Health Conditions

Have you had treatment for mental health problems? Do you have a mental health issue that affects your ability to do things in life?

Questions About Substance Use

Have you had four or more drinks on one occasion in the past month or have you used drugs or medication for nonmedical reasons in the past month? Has drinking or drug use been a problem for you?

Appendix K

Analysis of Problems that Occurred to Some Patients Who Died by Suicide While Receiving Psychotherapy and Medication

This is a summary of important issues in an interesting study that was published at the *American Journal of Psychiatry* in January 2006 by Hendin and his colleagues.

Problem # 1

Lack of Communication Between Care Providers

Communications between the current and previous therapists were rare. In some cases, after the patient's death, a former therapist shared information that might have helped resolve an impasse in the treatment.

In some cases where a therapist was providing psychotherapy and a psychiatrist was managing medication, they never communicated. Team had electronic access to each other's treatment notes, but they did not review them nor communicate directly.

Problem # 2

Permitting Patients or Their Relatives to Control the Therapy

In some cases, therapists allowed the patient or the patient's relative to control the course of the therapy. Suicidal patients frequently controlled their therapy, sometimes using the threat of suicide to do so. They may set certain conditions for living and insisted on the therapist's support in meeting those conditions. Sometimes, therapist complied, thinking that doing so was necessary to keep the patient in treatment and alive. A patient told the therapist "convince my parents to give me the necessary financial backing and I will stay alive" was the condition. Parents did not provide the financial support, and patient died by suicide.

Some patients more subtly exerted control by repeatedly bringing up or alluding to topics and then refusing to talk about them. Therapists accepted this behavior, largely out of fear of upsetting a potentially suicidal patient.

Problem # 3

Ineffective or Coercive Actions Resulting from the Therapist's Anxiety

Therapists' anxiety over possibility of suicide interfered with their ability to treat their patients effectively in some cases. Some patients made their immediate suicidal intent clear in the final visit, but therapists felt unable to intervene or ask a colleague for help. In some cases, the therapist of an imminently suicidal patient suggested

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hospitalization but left the decision to the patient who, in each case, rejected it and took his life shortly thereafter. In a case where a power struggle occurs between patient and therapist, the patient seemed to perceive suicide as a victory.

Problem # 4

Not Recognizing the Meanings of Patients' Communications

In some cases, the therapists failed to recognize the meaning of their patients' communications.

In six cases, the therapists misunderstood or took too literally what their patients were saying, thus failing to recognize a mounting suicide crisis.

A middle-aged man with a history of bipolar disorder and suicidal behavior became intensely anxious and unable to function socially and at work.

A patient called his psychotherapist to report that he had accidentally taken a double dose of his medication and asked whether this would be considered a suicide attempt. Patient died by suicide a week later.

Problem # 5

Untreated or Undertreated Symptoms

Major symptoms related to substance abuse, anxiety, and/or psychosis are not adequately addressed. Several patients in whom obvious substance abuse was not treated, they continued psychotherapy but died by suicide while receiving therapy.

Recommendations for Treatment

- Active communication among all treatment providers involved in the care of a suicidal patient.
- Problems related to patients' control of the therapy are of particular concern with suicidal patients because suicide is frequently an aspect of their need for control.
- Exploring what patients are trying to communicate by setting conditions for living is more likely to be effective than intervening to help patients meet the unrealistic conditions they have defined.
- Help patients who hint at critical subjects and then refuse to discuss them. The therapist's ability to help the patient explore such topics may be crucial in obtaining insight into the basis for the patient's suicidal feelings.
- Explicitly exploring the patient's feelings about medication non-compliance is essential.
- Although decisions regarding hospitalization are among the most difficult aspects of treating suicidal patients, it is essential for the therapist to be clear and decisive in dealing with this issue. When a therapist is faced with a patient who appears to be imminently suicidal but is unwilling to be hospitalized, forced hospitalization is preferable to allowing the patient to go home and think about it.
- Addressing and treating suicidal patients' substance abuse, particularly alcohol abuse is critical.

Psychotherapy can be helpful to many patients with mental illness. The author (Dr. Joseph Sadek) suggests that patients can be given these sheets to mark the areas that they would like to work on during psychotherapy.

Sadek Themes on psychotherapy (STOP) ©: Please mark x on the areas that you need:

	Ways to control my **anxiety and worries**
	Ways to control **my fears** (open spaces, elevators, heights, needles, animals)
	How to control **panic attacks** and prevent them from happening in the future
	Ways to **control my obsessions or rituals (COMPULSIONS)**
	How to improve my **low mood**
	How to stop my **feelings of guilt**
	How to **enjoy life** and things in life that I used to enjoy (such as sports or walks)
	How to stop **suicidal thoughts** or prevent killing myself
	Ways to start and **keep relationships** or friendship (or keep jobs)
	Ways to regulate my emotions and stop my **mood swings**
	Ways to **tolerate stress**
	Ways to stop **self-harm or cutting**
	Ways to stop my **impulsive sexual behaviour** and regulate my sexual urges or sexual addiction
	Ways to stop my impulsive **binge eating**
	How to accept myself the way I am and form solid **identity** (including my sexual identity)
	Ways to control my
	Ways to trust others and ways to stop my **paranoid thoughts**
	Ways to control my feelings of **abandonment (**that sometimes have no basis)
	Ways to become a good citizen and stop the behaviours that got me in **trouble with the law**
	How to cut down and stop using **illegal substances** and or abusing drugs
	How to cut down and stop **drinking alcohol**
	How to stop my **pornography or gambling addiction**

Sadek Themes on psychotherapy (STOP) ©: Please mark x on the areas that you need:

	How to regulate my **eating behaviour** or stop binging / purging or restricting food
	How to improve my **self-image**
	How to improve my **marriage or relationship** with my partner
	How to have a meaningful **relationship with my children or with my blended family**
	How to **be a parent** and positive role model and how to deal with defiant aggressive child
	How to **cope with elderly parents**
	How to adjust to **changes** (divorce, separation, death, illness, new transition, new job, new place)
	How to **change my behaviour** that I am very used to and I do not like
	How to find a meaning or **purpose to my life**
	Ways to learn **social skills**
	How to improve my **sleep**
	How to **reach my potential**
	How to **enjoy my life** (at work, at home, learn fun activities)
	Ways to stop myself from trying to be the **centre of attention**
	How to have **empathy and respect** for others
	Ways to change my feelings that I am **better than most people** and that others are stupid
	Ways to stop trying to **take advantage of others** or manipulate them
	How to stop my **unrealistic expectations** of power, brilliance and having a perfect lover
	How to be flexible and stopping myself from trying to **control** everything
	Ways to change my **miserable spending** habits and refusal to spend money on family or myself
	How to stop **relying on others** for reassurance or decision making
	Ways to stop my **avoidance** behaviour (avoid people unless they like me, avoid social stuff)

Sadek Themes on psychotherapy (STOP) ©: Please mark x on the areas that you need:

	How to deal with my **past trauma** (physical, sexual abuse or neglect during early years of life)
	Ways to feel better about **my parents** and forgive them for lots of things
	Ways to **forgive myself** for my past or current issues/ mistakes/ problems
	How to **stop my regrets** about things in the past and stop trying to punish myself
	Ways to cope with my feelings of **inferiority** and not being good enough child or adult
	Ways to accept **past failures** and move on
	Way to accept **unfairness and maltreatment** that I faced
	How to deal with my **feelings of hate** towards others (sibling, family, friends)
	Ways to **incorporate spirituality** in my life
	Ways to understand my **intelligence level**
	How to understand the areas of strength and weakness in my **cognitive profile**
	Understanding my **learning problems** and how to deal with them
	Ways to decrease my **hyperactivity**
	Ways to decrease my **interruption of others**
	How to **organize myself**, my schedule or my life
	How to stop **procrastination** and finish my tasks
	How to stop myself from being easily **distracted**
	How to improve my **attention to details**
	How to improve my **ability to sit down for long time and focus on tasks**
	How to **remember things**
	How to **stop losing things**
	How to **stop day dreaming** and motivate myself to do things

Table K1 Common risk factors for suicide

Interview risk profile	Individual risk profile
☐ Suicidal thinking or Ideation	☐ Ethnic, cultural risk group or refugee, LGBT
☐ Access to lethal means	☐ Family history of suicide
☐ Suicide intent or lethal plan or plan for after death (note)	☐ Trauma: as domestic violence/sexual abuse/neglect
☐ Hopelessness	☐ Poor self-control: impulsive/violent/ aggression
☐ Intense emotions: rage, anger, agitation, humiliation, revenge, panic, severe anxiety	☐ Recent suicide attempt
☐ Current alcohol or substance intoxication / problematic use	☐ Past suicide attempts
☐ Withdrawing from family, friends	☐ Mental illness or addiction
☐ Poor reasoning/judgment	☐ Depression/anhedonia
☐ Clinical intuition: assessor concerned	☐ Psychotic
☐ Recent dramatic change in mood	☐ Command hallucinations
☐ Recent crisis/conflict/loss	☐ Recent admission/discharge/ED visits
Illness management	☐ Chronic medical illness/pain
☐ Lack of clinical support	☐ Disability or impairment
☐ Non-compliance or poor response to treatment	☐ Collateral information supports suicide intent
	Circle of support
	☐ Lack of family/friends support
	☐ Caregiver unavailable
	☐ Frequent change of home

Reference

Kutcher S, Chehil S. Suicide risk management: a manual for health professionals. Malden, MA: Blackwell Publishing Ltd.; 2007.

Questions about this document, please contact Dr. Joseph Sadek.
Joseph.sadek@nshealth.ca

References

General References and Suggested Readings

Kutcher S, Chehil S. Suicide risk management: a manual for health professionals. Malden, MA: Blackwell Publishing Ltd.; 2007.

Palmer B, Pankratz V, Bostwick J. The lifetime risk of suicide in schizophrenia. Arch Gen Psychiatry. 2005;62:247–53.

Bostwick J, Pankratz V. Affective Disorders and Suicide Risk: A Reexamination. Am J Psychiatry 2000;157:1925–32.

Joiner T. Why people die by suicide. Cambridge: Harvard University Press; 2005.

Patel V, et al. Disease control priorities. Mental, neurological, and substance use disorders. 3rd ed. Washington, DC: World Bank Group; 2015.

Olfson M, Marcus SC, Bridge JA. Emergency department recognition of mental disorders and short-term outcome of deliberate self-harm. Am J Psychiatry 2013;170:1142–50.

Hawton K, Casañas I, et al. Risk factors for suicide in individuals with depression: a systematic review. J Affect Disord. 2013;147(1–3):17–28.

Ronquillo L, Minassian A, Vilke GM, Wilson MP. Literature-based recommendations for suicide assessment in the emergency department: a review. J Emerg Med. 2012;43(5):836–42.

Bryan CJ, Corso KA, et al. Therapeutic alliance and change in suicidal ideation during treatment in integrated primary care settings. Arch Suicide Res. 2012;16(4):316–23.

Jobes DA. The Collaborative Assessment and Management of Suicidality (CAMS): an evolving evidence-based clinical approach to suicidal risk. Suicide Life Threat Behav. 2012;42(6):640–53.

Wortzel HS, Matarazzo B, Homaifar B. A model for therapeutic risk management of the suicidal patient. J Psychiatr Pract. 2013;19(4):323–6.

Wilcox HC, Wyman PA. Suicide prevention strategies for improving population health. Child Adolesc Psychiatr Clin N Am. 2016;25(2):219–33.

Bolton JM, Gunnell D, Turecki G. Suicide risk assessment and intervention in people with mental illness. BMJ. 2015;351:h4978.

Calear AL, Christensen H, Freeman A, et al. A systematic review of psychosocial suicide prevention interventions for youth. Eur Child Adolesc Psychiatry. 2016;25(5):467–82.

Turecki G, Brent DA. Suicide and suicidal behaviour. Lancet. 2016;387(10024): 1227–39.

Chu C, Klein KM, Buchman-Schmitt JM, Hom MA, Hagan CR, Joiner TE. Routinized assessment of suicide risk in clinical practice: an empirically informed update. J Clin Psychol. 2015;71(12):1186–200.

Schaffer A, Isometsä ET, Azorin JM, et al. A review of factors associated with greater likelihood of suicide attempts and suicide deaths in bipolar disorder: part II of a report of the International Society for Bipolar Disorders Task Force on Suicide in Bipolar Disorder. Aust N Z J Psychiatry. 2015;49(11):1006–20.

Bennett K, Rhodes AE, Duda S, Cheung AH, Manassis K, Links P, Mushquash C, Braunberger P, Newton AS, Kutcher S, Bridge JA, Santos RG, Manion IG, Mclennan JD, Bagnell A, Lipman E, Rice M, Szatmari P. A youth suicide prevention plan for Canada: a systematic review of reviews. Can J Psychiatry. 2015;60(6):245–57.

Cheung G, Merry S, Sundram F. Medical examiner and coroner reports: uses and limitations in the epidemiology and prevention of late-life suicide. Int J Geriatr Psychiatry. 2015;30(8):781–92.

Inagaki M, Kawashima Y, Kawanishi C, et al. Interventions to prevent repeat suicidal behavior in patients admitted to an emergency department for a suicide attempt: a meta-analysis. J Affect Disord. 2015;175:66–78.

Dignam PT. Suicide prevention: let's start at the very beginning. Aust N Z J Psychiatry. 2015;49(1):16–7.

Fowler JC (2012). Suicide risk assessment in clinical practice: pragmatic guidelines for imperfect assessments. Psychotherapy, 49(1), 81–90.

Rimkeviciene J, O'Gorman J, De Leo D. Impulsive suicide attempts: a systematic literature review of definitions, characteristics and risk factors. J Affect Disord. 2015;171:93–104.

Sher L, Fisher AM, Kelliher CH, et al. Clinical features and psychiatric comorbidities of borderline personality disorder patients with versus without a history of suicide attempt. Psychiatry Res. 2016;246:261–66.

Russ MJ. Constant observation of suicidal patients: the intervention we love to hate. J Psychiatr Pract. 2016;22(5):382–8.

Dubovsky AN, Kiefer MM. Borderline personality disorder in the primary care setting. Med Clin North Am. 2014;98(5):1049–64.

Helleman M, Goossens PJ, Kaasenbrood A, van Achterberg T. Evidence base and components of Brief Admission as an intervention for patients with borderline personality disorder: a review of the literature. Perspect Psychiatr Care. 2014;50(1):65–75.

Turecki G, Brent DA. Suicide and suicidal behaviour. Lancet. 2016;387(10024): 1227–39.

Jacobson CM, Gould M. The epidemiology and phenomenology of non-suicidal self-injurious behavior among adolescents: a critical review of the literature. Arch Suicide Res. 2007;11(2):129–47.

Cardell R, Bratcher KS, Quinnett P. Revisiting "suicide proofing" an inpatient unit through environmental safeguards: a review. Perspect Psychiatr Care. 2009;45(1): 36–44.

Bowers L, Banda T, Nijman H. Suicide inside: a systematic review of inpatient suicides. J Nerv Ment Dis. 2010;198(5):315–28.

Sher L. Suicide medical malpractice: an educational overview. Int J Adolesc Med Health. 2015;27(2):203–6. doi:https://doi.org/10.1515/ijamh-2015-5012.

Belik SL, Stein MB, Asmundson GJ, Sareen J. Relation between traumatic events and suicide attempts in Canadian military personnel. Can J Psychiatry 2009;54(2):93–104.

Conner KR, Bohnert AS, McCarthy JF, Valenstein M, Bossarte R, Ignacio R, Lu N, Ilgen MA. Mental disorder comorbidity and suicide among 2.96 million men receiving care in the Veterans Health Administration health system. J Abnorm Psychol. 2013;122:256–63.

Desai RA, Dausey DJ, Rosenheck RA. Mental health service delivery and suicide risk: the role of individual patient and facility factors. Am J Psychiatry. 2005;162(2):311–18.

Roy A, Carli V, Sarchiapone M. Resilience mitigates the suicide risk associated with childhood trauma. J Affect Disord. 2011;133(3):591–4.

Schulberg HC, Bruce ML, Lee PW, Williams JWJ, Dietrich AJ. Preventing suicide in primary care patients: the primary care physician's role. Gen Hosp Psychiatry. 2004;26(5):337–45.

Zamorski MA. Suicide prevention in military organizations. Int Rev. Psychiatry. 2011;23(2):173–80.

Suicide Risk assessment and Management References

Bernstein SL, D'Onofrio G. A promising approach for emergency departments to care for patients with substance use and behavioral disorders. Health Aff. 2013;32(12):2122–28.

Kaplan MS, McFarland BH, Huguet N, Conner K, Caetano R, Giesbrecht N, Nolte KB. Acute alcohol intoxication and suicide: a gender-stratified analysis of the National Violent Death Reporting System. Inj Prev. 2013;19(1):38–43.

Silverman MM, Berman AL, Sanddal ND, O'Carroll PW, Joiner TE. Rebuilding the tower of Babel: a revised nomenclature for the study of suicide and suicidal behaviors. Background, rationale, and methodology. Suicide Life Threat Behav. 2007;37(3):248–63.

Ahmedani BK, Simon GE, Stewart C, Beck A, Waitzfelder BE, Rossom R, et al. Health care contacts in the year before suicide death. J Gen Intern Med. 2014;29(6):870–877.

Mann JJ, Apter A, Bertolote J, Beautrais A, et al. Suicide prevention strategies: a systematic review. JAMA. 2005;294(16):2064–74.

Meyer RE, Salzman C, Youngstrom EA, Clayton PJ, Goodwin FK, Mann JJ, et al. Suicidality and risk of suicide—definition, drug safety concerns, and a necessary target for drug development: a brief report. J Clin Psychiatry. 2010;71(8):1040–6.

American Academy of Child and Adolescent Psychiatry (AACAP). Practice parameter for the assessment and treatment of children and adolescents with suicidal behavior. J Am Acad Child Adolesc Psychiatry. 2001;40(7 Suppl):24s–51.

American Psychiatric Association (APA). Practice guideline for the assessment and treatment of patients with suicidal behaviors. American Psychiatric Association; 2003.

The Assessment and Management of Risk for Suicide Working Group. VA/DOD Clinical Practice Guideline (CPG) for the assessment and management of patients at risk for suicide. 2013;Version 1.0:1–190.

Wasserman D, Rihmer Z, Rujescu D, SarchiaponeM, Sokolowski M, Titelman D, et al. The European Psychiatric Association (EPA) guidance on suicide treatment and prevention. Eur Psychiatry. 2012;27(2):129–41.

Registered Nurses' Association of Ontario (RNAO). Assessment and care of adults at risk for suicidal ideation and behaviour. Toronto, ON: Registered Nurses' Association of Ontario; 2009.

State of Victoria Department of Health. Working with the suicidal person: clinical practice guidelines for emergency departments and mental health services. Melbourne, VIC: Mental Health, Drugs, & Regions Branch, Victorian Government; 2010.

American Association for Suicidology (AAS). Core competencies for the assessment and management of individuals at risk for suicide. Assessing and Managing Suicide Risk (AMSR): Education Development Center, Inc. (EDC); 2004.

Clayton PJ. Suicide prevention: saving lives one community at a time. American Foundation for Suicide Prevention. http://www.afsp.org/index.php/content/

download/9544/169597/file/Saving_Lives_One_Community_at_a_Time.pptx. Accessed 18 Apr 2014.

Clayton PJ. Suicide and the elderly. American Foundation for Suicide Prevention. http://www.afsp.org/index.php/content/download/3015/54627/file/Suicide_and_the_Elderly.pptx. Accessed 18 Apr 2014.

International Association for Suicide Prevention (IASP). IASP guidelines for suicide prevention. http://www.iasp.info/suicide_guidelines.php. Accessed 18 Apr 2014.

Substance Use and Mental Health Services Administration (SAMHSA). Promoting emotional health and preventing suicide: a toolkit for senior living communities. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration; 2011.

Substance Use and Mental Health Services Administration (SAMHSA). Preventing suicide: a toolkit for high schools. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration; 2012.

Substance Use and Mental Health Services Administration (SAMHSA). Suicide Assessment Five-step Evaluation and Triage (SAFE-T). Substance Abuse and Mental Health Services Administration; 2009.

Priebe S, McCabe R, Bullenkamp J, Hansson L, Lauber C, Martinez-Leal, et al. Structured patient-clinician communication and 1-year outcome in community mental healthcare: cluster randomized controlled trial. Br J Psychiatry. 2007;191:420–26.

Riihimaki K, Vuorilehto M, Melartin T, Haukka J, and Isometsa E. Incidence and predictors of suicide attempts among primary-care patients with depressive disorders: a 5-year prospective study. Psychol Med. 2014;44(2):291–302.

Coverdale JH, Roberts LW, Louie AK. Encountering patient suicide: emotional responses, ethics, and implications for training programs. Acad Psychiatry. 2007;31(5):329–32.

Brown GK. A Review of suicide assessment measures for intervention research with adults and older adults. Bethesda: National Institute of Mental Health; 2002.

Bryan CJ, Rudd MD. Advances in the assessment of suicide risk. J Clin Psychol. 2006;62(2):185–200.

Stanley B, Brown GK, (with Karlin B, Kemp, JE, VonBergen, HA). Safety plan treatment manual to reduce suicide risk: veteran version: U.S. Department of Veterans Affairs; 2008.

Brown GK, Ten Have T, Henriques GR, Xie SX, Hollander JE, Beck AT. Cognitive therapy for the prevention of suicide attempts: a randomized controlled trial. JAMA J Am Med Assoc. 2005;294(5):563–570.

Currier GW, Litts D, Walsh P, Schneider S, Richardson T, Grant W. Evaluation of an emergency department educational campaign for recognition of suicidal patients. Western J Emerg Med. 2012;13(1):41–50.

Loh A, Simon D, Wills CE, Kriston L, Niebling W, Härter M. The effects of a shared decision-making intervention in primary care of depression: a cluster-randomized controlled trial. Patient Educ Couns. 2007;67(3):324–32.

Linehan MM, Comtois KA, Murray AM, Brown MZ, et al. Two-year randomized controlled trial and follow-up of dialectical behavior therapy vs therapy by

experts for suicidal behaviors and borderline personality disorder. Archiv Gen Psychiatry. 2006;63(7):757–66.

Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Behavioral Health Statistics and Quality. Safety planning intervention: a brief intervention to mitigate suicide risk. Cogn Behav Pract. 2014;19(2):256–64.