Module A: Assessment and Determination of Risk for Suicide

Ideally, an individual at risk for suicide is identified before any suicidal behavior occurs. Early identification of suicidal ideation presents the greatest opportunity to reduce the risk of suicidal behavior including death. Suicidal events begin with suicidal thoughts and progress towards behaviors that can be potentially injurious behavior with intent to die as a result of the behavior. The progression from thoughts to behaviors can occur over minutes or years. Each step along the continuum presents an opportunity to intervene to prevent an act of self-directed violence (SDV). In some cases, a person at risk for death by suicide is identified only after a suicide attempt is made.

This Module describes a recommended framework for a structured assessment of a person suspected to be at some degree of risk for suicide. Suicide risk assessment remains an imperfect science, and much of what constitutes best practice is a product of expert opinion, with a limited evidence base. That said, the objective of risk assessment is to stratify individuals into levels of risk, denoted in this guideline as low, intermediate, and high acute risk. The identified level of risk dictates, to a large extent, the appropriate precautions for maintaining safety (preventing SDV behavior) and informs decisions regarding choice of care setting, management, and treatment plans to follow.

The term "risk" is used in this guideline both to convey information regarding known long-term risk factors for suicide and in developing a conceptual framework for the assessment of acute risk to help with identifying appropriate interventions or levels of care for individuals who have been identified as potentially experiencing suicidal ideation or intent. For example, it is well known that underlying mental disorders significantly increase the lifetime risk of suicide. However, in the initial evaluation of a potentially suicidal individual, the level of ideation, intent, or preparatory behavior will largely guide the initial risk stratification in terms of determining what level of care will be immediately required. The risk assessment framework used to guide clinical recommendations in this guideline applies largely to the level of intervention required over the short-term rather than the relative strength of known risk or protective factors in predicting suicide long-term.

Annotations

A. Person Suspected to Have Suicidal Thoughts (Ideation), a Recent Previous Suicide Attempt, or Self-directed Violence Episodes

BACKGROUND

Suicidal thoughts or behaviors may be identified in many different clinical settings and at various levels of progress toward a suicidal act. Most of the time suicidal thoughts do not result in suicidal acts. Suicidal ideation has a much higher incidence than suicide attempts. This guideline will assist providers to assess a patient identified with suicidal thinking, estimate the patient's level of risk, determine the appropriate setting for care, and develop a treatment plan.

Within the Veterans Health Administration and the Department of Defense, policies and procedures have been developed to identify persons at risk for suicide among selected high-risk for suicide populations. These efforts are important in their goal to identify "at-risk" individuals in order to facilitate early intervention. However, there is insufficient evidence to recommend for or against such screening measures for the general population (Pignone, 2002).

Patients identified through screening efforts or through routine clinical evaluations as having suicidal thoughts or ideation become subject to this guideline for further assessment and management of risk for suicide. Whether a suicidal person is identified by a screening tool as part of their military readiness; as part of routine healthcare; within specialized care for depression, post-traumatic stress disorder, or traumatic brain injury; or by a supervisor, colleague, loved one, or him/herself; the evaluation begins with the suicide risk assessment. Patients with mental disorders who are managed according to evidence-based CPGs and are stable have some risk for suicide as a result of their mental disorders – a known risk factor for suicide. However, if these patients do not report any suicidal thoughts (screen negative for suicide ideation) or other warning signs they should not be managed by this guideline.

RECOMMENDATIONS

1. Any patient with the following conditions should be assessed and managed using this guideline:
    a. Person is identified as possibly having risk for suicide during evaluation and management of mental disorders (Depression, bipolar, schizophrenia, PTSD), or medical condition (TBI, pain, sleep disturbance) known to be associated with increased risk for suicide
    b. Person reports suicidal thoughts on deployment-related assessments (e.g., PDHA/PDHRA), or on annual screening tools, or other evaluation such as mental health intake
    c. Person scores very high on depression screening tool and is identified as having concerns of suicide
    d. Person reports suicidal thoughts on depression screening tool
    e. Woman reports suicidal thoughts on depression screening tool during pregnancy or postpartum visits
    f. Person is seeking help (self-referral) and reporting suicidal thoughts
    g. Service member referred to health care provider by command, clergy, or family/unit members who have expressed concerns about the person's behavior
    h. Person for whom the provider has concerns about suicide- based on the provider's clinical judgment
    i. Person with history of suicide attempt or recent history of self directed violence.

DISCUSSION

Indication for Assessment of Risk for Suicide:

Population-Based Screening: Because of the inherent health risks of military service, the Department of Defense has developed population-based screening to facilitate early detection of health concerns that may impact military operational readiness. This routine screening occurs on a regular basis in the Periodic Health Assessment, in Pre-Deployment Health Assessments, in Post-Deployment Health Assessment immediately upon return from deployment, and again three months later during the Post-Deployment Health Re-Assessment. These screening instruments incorporate assessment tools for depression (PHQ-2), post-traumatic stress disorder (PHQ-4), and alcohol abuse (AUDIT-C).

Universal Screening: Recognizing the risk of depression in the general population, many healthcare systems have begun routine screening as part of regular health maintenance. Instruments like the PHQ-9 (which includes a question regarding presence of suicidal ideation) are widely accepted and administered to patients in primary care settings.

Mental Disorders (Psychiatric Disorders): Certain mental illnesses are considered to be risk factors for suicide and are characterized by a high rate of suicidal ideation (e.g., depression). Identification of suicidal ideation in the management of these illnesses should prompt formal comprehensive assessment and management of the risk for suicide.

Medical Conditions (Chronic pain): In many cases chronic pain and physical discomfort is associated with functional difficulties and disabilities that may increase of suicidal thoughts and ideation. Psychiatric comorbidity is common among individuals with a pain condition. Pain, depression, and disability are known to be mutually reinforcing. Back, neck and joint pain can be accounted for by co-morbid mental health disorders. There may be additional risk accompanying frequent headaches and 'other' chronic pain that is secondary to psychosocial processes not captured by mental disorders.

Medical Conditions (Sleep disorder): Sleep disturbance is prevalent in and strongly associated with a variety of psychiatric and medical conditions. Both subjective and objective sleep disturbances appear to predict elevated risk for suicide. Multiple investigations, diverse in design, methodology, and the assessment of suicidal behaviors identify insomnia and poor sleep quality symptoms as significant suicide risk factors. Nightmares also appear more common among suicidal versus nonsuicidal individuals with major depression.

Indicated Screening: Certain groups of patients are considered to be at elevated risk for specific health conditions by the nature of a demographic characteristic, exposure to a threat, biological, physical characteristic, or occurrence of a related illness or symptom. For example, myocardial infarction patients are at risk for depression, women during pregnancy or in postpartum period are at risk for depression. As such, high-risk groups may be subject to focused screening. Any positive screen in these high-risk groups should be followed with a focused assessment.

Clinical Assessment: When patients present to a health care provider with complaints regarding symptoms of depression or suicidal thoughts, the focus is on conducting an evaluation to assess the nature, extent and other characteristics of suicidal behavior or risk for suicidal behavior with the goal of formulating a treatment plan. The patient has, in essence, self-screened for evaluation, and formal assessment is conducted to establish a diagnostic or other clinical formulation of the presenting problem. The therapeutic interventions that follow will first address the suicidal thoughts and behaviors regardless of the psychiatric diagnosis.

Referral from Non-Clinical Sources: Military members and Veterans interact with many helping agencies as well as commands, leaders, Chaplains, family members and unit peers. Many of these agencies and all Service members have suicide prevention training to identify persons at risk for suicide. Programs such as Applied Suicide Intervention Skills Training (ASIST) or "Ask, Care, Escort" (ACE) are conducted by helping professionals and lay persons ("gatekeepers") to prepare Service members to identify those at risk and facilitate their referral to qualified professional help.

B. Assess Risk for Suicide

Suicide risk assessment is a process in which the healthcare provider gathers clinical information in order to determine the patient's risk for suicide. The risk for suicide is estimated based on the patient's suicidal thoughts and intent, suicide related behavior, warning signs, risk and protective factors.

BACKGROUND

Suicide risk assessment is the process by which clinicians collect evidence and use their training to try to determine who is at high risk for suicide behavior. The ultimate goal of suicide risk assessment is to: Identify patients who are in need of immediate intervention to prevent a suicidal act; determine the appropriate treatment setting to optimize safety; deliver clinical interventions; and formulate a treatment plan that reduces the risk for future suicidal thoughts or behaviors.

A person's risk for suicide is dynamic: changing over time based on affective states, life events, and the complex interplay of risk and protective factors. Evaluation of these factors plays an important role in the overall assessment. A suicide risk assessment must include the evaluation of the patient's internal experience, thoughts, beliefs, and attitudes; their external world of relationships and stressors; as well as the myriad of factors that increase the likelihood of suicide and those that prevent them from action. All of these data must then be integrated by the clinician who must ultimately use clinical judgment to formulate a risk assessment and treatment plan.

Suicidal Ideation	Thoughts of engaging in suicide-related behavior. Various degrees of frequency, intensity, and duration
Suicidal Intent	There is past or present evidence (implicit or explicit) that an individual wishes to die, means to kill him/herself, and understands the probable consequences of his/her actions or potential actions. Suicidal intent can be determined retrospectively and inferred in the absence of suicidal behavior. Extent of expectation to carry out the plan and the belief that the plan/act to will be lethal
Preparatory Behavior	Acts or preparation towards engaging in Self-Directed Violence, but before potential for injury has begun. This can include anything beyond a verbalization or thought, such as assembling a method (e.g., buying a gun, collecting pills) or preparing for one's death by suicide (e.g., writing a suicide note, giving things away)

Suicide Surveillance: Uniform Definitions and Recommended Data, *Centers for Disease Control and Prevention (CDC, 2011).*

Estimating the Risk for Suicide

Determination of suicide risk should include three tasks:

1. Gathering information related to the patient's intent to engage in suicide-related behavior.
2. Evaluating factors that elevate or reduce the risk of acting on that intent.
3. Integrating all available information to determine the level of risk and appropriate setting for care.

Assessing for current intent and the degree of intent for suicide is a key component of the assessment process. The first aspect of the clinical assessment of suicide risk is the evaluation of the patient's **thoughts** of suicide, the **intention** to act on those thoughts, and the desire or the ability of the patient to not engage in suicidal behaviors. Any evidence of action toward a suicide attempt suggests a higher level of risk. Suicidal **preparatory behaviors** include the development of a plan to end one's life, rehearsing a plan, or taking steps to prepare for an attempt (e.g., stockpiling medications, buying a gun, tying a rope into a noose). Assessing the lethality of the plan is important, but also important is the patient's estimation of the lethality and understanding of the probable consequences of his/her actions or potential actions. Many suicidal individuals may reveal **warning signs** or signals of their intention to engage suicidal behaviors. These warning signs are observations of precipitating emotions, thoughts, or behaviors that are most proximally associated with a suicidal act and reflect imminent risk.

Three direct warning signs portend the highest likelihood of suicidal behaviors occurring in the near future. Observing these warning signs warrants immediate attention, mental health evaluation, referral, or consideration of hospitalization to ensure the safety, stability and security of the individual:

- **Suicidal communication** - writing or talking about suicide, wish to die, or death (threatening to hurt or kill self) or intention to act on those ideas.
- **Preparations for suicide** - evidence or expression of suicide intent, and/or taking steps towards implementation of a plan. Makes arrangements to divest responsibility for dependent others (children, pets, elders), or making other preparations such as updating wills, making financial arrangements for paying bills, saying goodbye to loved ones, etc.
- **Seeking access or recent use of lethal means** - such as weapons, medications, toxins or other lethal means.

These signals are likely to be even more dangerous if the person has previously attempted suicide, has a family history of suicide and/or intends to use a method that is lethal and to which he/she has access.

Once the patient's suicidal ideation, intent and behaviors are assessed then other factors that influence risk should be considered in a systematic way to finalize the determination of risk level. These factors may include risk as well as protective factors that, if modifiable, could become the focus of clinical intervention to reduce the risk for suicide:

- **Risk Factors -** increase the likelihood of suicidal behavior and include modifiable and non-modifiable indicators.
- **Protective Factors -** are capacities, qualities, environmental and personal resources that increase resilience drive individuals towards growth, stability, and health and increase coping with different life events and decrease the likelihood of suicidal behavior.

Basing the assessment of risk on an accumulation of risk factors alone is not realistic. Many risk factors are not modifiable. Awareness of the risk factors may alert the clinician to general levels of risk, but it is the key contextual triggering factors and the person's current mental state, suicidal intent and behavior that are most immediately important.

Finally, the formulation of the level of risk for suicide should also determine the most appropriate care environment in which to address the risk and provide the care needs. The first priority in determining the care setting is safety. Patients assessed as having a clear intention of taking their lives will require higher levels of safety protection than those who are able to maintain their own safety. Patients who are at high-risk for suicide require evaluation by mental health professions, and possible inpatient care to provide for

increased level of supervision and higher intensity of care. Those at intermediate and low risk may be referred to an outpatient care setting and with appropriate supports and safety plans, may be able to be followed-up in the community.

RECOMMENDATIONS

1. A suicide risk assessment should first evaluate the three domains: suicidal thoughts, intent, and behavior including warning signs that may increase the patient's acuity. (See Annotation C)
2. The suicide risk assessment should then include consideration of risk and protective factors that may increase or decrease the patient's risk of suicide. (See Annotation D)
3. Observation and existence of warning signs and the evaluation of suicidal thoughts, intent, behaviors, and other risk and protective factors should be used to inform any decision about referral to a higher level of care. (See Annotation E)
4. Mental state and suicidal ideation can fluctuate considerably over time. Any person at risk for suicide should be re-assessed regularly, particularly if their circumstances have changed.
5. The clinician should observe the patient's behavior during the clinical interview. Disconnectedness or a lack of rapport may indicate increased risk for suicide.
6. The provider evaluating suicide risk should remain both empathetic and objective throughout the course of the evaluation. A direct non-judgmental approach allows the provider to gather the most reliable information in a collaborative way, and the patient to accept help.

How to Approach the Assessment of Risk for Suicide?

The evaluation of a patient's risk for suicide is often performed during a time of crisis during which the person may feel threatened that his/her sharing of suicidal thoughts and behaviors will result in the loss of autonomy through hospitalization, behavioral restriction, or the loss of esteem through recognition of psychiatric illness and the associated stigma. This crisis may confound the risk assessment if the identified patient seeks to minimize her/his symptoms in order to be released, or to reassure loved ones or the clinician.

Stigma may play a role in discouraging help-seeking behavior for those at risk for suicide and self-directed violence. It is therefore important for clinicians to be aware of the potential for patients to minimize their suicidal risks and try to reassure and convince the clinician they can be released from care.

Patients in a suicidal crisis often feel a great degree of shame and tend to be exquisitely sensitive to being judged. Therefore, a neutral, non-judgmental assessment is more likely to elicit reliable data and foster an alliance with the patient. The assessment should be stepwise, from general to specific questions. More detailed exploration is indicated if risk factors for suicide become apparent. It is important to recognize that risk may still be high in persons who are not explicitly expressing ideation or plans, searching for means, or threatening suicidal behavior. Persons who may truly intend to end their lives may conceal warning signs. If the patient is not willing or able to provide accurate information, then the clinician may need to relay on objective observations and demonstrated behaviors. Consultation with mental health professionals is advisable in such instances.

Some providers fear that by asking about suicide they may prompt the patient to feel suicidal. However, evidence shows that direct assessment of suicidal ideation and intent does not increase the risk for suicide. There is no risk of causing suicidality by talking about it; there is a risk of ignoring or missing

suicidality if the topic is avoided. Questions should be framed in a non-judgmental way to enhance the probability of eliciting a truthful response.

Examples of questions to be asked when assessing suicidality are included in the following recommendations. The examples are provided here to assist clinicians in the choice of words and phrases and in illustrating alternative approaches for eliciting information. In some cases other suicide risk assessment tools can assist in detecting incongruity between a person's level of distress and his or her stated level of intent regarding suicide. Additional useful information on how to approach the questioning and the assessment can be found on several websites [e.g., SPRC, SAMHSA].

C. Assessment of Suicidal Ideation, Intent and Behavior

Assess the patient's thoughts of suicide, the intention to act on those thoughts, and behaviors that demonstrate warning signs.

Suicidal self-directed violence can be conceptualized as a continuum with thoughts about death at one end and lethal suicidal acts at the other. Suicide risk often develops in a stepwise fashion with increasing and more specific ideation and planning overcoming ambivalence and the individual becoming more and more determined (Van Orden, 2010).

The first step in assessing suicide risk involves asking the patient direct questions to determine where the individual falls on this continuum. Has the patient advanced beyond thoughts of death, are the necessary components of suicidal intent present (wishes to die, means to kill oneself and understanding of the consequences of actions). In some cases suicide has already been attempted or acts or preparation towards engaging in Self-Directed Violence can be observed. The circumstances of the individual patient in regards to the continuum are the first clue in formulation of the level of risk for suicide.

C1. Suicidal Ideation/Thoughts

Ask the patient if he/she has thoughts about wishing to die by suicide, or thoughts of engaging in suicide-related behavior. The distinction between non-suicidal self-directed violence and suicidal behavior is important.

BACKGROUND

The assessment of risk for suicide begins with query regarding ideation and gaining an understanding of the patient's suicidal thoughts with the goal of identifying suicidal intent. Suicidal thoughts can lead to suicidal behavior. Thoughts may be persistent or fleeting, with the former being more likely to compel action than the latter. Therefore it is important to understand the nature, intensity, frequency and duration of any suicidal thoughts a person is experiencing as part of any suicide risk assessment. Inquire about recent ideation (preceding 2 weeks) and past events. In addition, explore if the suicidal thoughts are current, being experienced by the patient during the interview itself.

The nature and frequency may or may not be related to suicidal intent. Suicidal ideation is assumed to be present in the majority of suicide attempts and completed suicides; however many who attempt suicide deny suicidal ideation prior to attempt, and many individuals have suicidal thoughts without making attempts.

Remember, asking directly does not increase patient's ideation, but rather indicates that you are ready to listen and help.

RECOMMENDATIONS

1. Patients should be directly asked if they have thoughts of suicide and to describe them. The evaluation of suicidal thoughts should include the following:

a. Onset (When did it begin)
b. Duration (Acute, Chronic, Recurrent) Intensity (Fleeting, Nagging, Intense)
c. Frequency (Rare, Intermittent, Daily, Unabating)
d. Active or passive nature of the ideation ('Wish I was dead' vs. 'Thinking of killing myself')
e. Whether the individual wishes to kill themselves, or is thinking about or engaging in potentially dangerous behavior for some other reason (e.g., cutting oneself as a means of relieving emotional distress)
f. Lethality of the plan (No plan, Overdose, Hanging, Firearm)
g. Triggering events or stressors (Relationship, Illness, Loss)
h. What intensifies the thoughts
i. What distract the thoughts
j. Association with states of intoxication (Are episodes of ideation present or exacerbated only when individual is intoxicated? This does not make them less serious; however may provide a specific target for treatment)
k. Understanding regarding the consequences of future potential actions

Example of Questions on Ideation:

"With everything that has been going on, have you been experiencing any thoughts of killing yourself?"

- *When did you begin having suicidal thoughts?*
- *Did any event (stressor) precipitate the thoughts?*
- *How often do you have thoughts of suicide?*
- *How long do they last?*
- *How strong are the thoughts of suicide?*
- *What is the worst they have ever been?*
- *What do you do when you have these (suicidal) thoughts?*
- *What did you do when they were the strongest ever?*
- *Do thoughts occur or intensify when you drink or use drugs?*

C2. Suicidal Intent

Assess for past or present evidence (implicit or explicit) that the individual wishes to die, means to kill him/herself, and understands the probable consequences of his/her actions or potential actions.

BACKGROUND

Assessing for current intent and the degree of intent for suicide is a key component of the assessment process. The presence of intent to act upon suicidal thoughts is generally indicative of high risk for suicide. Therefore it is important to understand the extent to which the patient: 1) wishes to die; 2) means to kill him/herself; 3) and understands the probable consequences of his/her actions or potential actions.

Patients with active suicidal ideation may have the intent to act, a plan to act, both, or neither. The evolution of intent can occur over minutes or years. In some cases the intent stage may be very brief and the suicidal ideation may propel to a behavior or suicide act.

The assessment for suicidal intent can be challenging:

- Although many patients find it a relief to finally be able to discuss their thoughts and plans, patients who have the most serious suicidal intent may be the most likely to withhold their intent. The determination of suicide intent may be based upon a blend of what the patient tells the clinician (the stated intent), how plans and action may indicate the actual intent, and what the patient consciously or unconsciously withholds. Explicit evidence is generally objective behaviors that may include things like a note or statement related to the wish to die, or making preparations for death (giving away items, completing a will). To understand the strength and desire of the patients who state they "wish to die" it is also useful to identify what are their reasons for living. Do they state that, although they think about suicide, they don't think they "could ever bring themselves to leave their family" or "they would never do it because it would leave their children without a parent". On the other hand, it is also helpful when the answer is "Very likely," "Why not?" or "No one cares…"
- The existence of suicidal intent can also be reflected in the level of the patient's expectation to carry out a plan and the belief that the plan/act will be lethal. Therefore, patients should be asked if they have developed a plan to end their life. A well-formulated plan to attempt suicide indicates greater thought and intent about the possibility of action. The lethality of the plan is indicative of risk in that death is more likely with a firearm than a drug overdose. The feasibility of the plan should also be considered. How accessible/realistic is the stated plan for suicide is important in determining the level of the risk.
- Also critically important are the patient's thoughts about "how" they would make an attempt. Will they isolate themselves in a remote location to avoid detection? Have they considered the consequences of their action? Planning to make the intent known to others may reveal insight in a hope to be interrupted and rescued.
- The extent, thoroughness, and time spent by the patient on suicidal planning may be a better reflection of the seriousness of the intent and the proximity of the patient's desire to act on that intent. It is important to bear in mind that medical and/or psychiatric conditions (e.g., delirium, intoxication, psychosis) can impair an individual's ability to understand the probable consequences of their actions or potential actions.
- There is often a great deal of contingency planning around controlling suicidal behavior, whereby the patient believes suicide would not be attempted if certain conditions existed, but would be acted upon under other circumstances. It is important to understand these contingencies to better assess an individual's actual intent at a given point in time. For example, and individual might state that they would only kill themselves if a medical condition took a turn for the worse.

RECOMMENDATIONS

1. Patients should be asked the degree to which they wish to die, mean to kill him/herself, and understand the probable consequences of his/her actions or potential actions
2. The evaluation of intent to die should be characterized by:
    a. Strength of the desire to die
    b. Strength of determination to act
    c. Strength of impulse to act or ability to resist the impulse to act
3. The evaluation of suicidal intent should be based on indication that the individual:
    a. Wishes to die
    b. Means to kill him/herself

c. Understands the probable consequences of the actions or potential actions
d. These factors may be highlighted by querying regarding how much the individual has thought about a lethal plan, has the ability to engage that plan, and is likely to carry out the plan

Example of Questions on Intent:
- *Do you wish you were dead?*
- *Do you intend to try to kill yourself?*
- *Do you have a plan regarding how you might kill yourself?*
- *Have you taken any actions towards putting that plan in place?*
- *How likely do you think it is that you will carry out your plans?*

C3. Preparatory Behavior

Assess if the patient has begun to show actual behavior of preparation for engaging in Self-Directed Violence (e.g., assembling a method, preparing for one's death).

BACKGROUND

Assessment of risk for suicide may find that the patient has already begun to take specific action in implementing their plan to kill themselves (e.g., buying a gun, collecting pills, assembling methods), or started to make preparation for the aftermath of their death (e.g., giving away their belonging, changing a will, or sending notes to loved ones). These acts and behaviors are defined as preparatory behaviors and put the patient at the high risk for suicide. Research has shown that resolved plans and preparatory behavior predicted death by suicide and history of suicide attempts.

Gathering information regarding preparatory behaviors may require exploring other sources of information about the patient. This may require a careful discussion with the patient and obtaining the patient's consent. Peers, unit members, and command elements may play a critical role in corroborating information regarding psychosocial functioning and preparatory behavior.

RECOMMENDATIONS

1. Clinicians should evaluate preparatory behaviors by inquiring about:
    a. Preparatory behavior like practicing a suicide plan. For example:
        - Mentally walking through the attempt
        - Walking to the bridge
        - Handling the weapon
        - Researching for methods on the internet
    b. Thoughts about where they would do it and the likelihood of being found or interrupted?
    c. Action to seek access to lethal means or explored the lethality of means. For example: (See Annotation D5)
        - Acquiring a firearm or ammunition
        - Hoarding medication
        - Purchasing a rope, blade, etc.
        - Researching ways to kill oneself on the internet
    b. Action taken or other steps in preparing to end one's life:
        - Writing a will, suicide note

- Giving away possessing
- Reviewing life insurance policy

2. Obtain collateral information from sources such as family members, medical records, and therapists.

> *Examples of Questions on Preparation:*
> • *Do you have a plan or have you been planning to kill yourself?*
> *If so, how would you do it? Where would you do it?*
> • *Do you have the (drugs, gun, rope) that you would use? Where is it right now?*
> • *Do you have a timeline in mind for killing yourself?*
> • *Is there something (an event) that would trigger acting on the plan?*
> • *How confident are you that your plan will end your life?*
> • *What have you done to begin to carry out the plan?*
> • *Have you made other preparations (e.g., updated life insurance, made arrangements for pets)?*

C4. Previous Suicide Attempt

Obtain information from the patient and other sources about previous suicide attempts. Historical suicide attempts may or may not have resulted in injury, and may have been interrupted by the patient or by another person prior to fatal injury.

BACKGROUND

The suicidal behavior may have intensified even further to include a non-fatal suicide attempt, interrupted by self or other [e.g., overdosing on drugs but calling for help (911) or vomiting immediately; or being found by someone (family/first responders and being saved)]. A suicide attempt may or may not have resulted in injury. History of a past suicide attempt is one of the strongest and most reliable predictors of future suicidal behavior.

While the literature regarding the impact of a recent suicide attempt on future behavior varies in regard to the time frame for the definition of recent, the general level of concern relating to a past attempt is increased with high lethality events, and decreased when past events are more temporally remote. Individuals with a history of multiple attempts often present a more complicated clinical picture. Consultation with a mental health professional is indicated.

RECOMMENDATIONS

1. The assessment of risk for suicide should include information from the patient and collateral sources about previous suicide attempt and circumstances surrounding the event (i.e., triggering events, method used, consequences of behavior, role of substances of abuse) to determine the lethality of any previous attempt:
    a. Inquire if the attempt was interrupted by self or other, and other evidence of effort to isolate or prevent discovery
    b. Inquire about other previous and possible multiple attempts
    c. For patients who have evidence of previous interrupted (by self or other) attempts, obtain additional details to determine factors that enabled the patient to resist the impulse to act (if self-interrupted) and prevent future attempts.

DISCUSSION

According to the framework of Joiner's Interpersonal Theory, three constructs are necessary, sufficient, and proximal causes of lethal suicidal behavior. Two of these are primarily related to suicidal desire—thwarted belongingness and perceived burdensomeness—and one primarily related to capability—learned fearlessness of physical pain, physical injury, and death itself (i.e., the acquired capability for suicide).

This latter factor provides a framework for understanding the complex relations between a history of past attempts and risk for future suicidal behavior. According to the theory, the most direct route (but not the only route) to acquiring the capability for suicide is by engaging in suicidal behavior, either through suicide attempts, aborted suicide attempts (preparing for the attempt and nearly carrying it out), or practicing and/or preparing for suicidal behavior (e.g., hoarding medications; buying a gun with intent to engage in suicidal behavior; and imagining one's death by suicide). Although Joiner and his colleagues (e.g., Van Orden et al., 2010) have been clear that they invite ongoing empirical scrutiny of the theory, there is considerable empirical support to date (summarized in Van Orden et al., 2010).

Previous Attempt

Several studies indicate that one of the most reliable and potent predictor(s) of future suicidal ideation, attempts, and death by suicide is having a prior history of this type of behavior.

The risk for completed suicide is considerably increased in individuals with a previous suicide attempt: 0.5% to 2% at one year, above 5% at nine years (Owens, 2002). Repetition rates are high (e.g., 16% at 1 year, 21% at 1 to 4 years and 23% at over 4 years) Owens, 2002).

Review of risk factors for suicide indicates that a history of a past suicide attempt is one of the strongest and most reliable predictors of suicidal behavior; however, the literature also indicates that the majority of individuals who attempt suicide will not eventually die by suicide and that many people who die by suicide have not previously attempted (Rudd, Joiner, & Rajab, 1996). One important risk may be regretting having survived a suicide attempt. It was found to be associated with later death from suicide (Henriques et al., 2005).

Multiple attempts

The presence of multiple past attempts is an especially strong predictor of lethal suicidal behavior in adults (Christiansen et al., 2007; Haw et al., 2007; Suominen et al., 2004; Zonda, 2006), as is a previous attempt with high medical lethality (Gibb, et al., 2005). A 37-year longitudinal study indicated that the elevation in risk for lethal suicidal behavior conferred by a history of a previous attempt persists over the lifetime (Suominen et al., 2004).

Previous researchers have subsumed multiple attempters under the general category of attempters. The relationships among suicide ideators, attempters, and multiple attempters were explored in 332 psychiatric patients referred specifically for suicidal ideation or behavior (Rudd et al., 1996). Comparisons across a range of variables, including Axis I DSM diagnoses of depressive and anxiety symptoms, suicidal ideation, hopelessness, problem solving, and a range of personality features revealed that multiple attempters presented a more severe clinical picture and, accordingly, elevated suicide risk compared with single attempters and ideators. Observed differences between groups were maintained when attempters with "questionable intent" (i.e., those making equivocal attempts) were excluded from the analyses.

Some research on effectiveness of treatment intervention has shown difference in outcome between single and multiple attempters (Hatcher 2011).

C5. Warning Signs – Indications for Urgent/Immediate Action

Recognize precipitating emotions, thoughts, or behaviors that are most proximally associated with a suicidal act and reflect high risk

Many suicidal individuals reveal warning signs or signals of their intention to engage suicidal behaviors, thereby providing clinicians or other supportive persons the opportunity to recognize an impending suicidal crisis and intervene.

Three **direct** warning signs portend the highest likelihood of suicidal behaviors occurring in the near future. Observing these warning signs warrants immediate attention, mental health evaluation, referral, or consideration of hospitalization to ensure the safety, stability and security of the individual:

- **Suicidal communication** - **writing** or talking about suicide, wish to die, or death (threatening to hurt or kill self))
- **Seeking access or recent use of lethal means**: such as weapons, medications, or other lethal means
- **Preparations for suicide** - evidence or expression of suicide intent, and/or taking steps towards implementation of a plan. Makes arrangements to divest responsibility for dependent others (children, pets, elders), or making other preparations such as updating wills, making financial arrangements for paying bills, saying goodbye to loved ones, etc.

These signals are likely to be even more dangerous if the person has previously attempted suicide, has a family history of suicide and/or intends to use a method that is lethal and to which he/she has access.

Other **indirect** warning sign presentation(s) or behavioral expressions that may indicate increased suicide risk and urgency in a patient at risk for suicide

RECOMMENDATIONS

1. Assess for other warning signs that may indicate likelihood of suicidal behaviors occurring in the near future, and require immediate attention:

- **Substance abuse** – increasing or excessive substance use (alcohol, drugs, smoking)
- **Hopelessness** – expresses feeling that nothing can be done to improve the situation
- **Purposelessness** – express no sense of purpose, no reason for living, decreased self-esteem
- **Anger** – rage, seeking revenge
- **Recklessness** –engaging impulsively in risky behavior
- **Feeling Trapped** – expressing feelings of being trapped with no way out
- **Social Withdrawal** – withdrawing from family, friends, society
- **Anxiety** – agitation, irritability, angry outbursts, feeling like wants to "jump out of my skin"
- **Mood changes** – dramatic changes in mood, lack of interest in usual activities/friends
- **Sleep Disturbances** – insomnia, unable to sleep or sleeping all the time
- **Guilt or Shame** – Expressing overwhelming self-blame or remorse

DISCUSSION

These warning signs are based on an expert panel's recommendations (Rudd et al., 2006). And have very limited empirical basis generally. Moreover, there is a true paucity of controlled data on warning signs in Veterans or Military Service members.

As thoughts of death become more specific regarding suicide, the following may be observed and indicate an increased risk:

- Feelings of hopelessness,
- Sense of isolation or alienation (being alone and misunderstood)
- Negative ruminations, self-pity
- Inactivity and social withdrawal
- Inhibited aggression turned toward the self (auto-aggression)
- Suicidal fantasies and planning
- Dysphoria
- Somatic symptoms such as sleep problems, fatigue, and loss of appetite.