

Once the decision to die by suicide is made, the suicidal person may be less agitated and appears more stable, leading clinicians to underestimate the suicide risk. Presence of the above behavioral characteristics should be considered a warning sign.

D. Assessment of Factors that Contribute to the Risk for Suicide

Assess factors that are known to be associated with suicide (i.e., risk factors, precipitants) and those that may decrease the risk (i.e., protective factors).

BACKGROUND

Suicide usually occurs in a crisis and rarely happens in the absence of other important factors. For a suicide act to take place it usually requires a predisposition, a precipitating event or trigger, and the capability (method and access to means) to carry it through. Being aware of these allows possible interventions to decrease the risk at various stages of the crisis.

Risk factors help distinguish a higher risk group from a lower risk group. Risk factors may be modifiable and non-modifiable. Both modifiable and non-modifiable risk factors inform risk formulation and modifiable risk factors may also be targets of intervention. The goal of risk factor assessment will vary depending on the clinical setting and level of care.

The presence of risk factors may increase risk for suicide, but the acuity of risk is further established by the presence of warning signs. For example, not all persons who are unemployed are at risk for suicide. However, if an unemployed person becomes increasingly hopeless about his or her future, possibly due to extreme financial difficulties or inability to support family, and begins to express purposelessness (decrease of self-esteem), then that person may be at high risk for suicide.

Predicting with certainty whether any given individual will actually attempt suicide is difficult, if not impossible. However, it is important to know that in many cases, people who die by suicide have communicated suicidal thoughts and feelings and their intent to kill themselves to someone prior to the suicidal act (Average 29% of suicides in DoDSER 2009-2011), and suggested missed opportunities for life-saving interventions. It is possible to recognize changes in behavior and the existence of crises that place people at high risk and may precipitate suicidal behavior. Friends, family members, commanders, and relatives who come into contact with the person can help.

Knowledge of risk factors may help to target intervention that will prevent the potentially destructive process in which a person is involved. Action may then be taken to reduce the risks. For example, experiences such as history of traumatic events, chronic illness and disability, lack of social support and extreme loss (i.e., financial, personal, social), and substance abuse are important for understanding the origins of risk. These risk factors in the absence of warning signs may represent a less immediate risk for suicide. Focusing intervention to mitigate these stressors can reduce the risk and avoid the progression into warning signs of suicidal behavior.

Once the decision to die by suicide is made, the suicidal person may paradoxically appear less agitated and more stable, leading clinicians to underestimate suicide risk. Therefore, a sudden apparent decrease in distress in an individual recently deemed to be at high risk of suicide warrants caution and reassessment or risk.

RECOMMENDATIONS

1. Providers should obtain information about risk factors during a baseline evaluation – recognizing that risk factors have limited utility in predicting future behavior.
2. Providers should draw on available information including prior history available in the patient's record, inquiry and observation of the patient, family or military unit members and other sources where available.

3. Assessment tools may be used to evaluate risk factors, in addition to the clinical interview, although there is insufficient evidence to recommend one tool over another.
4. The baseline assessment should include information about risk factors sufficient to inform further assessment if conditions change such as firearm in the home, social isolation, history of depression, etc.
5. Risk factors should be considered to denote higher risk individuals (e.g., those with a history of depression) and higher risk periods (e.g., recent interpersonal difficulties).
6. Risk factors should be solicited and considered in the formulation of a patient's care.
7. Reassessment of risk should occur when there is a change in the patient's condition (e.g., relapse of alcoholism) or psychosocial situation (e.g., break-up of intimate relationship) to suggest increased risk. Providers should update information about risk factors when there are changes in the individual's symptoms or circumstances to suggest increased risk.
8. Patients ages 18 to 25 who are prescribed an antidepressant are at increased risk for suicidal ideation and warrant increase in the frequency of monitoring of these patients for such behavior
9. For Military Service person in transition the provider should:
 - a. Inquire about changes in the patient's life and be aware of other indicators of change (retirement physical, overseas duty screening, etc.).
 - b. Be willing to discuss and consider methods to strengthen social support during the transition time if there are other risk factors present.

DISCUSSION

For discussion of the evidence regarding factors contributing to the risk for suicide see [Appendices B1-B4](#)

D1. Risk Factors / Precipitants

Risk factors distinguish a higher risk group from a lower risk group. Risk factors may be modifiable or non-modifiable and both inform the formulation of risk for suicide. Modifiable risk factors may also be targets of intervention.

BACKGROUND

Factors that may increase risk or factors that may decrease risk are those that have been found to be statistically related to the presence or absence of suicidal behaviors. They do not necessarily impart a causal relationship. Rather they serve as guidelines for the clinician to weigh the relative risk of an individual engaging in suicidal behaviors within the context of the current clinical presentation and psychosocial setting. Individuals differ in the degree to which risk and protective factors affect their propensity for engaging in suicidal behaviors. Within an individual, the contribution of each risk and protective factor to their suicidality will vary over the course of their lives.

No one risk factor, or set of risk factors, necessarily conveys increased suicide risk. Nor does one protective factor, or set of protective factors, insure protection against engagement in suicidal behaviors. Furthermore, because of their different statistical correlations with suicidal behaviors, these factors are not equal and one cannot “balance” one set of factors against another in order to derive a sum total score of relative suicide risk. Some risk factors are immutable (e.g., age, gender, race/ethnicity), while others are more situation-specific (e.g., loss of housing, exacerbation of pain in a chronic condition, and onset or exacerbation of psychiatric symptoms).

PSYCHOLOGICAL FACTORS

- Suicide of relative, someone famous, or a peer
- Suicide bereavement
- Loss of loved one (grief)
- Loss of relationship (divorce, separation)
- Loss of status/respect/rank (public humiliation, being bullied or abused, failure work/task)

SOCIAL FACTORS

Stressful Life Events (acute experiences)

- Breakups and other threats to prized relationships
- Other events (e.g., fired, arrested, evicted, assaulted)

Chronic Stressors (ongoing difficulties)

- Financial Problems
 - Unemployment, underemployment
 - Unstable housing, homeless
 - Excessive debt, poor finances (foreclosure, alimony, child support)
- Legal Problems (difficulties)
 - DUI/DWI
 - Lawsuit
 - Criminal offence and incarceration
- Social Support
 - Poor interpersonal relationship (partner, parents, children)
 - Geographic isolation from support
 - Barriers to accessing mental health care
 - Recent change in level of care (discharge from inpatient psychiatry)

MENTAL DISORDERS

- Mood or affective disorder (major depression, bipolar, post-partum)
- Personality disorder (especially borderline and antisocial)
- Schizophrenia
- Anxiety (PTSD, Panic)
- Substance Use Disorder (alcohol, illicit drugs, nicotine)
- Eating disorder
- Sleep disturbance or disorder (See [Appendix B-4](#))
- Trauma (psychological)

MEDICAL CONDITIONS

- History of Traumatic Brain Injury (TBI)
- Terminal disease
- HIV/AIDS
- New diagnosis of major illness
- Having a medical condition
- Worsening of chronic illness
- Intoxication
- Substance withdrawal (alcohol, opiates, cocaine, amphetamines)
- Use of prescribed medication w/ warning for increased risk of suicide (See [Appendix B-3](#))

Physical Symptoms

- Chronic pain
- Insomnia
- Function limitation

MILITARY-SPECIFIC

- Disciplinary actions (UCMJ, NJP)
- Reduction in rank
- Career threatening change in fitness for duty
- Perceived sense of injustice or betrayal (unit/command)
- Command/leadership stress, isolation from unit
- Transferring duty station (PCS)
- Administrative separation from service/unit
- Adverse deployment experience
- Deployment to a combat theater

PRE-EXISTING & NON-MODIFIABLE

- Age (young & elderly)
- Gender (male)
- Race (white)
- Marital status (divorce, separate, widowed)
- Family history of:
 - Suicide/ attempt
 - Mental illness (including SUD)
 - Child maltreatment trauma-physical/psychological/sexual
 - Sexual trauma
- Lower education level
- Same sex orientation (LGBT)
- Cultural or religious beliefs

D2. Impulsivity

BACKGROUND

Impulsivity is considered a risk factor for suicide and usually refers to the “the inability to resist a drive or stimulus, or a behavior that occurs without reflection or consideration for [its] consequences” (Zouk, 2006). Assessment of risk for suicide should focus on both, as a distinct component of the suicidal act itself (e.g., loss of control, acting on a whim), and impulsivity as a trait of the individual (e.g., demonstrating inappropriate behaviors such as temper outbursts or sexual indiscretions, using substances exacerbating adverse impulsive behaviors).

RECOMMENDATIONS

1. The assessment of risk for suicide should include evaluation of impulsivity by determining whether the patient is feeling out of control, engaging impulsively in risky behavior
2. Assess if impulsive recklessness and risk-taking characterize the pattern of behavior and life style of the individual and therefore may limit the ability to control his/her behavior.

DISCUSSION

Impulsivity has been correlated with higher rates and greater lethality of suicide attempts (Javdani et al., 2011), and is commonly associated with borderline personality (LeGris J., 2006), bipolar disorder (Swann et al., 2005), alcohol dependence, and executive dysfunction secondary to major depression (Keilp et al., 2001). Mild to severe traumatic brain injuries are also associated with increased disinhibition/impulsivity and correlated with increased suicidal behavior (Yurgelun-Todd et al., 2011). Increased social support may mitigate impulsiveness (Kleiman et al., 2012).

Paradoxically, while commonly held lay and even professional perceptions of suicide include the notion that most involve impulsivity; current research demonstrates that most suicides actually follow a plan, and thus are potentially foreseeable. This important distinction is based upon the critical difference between “state impulsivity” (traditional notion of suicide resulting from impulsive act) and impulsivity as a “trait or personality variable” exhibited throughout one’s life. This corresponds to recent understandings based on research (Thomas Joiner) indicating suicides involve 3 critical factors: 1. A sense of perceiving oneself as burdensome to others; 2. A lack of belongingness; and 3. A learned capability for self-injury based upon experiencing activities that “foster fearlessness of and competence for suicide.” Subsequent research has demonstrated that impulsive traits do not predict suicide attempt impulsivity, and that non-impulsive attempts were more lethal (Smith et al., 2008).

An individual’s degree of impulsivity should be one component of the assessment of risk for suicide, as “impulsivity increases the likelihood that an individual will acquire the capability for suicide.” (Smith et al., 2008 p.12). Furthermore, clinicians “should not be overly focused on an individual’s level of impulsivity per se; rather, more time should be spent determining whether the individual’s level of impulsivity has in fact led to a lifestyle fraught with painful and provocative experiences, which should be included in the risk assessment as well” (Smith et al., 2008 p.12).

D3. Protective Factors

Protective factors are capacities, qualities, environmental and personal resources that drive individuals towards growth, stability, and health and may reduce the risk for suicide.

The assessment for protective factors can identify potential strengths and resiliency that may be used to buffer suicide risk. Recognizing protective factors can be a means to encourage hope among persons at risk. These factors should be capitalized upon to mitigate risk in both the short and long-term.

RECOMMENDATIONS

1. Assessment should include evaluation of protective factors, patient's reason to for living, or other factors that mitigate the risk for suicide.

Social Context Support System

- Strong interpersonal bonds to family/unit members and community support
- Employed
- Intact marriage
- Child rearing responsibilities
- Responsibilities/duties to others
- A reasonably safe and stable environment

Positive Personal Traits

- Help seeking
- Good impulse control
- Good skills in problem solving, coping and conflict resolution
- Sense of belonging, sense of identity, and good self-esteem
- Cultural, spiritual, and religious beliefs about the meaning and value of life
- Optimistic outlook -Identification of future goals
- Constructive use of leisure time (enjoyable activities)
- Resilience

Access to Health Care

- Support through ongoing medical and mental health care relationships
- Effective clinical care for mental, physical and substance use disorders
- Good treatment engagement and a sense of the importance of health and wellness

DISCUSSION

Research on protective factors has lagged behind research on risk factors and, therefore, the listing represents a preliminary starting point that is based on available data, clinical experience, and theory. Although clinicians are encouraged to use this list of protective factors in their risk formulations, they should recognize that it is based on limited evidence and is no doubt incomplete. It may be more useful for clinicians to think about ways in which existing protective factors can be strengthened in the context of treatment planning, rather than attempting to weigh them as mitigating overall risk.

D4. Substance Abuse and Disorder

BACKGROUND

Substance use disorders are a prevalent and strong risk factor for suicide attempts and suicide. The recommendations for assessment of risk for suicide in this (Module) guideline generally apply to individuals with substance use disorders and should be followed.

Three key additional issues to bear in mind in working with this population refer to assessing intoxicated patients, differentiating unintentional and intentional overdose events, and special assessment considerations.

Individuals at acute risk for suicidal behavior who appear to be under the influence of alcohol or other drugs, either based on clinical presentation or objective data (e.g., breath or laboratory tests), should be maintained in a secure setting until intoxication has resolved. Risk assessment needs to be repeated once the patient is sober in order to determine appropriate next steps. Risk management options include, but are not limited to, admitting the patient for inpatient hospital care, making a referral for residential care, detoxification, or ambulatory care, or scheduling outpatient follow-up in the near future.

Intentional overdose is the most common method of attempted suicide. Therefore, the possibility that an overdose event was an intentional act of self-directed violence should always be considered. Obtaining additional information from family members, treatment providers, medical records, etc., can be invaluable in making the determination between intentional and unintentional overdose in equivocal cases.

The same factors that confer risk for suicidal behavior in non-substance abusers generally also confer risk among individuals with substance use disorders. For example, depression is a potent risk factor in both substance abusers and non-substance abusers. The presence of comorbidities (e.g., substance use disorder plus mood disorder) is the rule rather than the exception in high-risk clinical populations.

RECOMMENDATIONS

1. All patients at acute risk for suicide who are under the influence (intoxicated by drugs or alcohol) should be evaluated in an urgent care setting and be kept under observation until they are sober.
 - a. Patients who are under the influence should be reassessed for risk for suicide when the patient is no longer acutely intoxicated, demonstrating signs or symptoms of intoxication, or acute withdrawal
 - b. Obtaining additional information from family members, treatment providers, medical records, etc., can be invaluable in making the determination between intentional and unintentional overdose in equivocal cases.
 - c. Intoxicated or psychotic patients who are unknown to the clinician and who are suspected to be in at acute risk for suicide should be transported securely to the nearest crisis center or emergency department for evaluation and management. These patients can be dangerous and impulsive; assistance in transfer from law enforcement may be considered.
2. Intoxication with drugs or alcohol impairs judgment and increases the risk of suicide attempt. Use of drugs or alcohol should routinely be assessed with all persons at any risk for suicide.
3. Assess the presence of psychiatric and behavioral comorbidities (e.g., mood, anxiety disorder, aggression) in patients with substance use disorder at risk for suicide.
4. Recognize that assessment of social risk factors such as disruptions in relationships and legal and financial difficulties are important in individuals with substance use disorders.

DISCUSSION

Assessment of Intoxicated suicidal patient

In some individuals, SUD and suicidality may be temporarily related. Alcohol intoxication significantly increases suicide risk. The acute effects of intoxication may heighten psychological distress, increase aggressiveness, enhance suicide-specific expectancies, encourage making a suicide attempt, and inhibiting the generation and implementation of adaptive coping strategies. Among individuals contemplating suicide, these events may be sufficient to propel suicidal thoughts into action (Hufford, 2001). Intoxicated people are more likely to attempt suicide by using means that have a very low probability of survival. There is evidence that alcohol intoxication predicts the use of more lethal means (e.g. a firearm) in the suicide (Brent et al., 1987; Hufford, 2001). The disinhibition produced by intoxication probably facilitates suicidal ideas and increases the likelihood of suicidal thoughts being put into action, often impulsively (Sher 2006).

In managing intoxicated patients, some guidelines should be kept in mind. First, suicidal thoughts or behavior are not typical consequences of acute substance use and suggest the individual is at increased risk. Accordingly, detoxification alone is never sufficient in the presence of suicidal thoughts or behavior.

Second, there is high potential for minimization in individuals who deny suicidal thoughts once intoxication has resolved. Therefore, consulting other sources of information (e.g., medical record, collateral reports) is invaluable in making a risk formulation. Third, mood disorders confer risk for suicidal behavior whether they are induced by substances or occur independently of substance use (Aharonovic et al., 2002; Preuss et al., 2002). Therefore, risk for suicidal behavior must be addressed regardless of the etiology of a mood disturbance. Moreover, substance-induced vs. independent mood disorders (and other mental disorders) are difficult to disentangle in acute care settings and, as a result, such diagnoses should be made with appropriate caution (e.g., through use of provisional diagnoses). Fourth, more than a third of suicide deaths occur among individuals who had been drinking (Cherpitel et al., 2004), typically at high levels of alcohol consumption (Kaplan et al., 2012), and controlled reports confirm that acute alcohol use is a potent risk factor for suicidal behavior (Borges et al., 2000; Branas et al., 2011, Powell et al., 2001). Such data forcefully show that individuals who are under the acute influence of alcohol are at more (not less) risk for suicidal behavior, with potentially deadly consequences.

Risk assessment in Individuals with substance use disorders

SUDs and suicidality may also have a more distal relationship. For example, SUDs may lead to substance-related social, academic, and/or legal problems, which in turn may cause and/or worsen co-occurring psychiatric symptoms, and eventually lead to the development of suicidal thoughts or behavior (Hufford, 2001). Several risk factors are more likely to be observed among individuals with substance use disorders including aggression and impulsivity, disruptions in relationship, and legal and financial difficulties (Conner & Ilgen, 2011).

A substantial body of knowledge suggests that substance use – both drugs and alcohol – is associated with mental disorders. Co-occurring mental and substance use disorders are a common and potent combination among those who die by suicide. Psychological autopsy studies conducted internationally showed that mood disorders (particularly major depression) and substance use disorders were the most common disorders in people who died by suicide, and that 38 percent had a substance use disorder(s) plus one or more other psychiatric disorder(s) (Cavanagh et al., 2003).

Ilgen, Downing et al., (2009) identified subgroups of patients with depression treated in the Veterans Affairs health system with significantly high or low rates of suicide during a 7-year follow-up period, during which 7,684 veterans committed suicide. Patients with SUDs who were admitted as inpatients for treatment of mental health disorders and were non-African American were at highest risk for suicide. Male patients with bipolar disorder and female patients with SUDs were especially at risk. The authors concluded, “The examination of higher-order interactions among potential risk factors improves the reliability of identifying increased suicide risk among patients who are depressed.” (Ilgen 2009). Substance-induced depression and other substance-induced psychiatric symptoms are likely to be observed among individuals with substance use disorders (Conner & Ilgen, 2011).

There is little data on substance-specific risk factors after taking into account inherent differences between users of one substance (e.g., opiates) vs. another (e.g., alcohol). Research on suicidal thoughts and behaviors associated with different substances including acute drug effects and withdrawal states are needed. For example, depressed mood associated with cocaine withdrawal is very likely one explanation (among several) for the link between cocaine and suicidal thoughts and behavior (Marzuk et al., 1992), and clinically it is important to attend to potential risk during cocaine withdrawal.

Disentangling Unintentional vs. Intentional Overdose

Intentional overdose is the most common method of attempted suicide. Therefore, the possibility that an overdose event was an intentional act of suicide should always be considered. The differentiation between unintentional and intentional overdose is generally straightforward in patients who are forthcoming. However, many patients will attempt to mask a suicide attempt as unintentional, and the

differentiation is especially challenging in patients with a history of substance abuse (Bohnert et al., 2010). Unfortunately, there is limited data on the differentiation between unintentional overdose and suicidal behavior (i.e., intentional overdose) in substance abusers (Bohnert et al., 2010). Available data indicate that risk factors for suicide attempt (compared to unintentional overdose) include female sex, comorbid depression, interpersonal distress or disruption, and use of substances other than one's drug of choice (Bohnert et al., 2010; Bohnert et al., 2011; Conner et al., 2007). Prior suicide attempt(s) also increases the likelihood that a recent overdose event was intentional. A telltale risk factor for unintentional overdose (compared to suicide attempt) is a recent loss of tolerance, for example due to incarceration or detoxification (Bohnert et al., 2010). It may also be presumed that individuals using recreational drugs with high potential for miscalculation, for example intoxicants sold in head shops as "bath salts", were more likely to experience unintentional overdose. Complicating the differentiation between intentional and unintentional overdose, there are some common risk factors for both including severe substance use history, and some substance abusers will have a history of both events (Bohnert et al., 2010) Although not typical, there are instances when intentionality is equivocal even among substance abusers who are forthcoming, for example a case where the individual was experiencing suicidal ideation when he or she overdosed but appears not to have resolved to make an attempt, or when a distressed individual knowingly pushed the limits of dosage and stated to the effect "I didn't care if I lived or died" but seemed to have no clear agenda for suicide.

Obtaining additional information from family members, treatment providers, medical records, etc., can be invaluable in making the determination between intentional and unintentional overdose in equivocal cases. Use of reliable, standard interview items may also be of assistance (Britton, Wines, & Conner, 2012).

D5. Assess Access to Lethal Means

Assess the availability or intent to acquire lethal means including firearms and ammunition, drugs, poisons and other means in the patient's home. For Service members, this includes assessing privately owned firearms.

BACKGROUND

Military Service members and Veterans are at risk for lethal suicidal behavior and are more likely to use firearms as the suicide method; the increased risk for use of firearms is notable, given that this population has extensive exposure to firearms, and ample opportunities to have access to them. Certain military occupations have daily access to firearms; and the majority of military personnel have at least some weapons training.

Providers should assess the presence and the access to lethal means including firearms and ammunition, as well as prescribed and over the counter drugs, poisons and other means in the patient's home.

RECOMMENDATIONS

1. Assessment of presence and access to lethal means should include:
 - a. Fire Arms: Always inquire about access to fire arms and ammunition (including privately-owned firearm) and how they are stored
 - b. Medications: Perform medication reconciliation for all patients. For any current and/or proposed medications consider the risk/benefit of any medications which could be used as a lethal agent to facilitate suicide. Consider prescribing limited supplies for those at elevated risk for suicide, or with histories of overdose or the availability of a caregiver to oversee the administration of the medications.
 - c. Household poisons: Assess availability of chemical poisons, especially agricultural and household chemicals. Many of these are highly toxic.

DISCUSSION

There is a significant positive association between accessibility to lethal means and suicide events (Humeau et al., 2007). Limited evidence based on observational studies and available population data for event methods used in suicide and non-fatal attempts were identified in general population, Veterans and DOD Service members.

General Population

Several studies have addressed the issue of different patterns of methods used in male and female suicide populations as the primary reason for gender differences in suicide mortality. Traditionally, women have selected suicide methods that are less lethal and men have chosen techniques that are more violent and whose consequences are irreversible. Hanging was the most predominant method of suicide in all European countries combined. In fact, 54.3% of males and 35.6% of females died from hanging (Varnik, 2008).

A study of suicide methods in a large number of cases in Japan and the United States revealed that Japan had a very high proportion of hanging (70.4% for males and 60% for females); this proportion was much lower (18.2% for males and 16.2% for females) in the United States. Similarly, an Australian study reported hanging in 32% of its cases. Firearms, a highly lethal method, ranked the third among males (9.7%) and were rarely used among females (1.3%) in European countries combined. In the United States, respective proportions were much higher—63.1% and 37.2% (Ojima 2004). An Australian study reported the use of firearms in 22% of total suicides. Limiting access to firearms has been found to be an effective means of reducing suicide mortality (Leenaars, 2004; Shenassa 2003).

In the U.S. between 1999 and 2004, 54.6% of suicide deaths were attributed to firearms, 20.4% to suffocation, and 17.2% to poisoning (CDC). Two studies from the United States did indicate that firearm accessibility, especially handguns, was associated with a higher risk of suicide in older adult men (Birckmayer et al., 2001; Conwell et al., 2002).

Among drug-related suicide attempts by persons aged 18 or older who visited Emergency Departments, 33.2% involve alcohol, 28.4% illicit drugs like cocaine or marijuana, 59% psychotropic medications, and 36% pain medications, such as opioids, nonsteroidal anti-inflammatory agents, and acetaminophen (SAMHSA, 2006).

Veterans

People who use firearms in a suicide attempt have a higher rate of suicide deaths than people who use other means, simply because firearms are more lethal than other means (Brent et al., 1991; Shenassa et al., 2003; Miller, 2008).

Suicidal Veterans are more likely to own a firearm than their nonsuicidal counterparts (Lambert et al., 1997; Thompson et al., 2006). Veterans are also more likely to use a firearm to complete suicide than members of the general population (Kaplan et al., 2007; Desai et al., 2005). A survey of combat Veterans in a posttraumatic stress disorder rehabilitation program found that 75% of Veterans reported owning firearms, 59% had considered using a firearm to complete suicide, and 38% had loaded a firearm with suicide in mind while intoxicated. Although some research has shown that firearm access or ownership is associated with an increased risk of suicide among Veterans, most of the studies focused exclusively on VA male patients (Kaplan 2007; Lambert 1997; Desai 2005; Freeman 1994).

The rate, prevalence, and relative odds of firearm use among Veteran suicide decedents were studied by Kaplan (2009). Data from the National Violent Death Reporting System (NVDRS) from 2003 to 2006 was used to estimate the rates of firearm suicide among Veterans and non-Veterans. The firearm suicide rate among male Veterans (all ages) was 81% higher compared with their non-Veteran counterparts. Female Veteran suicide rate was nearly three times higher than among nonveterans (9.8 versus 3.4 per 100,000). With the exception of older women (age older than 65years), female Veterans had higher suicide rates than their non-Veteran counterparts. At all ages, Veterans had higher proportions of suicide involving firearms than non-Veterans. Veterans aged 18 to 34 and >65 years had the highest firearm suicide rates.

Strikingly, firearm suicide rate among male Veterans aged 18 to 34 years was 150% higher than that of their non-Veteran counterparts (Kaplan, 2009).

VHA – Event Method of Suicide (%)		
Year	2001-2009	2009
Total number of Suicides	(16,088)	(1,788)
Mean	Frequency (%)	
Firearm	67	66.7
Drugs /Substances	14.4	14.2
Hanging, strangulation	11.7	12.1
Other	6.8	7

VHA - Event Method of Non Fatal Attempt **	
Year	2009-2011
Total number of Attempters	(28,087)
Mean	Frequency (%)
Poisoning	49
Other/Not provided	14
Multiple methods indicated	10
Sharp object	9
Hanging, strangulation, suffocation	7
Firearms	5
Jumping	4
Other (Automobile, drowning, Fire)	2

** Based on SPAN and Most Recent VHA utilization (FY09-FY11) (Missing Data = 7586)

According to the most recent available data (VHA National Serious Mental Illness Treatment Resource and Evaluation Center (SMITREC), between FY 2001 and 2009, the means of suicide death among 16,088 Veterans 18 and older who utilized VHA services were: firearms, 67.0%; poisoning, 14.8%; strangulation, 11.7%; and other, 6.5. Firearms are, by far, the most common means for suicide among Veterans. In 2009, 66.7% of suicides among Veterans utilizing VHA health care services used firearms as a means. This proportion was comparable to the 69.2% among all Veterans included in the 2009 National Violent Death Reporting System. However, only 48.3% of non-Veterans included in the National Violent Death Reporting System utilized firearms.

DoD Service Members

Increasing numbers and rates of military member suicides have been by firearms. More than half of military suicide decedents had a firearm in the home or immediate living environment (Kinn, 2011).

According to the most recent available data (DODSER 2011) Service Members most frequently used firearms to end their lives (59.93% for all firearms, 49.13% for non-military issue firearms), or hanging (20.56%). Drug overdose was the most frequent method for suicide attempt (59.79%), followed by injury with a sharp or blunt object (11.98%). Firearms were present in the home or immediate environment of 50% of suicide decedents and of 11% Service members who attempted suicide.

Although the use of firearms is generally associated with men, the data reported suggest that firearms among female Veterans deserve particular attention among health professionals within and outside the Veterans' Affairs system. Suicides among female Service members are relatively uncommon, and suicide

methods likely vary by service. Still, it is noteworthy that, in contrast to the experience of civilian females, firearms – not poisoning – was the leading method of suicide among female Military members (DODSER 2010).

In addition, the focus should not be exclusively on the Operation Enduring Freedom/Operation Iraqi Freedom military cohort but also on men and women who served in earlier combat theaters, including the Gulf war, Vietnam Era, Korean Conflict, and World War II (Kaplan, 2009).

DODSER data for lethal means used in suicide death illustrates the significantly higher likelihood of death using a firearm versus other methods:

DOD – Event Method of Suicide (%)			
Year	2011	2010	2009
Total number of Suicides	(287)	(281)	(291)
Mean	Frequency (%)		
Non-Military Firearm	41 } 52	48 } 62	49 } 67
Military Issue Firearm	11 }	14 }	18 }
Hanging	21	25	23
Drugs	4	5	3
Jumping	1	<1	2
Drowning	<1	1	0
Unknown	8	2	2

The distribution and rank order for deaths are very different from those for non –fatal attempts.

DOD – Event Method of non fatal Attempt		
Mean	2011	2010
Drugs	60	58
Non-Military Firearm	5	3
Military Issue Firearm	2	2
Hanging	9	8
Sharp or blunt object	12	14
Jumping	1	3
Drowning	<1	1
Other causes	<1	<1

E. Determine the Level of Risk (Severity of Suicidality)

Determine the level of the risk for suicidal self-directed violence to establish the appropriate setting of care and to implement treatment interventions targeting the specific level of risk.

BACKGROUND

The formulation of the level of risk for suicide guides the most appropriate care environment in which to address the risk and provide safety and care needs. The first priority is safety. Patients assessed as having a clear intention of taking their lives will require higher levels of safety protection than those with less inclination toward dying. Patients who are at high-risk for suicide may require inpatient care to provide for increased level of supervision and higher intensity of care. Those at intermediate and low acute 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.

Considering all the information gathered in the assessment, the clinician will formulate the level of risk in one of the following categories: (See Table 1 on Page 48, for indications of risk level)

HIGH ACUTE RISK FOR SUICIDE

High-acute risk patients include those with warning signs, serious thoughts of suicide, a plan and/or intent to engage in lethal self-directed violence, a recent suicide attempt, and/or those with prominent agitation, impulsivity, psychosis. In such cases, clinicians should ensure constant observation and monitoring before arranging for immediate transfer for psychiatric evaluation or hospitalization.

INTERMEDIATE ACUTE RISK FOR SUICIDE

Intermediate acute risk patients include those patients with suicidal ideation and a plan but with no intent or preparatory behavior. Combination of warning signs and risk factors to include history of self-directed violence (suicide attempt) increases a person's risk for suicide. Patients at intermediate risk should be evaluated by a Behavioral Health provider. The decision whether to urgently refer a patient to a mental health professional or emergency department depends on that patient's presentation. Patient who is referred may be hospitalized if further evaluation reveals that the level of illness or other clinical findings warrant it. The patient may be managed in outpatient care if patient and provider collectively determine that the individual is capable of maintaining safety by utilizing non-injurious coping methods and utilize a safety plan.

LOW ACUTE RISK FOR SUICIDE

Low acute risk patients include those with recent suicidal ideation who have no specific plans or intent to engage in lethal self-directed violence and have no history of active suicidal behavior. Consider consultation with Behavioral Health to determine need for referral to treatment addressing symptoms, and safety issues. These patients should be followed up for reassessment.

NOT AT ELEVATED ACUTE RISK FOR SUICIDE (Risk outside the scope of risk classification considered in this CPG for the purpose of determining action)

Persons with mental disorder who are managed appropriately according to evidence-based guidelines and do not report suicidal thoughts are outside the scope of the classification of risk for suicide in this CPG. Patients that at some point in the past had reported thoughts about death or suicide, but currently don't have any of these symptoms are not considered to be at acute risk of suicide. There is no indication to consult with behavioral health specialty in these cases, and the patients should be followed in routine care, continue to receive treatment for their disorder and be re-evaluated periodically for thoughts and ideation.

RECOMMENDATIONS

1. Patients at HIGH ACUTE RISK should be immediately referred for a specialty evaluation with particular concern for insuring the patient’s safety and consideration for hospitalization.
2. Patients at INTERMEDIATE ACUTE RISK should be evaluated by Behavioral Health specialty.
3. Patients at LOW ACUTE RISK should be considered for consultation with or referral to a Behavioral Health Practitioner.
4. Patients at NO elevated ACUTE RISK should be followed in routine care with treatment of their underlying condition, and evaluated periodically for ideation or suicidal thoughts.
5. Patient for whom the risk remains UNDETERMINED (no collaboration of the patient or provider concerns about the patients despite denial of risk) should be evaluated by a Behavioral Health Practitioner.

Table 1. Determine Level of Risk for Suicide and Appropriate Action in Primary Care

Risk of Suicide	Indicators of Suicide Risk	Contributing Factors †	Initial Action Based on Level of Risk
High Acute Risk	<input checked="" type="checkbox"/> Persistent suicidal ideation or thoughts <input checked="" type="checkbox"/> Strong intention to act or plan <input checked="" type="checkbox"/> Not able to control impulse OR <input checked="" type="checkbox"/> Recent suicide attempt or preparatory behavior ††	<input checked="" type="checkbox"/> Acute state of mental disorder or acute psychiatric symptoms <input checked="" type="checkbox"/> Acute precipitating event(s) <input checked="" type="checkbox"/> Inadequate protective factors	Maintain direct observational control of the patient. Limit access to lethal means Immediate transfer with escort to Urgent/ Emergency Care setting for Hospitalization
Intermediate Acute Risk	<input checked="" type="checkbox"/> Current suicidal ideation or thoughts <input checked="" type="checkbox"/> No intention to act <input checked="" type="checkbox"/> Able to control the impulse <input checked="" type="checkbox"/> No recent suicide attempt or preparatory behavior or rehearsal of act	<input checked="" type="checkbox"/> Existence of warning signs or risk factors †† AND <input checked="" type="checkbox"/> Limited protective factor	Refer to Behavioral Health provider for complete evaluation and interventions Contact Behavioral Health provider to determine acuity of the referral Limit access to lethal means
Low Acute Risk	<input checked="" type="checkbox"/> Recent suicidal ideation or thoughts <input checked="" type="checkbox"/> No intention to act or plan <input checked="" type="checkbox"/> Able to control the impulse <input checked="" type="checkbox"/> No planning or rehearsing a suicide act <input checked="" type="checkbox"/> No previous attempt	<input checked="" type="checkbox"/> Existence of protective factors AND <input checked="" type="checkbox"/> Limited risk factors	Consider consultation with Behavioral Health to determine: - Need for referral - Treatment Treat presenting problems Address safety issues Document care and rationale for action

† Modifiers that increase the level of risk for suicide of any defined level:

- **Acute state of Substance Use:** Alcohol or substance abuse history is associated with impaired judgment and may increase the severity of the suicidality and risk for suicide act
- **Access to means** : (firearms, medications) may increase the risk for suicide act
- **Existence of multiple risk factors** or **warning signs** or lack of protective factors

†† Evidence of suicidal behavior warning signs in the context of denial of ideation should call for concern (e.g., contemplation of plan with denial of thoughts or ideation)

E1. Suicide Risk Assessment Instruments

Risk factors can inform the assessment for any given individual, but are not predictive by themselves. While suicide risk assessment scales are no substitute for comprehensive evaluation and clinical judgment based on the history of the person, they may provide a structure for systematic inquiry about risk factors for repeated suicide attempts.

BACKGROUND

Rating scales can be helpful in the assessment process. However, a clinical assessment by a trained professional is required to assess suicide risk. This professional must have the skills to engage patients in crisis and to elicit candid disclosures of suicide risk in a non-threatening environment. The assessment should comprise a physical and psychiatric examination including a comprehensive history (with information from patient, parents and significant others whenever possible) to obtain information about acute psychosocial stressors, psychiatric diagnoses, current mental status and circumstances of prior suicide attempts. Assessment tools may be used to evaluate risk factors, in addition to the clinical interview, although there is insufficient evidence to recommend one tool over another.

RECOMMENDATIONS

1. Formulation of the level of suicide risk should be based on a comprehensive clinical evaluation that is aimed to assess suicidal thoughts, intent and behavior and information about risk and protective factors for estimating the level of risk.
2. Behavioral Health provider use of a standardized assessment framework may serve to inform a comprehensive clinical evaluation. The framework should:
 - a. Estimate the level of risk
 - b. Support clinical decision-making
 - c. Determine the level of intervention and indication for referral
 - d. Allow monitoring of risk level over time
 - e. Serve as the foundation for clinical documentation
 - f. Facilitate consistent data collection for process improvement
3. Assessment of risk for suicide should not be based on any single assessment instrument alone and cannot replace a clinical evaluation. The assessment should reflect the understanding [recognizing] that an absolute risk for suicide cannot be predicted with certainty.
4. There is insufficient evidence to recommend any specific measurement scale to determine suicide risk.

DISCUSSION

Utility of an assessment instrument depends upon each of several parameters, including, but not limited to: time/historical era, service delivery settings (e.g. primary care versus behavioral health), population (e.g., Military versus Veteran versus Civilian) and across clinical versus community-based). Consequently, it must be acknowledged that no single scale or assessment method is appropriate for all applications.

Important considerations in the selection of an assessment instrument include: the purpose, population, assessment setting, and context in which suicidal ideation and behavior emerges. For example, the suicide risk assessment setting and population associated with that setting would vary widely (e.g. primary care

patients versus deployed Military personnel). Furthermore, the selection of a tool will vary with the stage of assessment, e.g., screening of primary care patients will require different tools than assessment of risk among those who have already been screened as positive (higher risk than the general population).

Another consideration is the extent to which the tool guides the process of evaluation (e.g. the SAMHSA/SPRC safety card versus a check list versus a 4-item mnemonic, e.g. questions keyed to 4 P's in the 4P screener).

In lieu of an assessment tool that includes a scale, a comprehensive yet brief framework may include the relevant reminders and checklist designed to walk a professional through the risk assessment process. Such a framework tool should incorporate the key principles of assessment. This includes: specific suicide inquiry, determination of risk level, determination of level of intervention and documentation.

Advantages of Standardized Suicide Assessment Tools Across DoD and the VA Health Care Systems

There are several advantages for the use of same standardized assessment tool(s) across DoD and VA health care systems.

- In the clinical arena, standardization of measures would facilitate longitudinal monitoring of episodes of care over the pre- and post-military span of an individual's healthcare history
- Standardization of assessment tools across the DoD and VA would support longitudinal research on access to care, patterns of service seeking, and variation in symptom acuity and functional status in association with service seeking and/or treatment received. It would support evaluation of the predictive value of putative risk indicators (demographic, clinical and psychosocial) in relation to short- and longer-term outcomes in military and post-military (e.g. VA) settings
- Standardization of assessment tools across the DoD and VA could also contribute to continuous quality improvement of surveillance, clinical assessment, triage and intervention for prevention of suicide
- Therefore, it will be important to recommend criteria for selection to assist providers and facilities in identifying tools that can triage for more effective next steps, implementation of interventions, etc.
- Assessment of risk for suicide should not be based on any single assessment instrument alone. Structured and semi-structured suicides scales or risk factor checklists are not complete assessments in themselves but can help to inform a management plan
- Structured screening instruments can improve routine clinical assessment in the documentation and detection of lifetime suicidal behavior.

Disadvantages of Assessment Tools in General

- Forms are no substitute for spending time to know the patient.
- Only a few single suicide risk assessment methods have been empirically tested for reliability and validity.
- Standard practice encompasses a wide range of reasoned clinical approaches. The clinician's duty is to perform a competent suicide risk assessment by using a reasonable method.
- When substituted for clinical assessment, forms can increase the risk of missing a patient's suicidal intent.
- Forms tend to be focused on an event, whereas clinical assessment is a process.
- The best scales cannot perform the integrative function of clinical assessment and judgment.
- The range of general and individual suicide risk factors cannot be captured by any instrument, regardless of how sophisticatedly constructed.
- May result in false positive that may lead to unnecessary or harmful interventions
- Can take valuable clinical time to complete (especially in primary care) and negatively affect patient satisfaction.

To date, there is no single recommended method to assess for suicidality in routine practice. Research scales that have been tested but are not routinely used in clinical practice include, the Beck Scale for

Suicidal Ideation (SIS) (Beck et al., 1979), the Columbia Suicide Severity Rating Scale (Posner et al., 2007), the Sheehan Suicide Tracking Scale (Coric et al., 2009), the P4 addition to the PHQ-9, and the Nurses' Global Assessment of Suicide Risk (Cutcliffe et al., 2004). The scoring in these scales is sometimes complicated, and most have been tested in psychiatric specialty care. A few studies have used more complex algorithms to assess suicidality. Oquendo et al. (2003), provides a comprehensive discussion of the utility and limitations of research instruments in assessing suicide risk.

Other research scales and psychological instruments include the Hamilton Rating Scale for Depression (Ham-D), the Beck Depression Inventory (BDI, BDI-II), and the Inventory of Depressive Symptomatology (IDS). The Columbia Suicide History Form (CSHF), which determines lifetime suicide attempts, based on characteristics of suicide ideation; the Suicide Intent Scale (SIS), which identifies the wish to die; the Harkavy Asnis Suicide Survey (HASS), which detects suicide ideation and behavior; and the Beck Hopelessness Scale (BHS), which reveals negative attitudes about the future.

EVIDENCE

One non-systematic literature review that provides comprehensive lists of existing suicide assessment tools for adults and older adults Brown et al., (2002). The review describes the psychometric properties and validation studies for measures designed to assess suicidal ideation and behavior. The review highlights the need for further prospective research to establish the effectiveness of these assessment tools in predicting suicidal self-directed violence. The authors note that current research is insufficient to determine definitively whether or not there is a benefit in implementing existing screening tools for the prevention of suicide.

The review cites numerous measures that have demonstrated adequate internal reliability and concurrent validity, though it highlights the **Scale for Suicidal Ideation** and the **Beck Hopelessness Scale** as two of only very few measures that have shown associations with death by suicide. However, McMillan et al. (2007) meta-analysis concludes that the low specificity rate for identifying those at risk for future self-harm makes it unlikely that the Beck Hopelessness Scale will be "of use in targeting treatment designed to lower the rate of repetition."

Evidence Review of Assessment Tools (Summary of the VA-ESP Systematic review (Haney et al., 2012)

We examined the best available evidence from primary studies related to Veterans and members of the Military. Among the five primary studies that met our inclusion criteria, three are of limited quality. There were no studies identified that evaluated whether a risk assessment tool can accurately reclassify Veterans and Military personnel from low risk for suicide to higher risk. This leads to an inconclusive rating for the overall strength of evidence regarding assessment tools for suicide. Evidence of accurate reclassification would be necessary to increase this overall assessment of strength of evidence for research investigating suicide risk assessment tools.

Though the small number of studies provides insufficient and low strength evidence for the assessment of suicide risk, certain aspects of the findings warrant further discussion.

Two of the studies investigated assessment tools commonly used in VA settings: the PAI (Breshears et al., 2010) and the BDI-II (Hartl et al., 2005) whereas the other three studies investigated tools not commonly used in VA settings (Hendin, 2010; Nademin, 2008 (used in the AF)) or no longer commonly used in VA settings (Tiet et al., 2006). Of these latter three studies of assessment tools less common to VA settings, the IPS is lengthy and the results are seriously called into question due to the method of assessment and group comparison (one group was assessed by estimating history post-mortem and compared to responses from a living comparison group).

The study by Hendin et al. (2010) investigated the ASQ, a brief screening tool designed to assess risk for suicide. Though the sample was relatively small (n=283) and the study was rated as having an unclear risk of bias, preliminarily positive results and ease of implementation suggest that this tool warrants further research investigating potential for use and predictive power in a validation sample of Veterans or members of the Military. The ASQ increased odds of prediction of future suicidal behavior by 2.4 in a

logistic regression model adjusting for sex, substance abuse, and severity of depression. Using a cutoff of ≥ 3 , the ASQ resulted in sensitivity of 0.60 and specificity of 0.74 in this population. The study obtained a rating of unclear risk of bias because of insufficient information on how patients were selected to participate and no information on assessor blinding when assessing the suicidal behavior outcome. Because of the unclear risk of bias and relatively small sample size, this one study provides insufficient evidence that the ASQ predicts suicidal behavior.

Tiet et al. (2006), investigated the use of the Addiction Severity Index (ASI), a lengthy structured clinical interview designed to be used as an intake interview for a substance abuse treatment program. Their study examined over 34,000 Veterans who were assessed for intake as part of substance abuse treatment at 150 VAMCs nationwide. This assessment tool is not ideal for settings that require brief screening tools, though VAs used to use this assessment routinely, and, therefore, the information is readily available in a large number of Veteran medical charts for those Veterans who received substance abuse treatment in the past. As such, the information provided in this article is helpful in establishing risk factors based on an entire population of Veteran responses to routine intake items within the timeframe covered in the study. The authors report a decision tree, delineating all significant risk factors to predict future suicidal behavior. The significant predictors were suicide attempt history, suicide ideation history, recent alcohol abuse, recent cocaine abuse, violent behavior, hallucinations, and employment status. This study was rated as having an unclear risk of bias, largely because of the unclear independence of assessors; however, because of the large sample size (i.e., the entire population of Veterans who completed a structured and electronically documented substance abuse intake process), this single study provides moderate strength of evidence for the reported risk assessment capabilities of the ASI. As noted, however, the ASI is no longer routinely used in VA settings.

Of the tools commonly used in the VA, the following describes considerations for implementation as suicide risk assessment tools: the PAI, though commonly used in VAs and other settings as part of lengthy psychological assessments, is difficult to administer without training, time, and electronic scoring software; however, this tool could potentially be used to design new, brief assessment measures based on the content of the subscales and items predictive of suicidal self-directed violence as preliminary evidence from this one study on a small sample of Veterans who had TBIs. The BDI-II is a brief, easy to administer, easy to score depression-screening tool that is commonly used in VA settings. This tool was examined in conjunction with information on participants' previous suicide attempt history.

Breshears et al. (2010) investigated the use of the Personality Assessment Inventory (PAI) in a population of 154 Veterans with a history of TBI. The PAI is a lengthy assessment tool administered by a psychologist in the context of an in-depth psychological assessment. Breshears evaluated one of the subscales of the PAI, the Suicide Potential Index (SPI), designed to assess aspects of suicidality, and found that it predicted suicidal behavior after controlling for other risk factors. Although this measure is frequently used in VA settings as part of psychological assessments, it is not well suited for use as a brief screening tool and, therefore, would be less useful in primary care settings. The lack of applicability to primary care settings is related to the lengthiness of the overall measure, the computer scoring methods, and the training/educational requirements required for interpretation and scoring. The results suggest potential additive predictive power of the SPI subscale. However, the high risk of bias rating of this study due to lack of assessor blinding and other methodological flaws does not allow for strong conclusions on the basis of this study. Although lack of assessor blinding may be less concerning with more objective outcomes such as suicide, this study used chart review to document suicide attempts, making lack of blinding a potential source of bias. More research to confirm these preliminary findings regarding the use of the SPI subscale would be necessary before recommending its use in a clinical setting.

Nademin et al. (2008) describe the Interpersonal Psychological Survey (IPS), a 34-item measure, which they report as being associated with increased odds of suicide (Odds Ratio [OR]: 1.27). This study, however, was rated as having a high risk of bias due in large part to the inability to account for confounders and differences in assessment techniques between groups. The two groups they examined were 60 members of the Air Force who died by suicide and a matched sample of 122 members of the Air Force. Due to the retrospective nature of the study investigating suicide as the primary outcome,

assessors estimated scores on the assessment tools for the groups of participants who died by suicide, whereas the control group participants completed the measures by self-report. This difference in assessment techniques and other confounders associated with the groups being compared results in insufficient evidence that the IPS predicts suicide.

Hartl et al. (2005) reported findings for a sample of 630 male Veterans diagnosed with PTSD and participating in a residential treatment program. They examined the Beck Depression Inventory-II (BDI), a 21-item, commonly used screening tool for depression that includes an item asking about suicidal ideation. This measure, due to its brevity, frequent usage, and ability to be administered, scored, and interpreted by a variety of providers, has potential for widespread implementation in VA and military settings. Though the authors found that previous suicide attempt (four months prior to intake) was the strongest predictor of future suicide attempt following discharge, they report that BDI-II score was also a significant predictor of future suicide attempt. They reported model sensitivity of 0.63 and specificity of 0.80 in their exploratory sample of 409 Veterans. The replication study examining data on the remaining 221 Veterans used the cutoffs established in the exploratory study. Contrary to the exploratory model, the replication model resulted in sensitivity of 0.11 and specificity of 0.84. Overall, this study provides insufficient evidence for the BDI-II in predicting future suicide attempts in a Veteran population with PTSD due to the inconsistent results as well as the high risk of bias rating of this study.

E2. Detection, Recognition and Referral (in Primary Care)

Assessment of Suicide Risk in the Primary Care Settings:

BACKGROUND:

An integrated understanding of the individual biological, psychological, social and cultural factors impacting suicide and recognition of warning signs is necessary for effective risk assessment and determination. This understanding needs to be translated into effective evidence based screening and assessment framework that can be efficiently and broadly applied in the general medical setting.

Primary care and general medical settings are the entry point for the care of population health. Comprehensive Suicide Risk Assessment is not feasible in the primary care setting due to the time constraints and lack of suicide-specific specialty training in this setting. The goal, therefore, in primary care is to identify patients at risk and refer those at elevated risk to the appropriate level of care for specialty evaluation.

Primary care providers can play important roles in treating suicide risk. Patients may feel most comfortable confiding in their primary provider. As such, providers can be critical in making the connection therapeutic care for patients, and in encouraging patients to follow through and adhere to the treatment plan.

Primary care providers have an opportunity to develop higher sensitivity to identify these at risk patients and prevent suicide. The primary care provider must have a high index of suspicion to identify patients at risk for suicide. Somatic complaints are often a proxy for depression and anxiety. Patients presenting with insomnia, fatigue, pain, headaches, or memory loss should be screened for depression, anxiety, substance use and presence of acute stressors. When present, suicide screening and assessment may be appropriate.

Several risk-stratification protocols are used in primary care to recognize the urgency of medical conditions (e.g., chest pain, respiratory distress) and identify those patients needing referral and/or hospitalization. Similarly, primary care providers would benefit having an efficient way for assessing suicide risk in patients who have potential thoughts of self-harm. The assessment should distinguish the rare patient that need urgent referral to an emergency department/hospital from the majority of patients who can have initial treatment in collaboration with a behavioral health provider.

Primary care providers may find it useful to develop an office, or clinic, protocol that they can follow to streamline the process once a patient is identified as being at high or imminent risk--particularly if referral

to emergency services is indicated. Also, it may be useful for PCPs to identify a mental health provider in the area who they can call for assistance or a quick consultation.

Providers should follow a consistent framework that will structure the assessment process and include the key component for assessment of suicide risk. Real time availability for consultation with Behavioral Health staff is essential. Formulation of the level of risk will allow matching treatment in the appropriate context for the individual patient.

RECOMMENDATIONS:

1. Whether they have mental disorder or not, patients identified as having suicidal ideation (e.g., through routine screening for major depression or other health conditions) should receive a complete suicide risk assessment as defined in this guideline (See [Annotation B](#)).
2. When evidence of a mood, anxiety, or substance use disorder is present, patients should be asked about suicidal thoughts and behavior directly.
3. If suicidal ideation is present, the initial suicide risk assessment should be performed (See [Annotation B](#)).
4. Referral to specialty behavioral health care should be based on the level of risk and the available resources:
 - a. Patients at HIGH ACUTE RISK should remain under constant observation and monitoring before arranging for immediate transfer for psychiatric evaluation or hospitalization
 - b. Patients at INTERMEDIATE ACUTE RISK should be referred to, and managed by Behavioral Health Specialty Provider.
 - c. Patients at LOW ACUTE RISK should be considered for consultation with a Behavioral Health Practitioner.
 - d. When risk is UNDETERMINED (due to difficulty in determining the level of risk, or provider concerns about the patient despite denial of ideation or intent) the patient should be immediately referred for an evaluation by a Behavioral Health Specialty Provider.

Guidance for the Assessment of Suicide Risk in Emergency Department / Urgent care Settings:

Patient at HIGH ACUTE-RISK for suicide should be assessed and initially treated in emergency acute care setting

BACKGROUND:

There are many paths to the Emergency Department for patients at risk for suicide. Patients may be referred by a healthcare provider, a Suicide Lifeline, EMS or Police, a friend or loved one, or on their own initiative. As in primary care, a low index of suspicion is appropriate to screen for suicidal ideation or attempt. When suicidal ideation or behavior becomes the focus of attention, the patient should be managed to minimize the risk of death. In a busy Emergency Department, psychiatric patients can often be triaged as a low acuity; or placed out of sight, out of mind in a quiet room for evaluation by the behavioral health consultant. This approach places the patient and staff at risk of harm due to inadequate medical assessment and inadequate management of potentially disruptive behavior.

The evaluating clinician must also consider the safety of the clinic, the availability of support staff, and the availability of the necessary additional diagnostic capability when deciding on the appropriate setting for the evaluation.

RECOMMENDATIONS:

1. Providers should choose the setting for the initial evaluation to ensure the safety of the patient and the clinical staff so that potentially life-threatening conditions can be managed effectively. And make the appropriate steps to:
 - a. Secure all belongings to prevent access to lethal means and elopement from the Emergency Department.
 - b. Monitor the patient in a visible area, away from exits, with limited access to equipment that may be used to harm self or others.
 - c. Conduct a focused medical assessment to identify and manage any life-threatening conditions such as overdose, and assess medical stability.
 - Vital Signs, Physical Exam, Neurologic Exam, Mental Status Exam
 - ECG, Toxicology Screen, BAL, and other tests as indicated.
 - Treat life-threatening conditions.
 - d. Request Behavioral Health Consultation to conduct a thorough suicide risk assessment and recommend a treatment plan.

E3. Comprehensive Assessment for Risk for Suicide by Behavioral Health Provider

An experienced behavioral health practitioner should evaluate patients at intermediate to high acute risk for suicide

BACKGROUND:

The initial assessment of suicide risk must consider the existence of medically unstable conditions, and these must be evaluated and stabilized before the psychological and suicide evaluation can be safely performed. The initial medical evaluation should include a thorough history of recent suicidal behavior, use of any medications or substances of abuse, and any recent self-injurious behavior. A physical examination to include vital signs, cardiopulmonary examination, mental status examination, and neurological examination should be performed. When indicated, further diagnostic evaluation to include electrocardiogram, and laboratory screening to include hematology, renal and hepatic function, toxicology and alcohol/drug testing should also be considered.

After determining that the patient is medically stable, the goal is to gain a complete understanding of the patient's medical, social, and mental health history and recognize current risk factors for suicide as well as any signs and symptoms of psychiatric illness for diagnostic and treatment purposes.

The Behavioral Health practitioner must evaluate and integrate all available information to determine the patient's risk for suicide and formulate a plan that ensures the patient's safety as suicide-specific treatments are initiated. While the practitioner seeks to gain all available information and insights, many barriers exist that can obscure the assessment. Patients may present barriers to gaining a full assessment by withholding information due to defensiveness or embarrassment, or by simply being too depressed or intoxicated to reliably recall important aspects of their history. Due to the potential for unreliability in the acute crisis, collateral sources of information should be sought to validate the history. The accessibility of collateral sources also informs the treatment plan as it identifies potential sources of support for the patient.