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Psychiatric Emergencies: Assessing and Managing Suicidal Ideation

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SYNOPSIS

The assessment of suicide risk is a daunting, but increasingly frequent task for the outpatient practitioner. Guidelines for depression screening identify more individuals at risk for treatment and mental health resources are not always easily accessible. For those patients identified as in need of a formal risk assessment, this article reviews established risk and protective factors for suicide and provides a framework for the assessment and management of individuals at risk of suicide. The assessment should be explicitly documented with a summary of the most relevant risk/protective factors for that individual with a focus on interventions that may mitigate risk such as means restriction, psychotherapy and pharmacotherapy for psychiatric disorders or substance use, hospitalization, and safety planning.

Keywords

Depression; Mental Health; Prevention; Primary Health Care; Risk Assessment; Suicide

INTRODUCTION

Suicide is a complex personal and sociological phenomenon accounting for 1.6% of all deaths in the US. According to the Centers for Disease Control and Prevention (CDC), there were 42,773 suicides reported in the United States in 2014 (a rate of 13.4/100,000), which represents a 24% increase since 1999. Suicide is the 10th leading cause of death in all age groups with approximately 50% of those deaths involving firearms. Firearms account for 55% of suicides in males while poisoning is the most common means of suicide in females.

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For those aged 10–34, suicide remains the second leading cause of death behind unintentional injury. For those aged 35–54, it is the fourth leading cause of death in the United States, killing more people than liver disease, diabetes, stroke, or infection.[1]

While suicide remains the most common psychiatric emergency encountered by mental health providers, its management and risk factors are more commonly treated by primary care providers. Over 90% of individuals who complete suicide will present to their primary care provider within weeks to months of their death.[2–5] A primary care provider with a practice of approximately 2,000 patients will, on average, lose a patient to suicide every 3 years.[6] Growing requirements for depression screening in primary care render screening, assessing, and managing suicidal ideation and behaviors a more common element of practice. Yet, a majority of providers fail to screen for suicidal ideation and feel unprepared to do so. When evaluating standardized patients presenting with depressive symptoms, only 36% of providers screened for suicidal ideation with many potential barriers identified.[7] Over 40% of patients who present to primary care are hesitant to discuss their depressive symptoms, noting stigma, belief that depression is not a primary care problem, and belief that they should be able to control their own symptoms.[8] Many providers lack the time, space, access to subspecialty care, and mental health training to appropriately assess and manage suicidal patients.[9,10] In a study of 50 primary care providers who lost a patient to suicide, 88% of these patients endorsed suicidal ideation at their last visit, but such comments were at times felt to be attention-seeking or not significantly different from baseline. Providers also struggled with limited access to mental health services for their patients.[5] This challenge is also described when working with adolescent populations where risk factors are often interpreted as attention-seeking or part of normal development. In younger populations, open communication can be difficult and involving a support system can be more challenging.[11]

The aforementioned challenges make the process of assessing for suicide risk a daunting task for the busy practitioner. The purpose of this article is to cogently summarize the latest evidence and guidelines for suicide risk assessment and management with a focus for application in busy outpatient settings.

CHALLENGE

Suicidal ideation and behaviors, akin to the symptoms of an acute coronary syndrome or stroke, require immediate attention. Unlike their vascular emergency counterparts, however, no evidence-based algorithms exist to reliably assess, manage, and prevent suicide.[12] The low frequency of suicide is partly responsible for this difficulty. Suicides accounted for 1.6% of all deaths in the US in 2014. Even in higher risk demographic, such as older men, the overall prevalence of suicide is very low, particularly within a narrow time frame. Even when protocols have been applied to an inpatient psychiatric population with a higher baseline risk for suicide, positive predictive values remain less than 11%.[13] Adding to the complexity, the impact many of the variables associated with suicide at a population level may have varied impact at the level of the individual. For instance, marriage is generally protective of suicide,[14] but for a given patient it may be a key stressor driving suicidal thoughts, the primary reason to not act on suicidal thoughts, and everything in between. This

necessitates a contextual model of clinical decision making in what has been called the "quintessential clinical judgment."[15]

While our ability to predict suicide may seem grim, there has been increasing evidence that education of primary care providers, population-based suicide prevention strategies (such as media desensationalization and gun reform), and collaborative care models can reduce the rate of suicide through the identification and modification of certain risk factors and limiting access to lethal means.

MANAGEMENT GOALS

Management of suicide includes screening for suicidal ideation or behaviors, performing an assessment of the individual's current risk of imminent harm, and creating a treatment plan in collaboration with the patient and any involved supports. This process needs to be individualized, collaborative, and completed using a calm, cooperative, and curious interview style.

Screening Goals

The goal of suicide screening is to determine if an actionable risk is present. In a primary care setting, this screen should be efficient, easily completed by a front-office staff, and have high sensitivity (or low false negative rate).[16]

How to Screen

The **Patient Health Questionaire-9 (PHQ-9)** is a quick, subjective reporting scale that can be incorporated into the medical record. Affirmative responses to item 9 regarding thoughts of death or self-harm have a hazard ratios of 10 and 8.5 for attempts and deaths in a community setting, respectively.[17] It is in the public domain and available with instructions through the Substance Abuse and Mental Health Services Administration (SAMSHA) website (www.integration.samhsa.gov/images/res/PHQ%20-%20Questions.pdf). While many clinics defer to the PHQ-2 for depression screening, the cut-off for further depression assessment is typically three and can miss 50–60% of patients who would otherwise endorse suicidal ideation on item 9 of the extended version.[18]

The **Columbia Suicide Severity Rating Scale (C-SSRS)** is a public forum questionnaire that can help screen for suicide and form a detailed account of an individual's suicidal ideations or behaviors. It is easy to administer with minimal training, available in multiple languages, and easily included in an electronic medical record. In studies, it has reported sensitivity of 67%, specifically of 76%, positive predictive values of 14%, and negative predictive values of 98%.[19,20]

Table 1 includes types of screening questions that can help identify current suicide risk factors and depressive symptoms while enabling the general practitioner to discuss sensitive topics in an honest and comfortable environment.[21]

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Who to Screen

There is no current consensus on who should be screened for suicidal ideation or plans. The World Health Organization (WHO) currently recommends that all individuals over the age of 10 with any mental health disorder, epilepsy, interpersonal conflict, recent severe life event, or other risk factor for suicide should be asked about thoughts or plans to self-harm or attempt suicide.[20] Similarly, the Joint Commission recommends that all individuals with a behavioral or emotional disorder be screened for suicide.[22] In an updated review, the United States Protective Task Force (USPTF) found insufficient evidence to recommend suicide screening for the general population, noting that routine screening does not identify individuals at risk for suicide more than screening individuals with mental health disorders, emotional distress, or a history of suicide attempts.[23] Only the CDC currently recommends that all primary physicians screen the general population for both depression and suicide.[22]

In addition to the above guidelines, specific complaints or patient characteristics may warrant suicide screening. These include:

- Changes in mood, including any depressive symptoms, emotional distress, anger, irritability, or aggression[24,25]
- Anxiety or agitation[26,27]
- Sleep complaints[24]
- Evidence of unpredictable or impulsive behavior[25]
- Sudden change in life circumstances[28]
- Increase in alcohol or other drug use
- Increasing healthcare utilization, including hospitalizations, office visits, and emergency room visits[29]
- Therapy non-adherence, including medications, physical therapy, and psychotherapy
- Presentation because of family/friend – more than 50% of individuals who presented to primary care providers before suicide were convinced to do so by family or friends[30]

Despite concerns reported by both patients and general practitioners, a systematic review found no significant increase in suicidal ideation or behaviors when patients were asked about suicide, regardless of age, current level of depression, or history of suicidal behaviors.[31,32]

Assessment Goals

After screening has identified an individual at risk, a formal suicide risk assessment should occur with the following goals: identify modifiable and fixed risk factors, identify protective factors, clarify the current level of suicidal intent and planning, and estimate the current risk as low, moderate, or high to guide treatment and disposition.

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Current Assessment Guidelines

In a 2014 review of 10 published guidelines on suicide assessment and management, recommendations varied in length, depth, and content covered. Guidelines ranged from 15 to 190 pages and while the majority discussed evidence-based treatments for suicidal ideation and behaviors, few offered recommendations on how to select treatment and less than 60% included a standardized method of determining risk.[33] The published guidelines and resources that included sections on recommended risk categorizations and/or recommended interventions are included in Table 2.

How to Assess

Interviews between care providers and suicidal patients need to maintain or enhance the therapeutic alliance. All assessments should be conducted with curiosity, concern, calmness, and acceptance of the individual's current emotional and cognitive state.[34] Patients with suicidal ideation may feel hopeless, desperate, or cognitively overwhelmed, interfering with their ability to comprehend and convey these thoughts to others. Clinicians should stay attuned to their own reactions that may be non-therapeutic, such as hostility, avoidance of negative feelings, or the blurring of professional roles, possibly as a way to take on a savior role.[34]

In adolescent populations, the **HEADSS assessment** (Home, Education and employment, Activities, Drugs, Sexuality, and Suicide and safety) was developed in the Australian primary care setting to assess the psychosocial needs of younger populations and guide decision-making. The primary goal of any adolescent patient interview is to understand the developmental perspective of the patient while empowering them to participate in their healthcare, discuss sensitive topics with minimal discomfort, and to ultimately take any signs or symptoms of distress seriously.[35] In collaboration with general practitioners and the Charles Walker Memorial Trust, an interactive, case-based toolkit entitled "**The CWMT GP Toolkit – The Mental Health Consultation (With a Young Person)"** is available publicly and online (http://www.cwmt.org.uk/wp-content/uploads/2014/01/GPToolkit2013.pdf).

Risk Factors

One challenge with suicide risk factor assessment is that many risk factors are static, not modifiable, and are limited in helping determine who needs higher level of care. In a 1983 study, 30 suicides were documented in 803 veterans considered at high risk based on risk factors, but another 37 suicides were also completed in those not considered to be high risk by risk factors.[13]

In contrast, some risk factors may be more acute or sub-acute in nature, indicating a heightened risk for suicide in the near term.[36] Some of these more acute risk factors, referred to as "warning signs," were identified by a consensus panel formed by the American Association of Suicidology (AAS) to help clinicians appreciate what the patient is doing or saying in the present moment that may acutely increase their risk.[37] There is concern that even in the setting of significant protective factors, acute risk factors can significantly elevate an individual's risk for suicide.[38]

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Table 3 includes validated risk factors for suicide, separated by those associated with more acute suicide risk. Risk factors with asterisks represent factors that are potentially modifiable in the immediate clinical setting.

- **Prior suicide attempt** remains the strongest predictor of future attempts and completions.[39] There is increasing correlation between suicidal ideation and behaviors, especially for those presenting in an emergency room setting.[40,41] Although most individuals who self-harm do not go on to commit suicide, repeated self-harm even without intention to end life is a predictor of suicide and is typically present within the 12 months preceding suicide in young people.[42,43] It should be noted, though, that over 90% of suicides are completed on the first or second attempt.[44]
- **Suicidal ideation**, in contrast to a history of suicide attempts, may represent an increase in suicide risk, especially if this ideation has developed into the seeking of means to perform the action, increasing discussion about death, and rehearsal behaviors.[37] There is no documented difference between passive or active suicidal ideation in suicide course or outcome; as such, both should hold weight in suicide assessment.[45,46]
- **Stressful life events** must be considered within the circumstance and age of the patient. Common adolescent events include bullying (either as victim or perpetrator), disciplinary actions, legal issues, school difficulties, romantic break-ups, assaults, or problems relating to home-life.[47,48] For adults, financial difficulties, relationship losses, unemployment, and intimate partner violence all increase the risk for suicide attempts.[23,49–51] These events may ultimately resolve with time and action, but during a visit with a primary care provider, they are unlikely to be modifiable.
- All **psychiatric disorders**, with the exception of intellectual disability and later course dementias, are associated with an increased risk of suicidal ideation, attempts, and completions.[39,52,53] This risk is significantly greater during active periods of illness and correlates with severity of illness.[48,54] Hopelessness in the setting of depression increases the risk for suicide and is typically modifiable with treatment of the mental health disorder.[25,40]
- **Physical illnesses** such as pulmonary disease, cancer, stroke, diabetes, ischemic heart disease, and spine disorders are all independently associated with suicide completion.[55] Suicide decedents tend to spend more time in the hospital for both medical and psychiatric reasons in the months prior to their death, endorse lower global quality of life assessment scores, and suffer from more physical impairment.[29,53] Similar risk for depression and suicide is also found in adolescent populations with chronic physical illnesses.[56] While some illnesses cannot be cured, the amount of disability or functioning may be modifiable with therapy.
- **High-risk substance use or use disorders**, including alcohol, prescription, and illicit drugs, are associated with increased suicide risk, both in adult and

adolescent populations.[53,57] Twenty percent of suicides occur while individuals are intoxicated.[58] Increasing substance use despite worsening mood symptoms, associated dysfunction, and increasing suicidal ideation may lead to a more acute suicide risk compared to a previous baseline level of use.[37]

- Members of the **LGBTQ community** may be at increased risk for suicide, especially if they have not found acceptance within their community and main support system. This risk factor should be considered within the environment of the patient.[59,60]

Protective Factors

Similar to risk factors, most individuals have both modifiable and non-modifiable protective factors that may be enhanced during periods of acute distress to help prevent against suicide. The following questions can help elicit these factors:[36,61]

1. What keeps you going during difficult times?
2. What are your reasons for living?
3. What has kept you from acting on those thoughts?
4. What or who do you rely on for support during times like these?

Established protective factors against suicide are provided in Table 4, separated by modifiability.

Similar to risk factors, protective factors have to be considered within the context of the patient. For example, social obligation to a spouse is protective against suicide, but the presence of high-conflict or violence within the relationship significantly increases suicide risk.[34,61] Responsibility to children is felt to be protective in suicide, except in cases of post-partum mood and psychotic disorders, teen pregnancy, and extreme economic hardships.[34,62] Although pregnancy and motherhood has been studied as a protective factor, suicide remains the leading cause of maternal death in industrialized countries and vigilance in assessing for ante- and post-partum depression and anxiety cannot be overemphasized.[61,63,64]

Suicidal Evaluation

Part of a suicide risk assessment is gaining a very clear understanding of the individual's desire to complete suicide, their capability to do so, and their current suicidal intent. Some questions that can help elicit this information are included below.[36,61,65]

1. Why do you want to die?
2. Have you done anything in preparation for your death?
3. On a scale of 1–10, where would you rate your seriousness or wish to die?
4. Have you tried out any particular method or taken steps in rehearsal for suicide?

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Determining Level of Risk

The overall goal at this point is that the primary care provider has been able to adequately identify key risk factors, both modifiable and acute, and protective factors in order to rate the individuals current risk of suicide. This acute, current risk may differ from the patient's chronic level of suicide risk, the latter of which is typically based on static demographic factors that are not modifiable.[66] There can be ambiguity around risk factors and what may define a chronic and hard to manage risk versus an acute risk that must be dealt with immediately, necessitating clinical judgement. As many assessment and screening tools do, we propose that overall risk be defined as a manageable three levels (low, medium, or high). Individuals at the lowest and highest risk may be easiest to identify and those at more moderate levels of risk may require greater assessment to discern the most appropriate management strategy.[65]

Managing Level of Risk

Table 5 has been modified and adapted from Bryan and Rudd 2006 and the SAFE-T protocol developed through SAMSHA.[33,66] Both were chosen due descriptions of different risk categorizations and their concise response recommendations based on these categories. Although neither has been studied to predict or prevent suicide, they offer explicit guidance for the busy general practitioner.

While most providers may feel the primary purpose of a risk assessment is to determine disposition (home versus hospital), it should also be used to help guide other interventions, both pharmacologic and non-pharmacologic, and regardless of setting.

NON-PHARMCOLOGIC INTERVENTIONS

Brief therapeutic interventions, such as psychotherapy, case management, or supportive telephone calls and letters, are more effective for long-term suicide prevention when they are directed towards the symptoms of suicide, rather than indirectly targeting symptoms associated with suicide, such as depression or hopelessness.[20,67,68] These methods address suicide risk head-on in collaboration with patients in order to prevent suicide. The following interventions may be used as tools.

Safety Plan

Safety plans are prioritized lists of coping strategies and sources of support used during or preceding a suicidal crisis.[69] Steps in creating a safety plan include:

1. Recognize warning signs
2. Identify and use internal coping strategies
3. Use interpersonal supports as a means of distraction from unpleasant thoughts or urges
4. Contact friends or family to help resolve the crisis
5. Contact a mental health provider/agency

6. Reduce potential use of lethal means

Ideally, these steps should be detailed, written, kept in a personal spot, and followed in a step-wise fashion until the crisis resolves.[70] Safety plans have been shown to reduce suicide attempts, completions, depressive symptoms, anxiety, and hopelessness within 3 months compared to interventions without safety plans.[71] Safety plans should not be confused with so called "no-harm" or contracts for safety, which have not been shown to reduce suicide or suicidal behavior, offering only false reassurance to the provider.[47] An example template for a safety plan can be found online at http://www.sprc.org/sites/default/files/Brown_StanleySafetyPlanTemplate.pdf

Means Restriction

Access to lethal means of suicide remains a significant risk factor for all age groups and interventions that minimize these means remain the most impactful form of primary prevention against suicide.[47,72] Firearms are of specific importance, as they remain the most common suicidal method and account for over 50% of suicide-related deaths, following by suffocation, hanging, poisoning, and overdose.[73] If guns remain in the home, they should be unloaded, locked, and stored separately from ammunition.[74] Restricting access to drugs and alcohol has also been shown to reduce suicide rates, especially when substance abuse is considered a risk factor or warning sign for the individual.[75]

Psychotherapy

In a pooled sample of 11 trials, psychotherapy regardless of methodology was shown to reduce suicide attempts by over 30%.[73,76] The most robust literature exists for the ability of cognitive behavior therapy, dialectical behavioral therapy, and problem-solving therapy to reduce self-harm, suicide behavior, and suicidal ideation.[77–80]

While primary care providers are unlikely to be providing psychotherapy, successful referrals to qualified individuals may be enhanced by the provider's knowledge and confidence in its effectiveness in addition to a therapeutic alliance. The risk of suicide attempts increases the month before and after starting treatment, regardless if treatment is medications or psychotherapy, making close follow-up very important.[81]

Follow-up Care

Intensive management that includes weekly follow-up and assertive outreach by clinic personal after missed appointments has been shown to significantly reduce suicide rates in the United Kingdom.[82] Other follow-up interventions, such as telephone calls, letters, and post-cards have shown some benefit for reducing repeat suicide attempts.[20,83]

National crisis lines are also effective at reducing an individual's sense of crisis, confusion, helplessness, and suicidality. This effect is improved when a standardized suicide risk assessment algorithm has been implemented.[84]

Referral to Mental Health Provider

In addition to the suggested interventions for referral given in Table 5, referral can be considered for any patient at risk of suicide.[85] Physicians should refer patients to mental

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health providers when they are past their comfort level, following failed response to treatment trials for the psychiatric disorder, if the patient's suicidal thoughts are persistent, if there is suspicion for current psychotic symptoms (hallucinations, delusions, disorganized thinking), or when hospitalization may be warranted.[65,85,86]

Collaborative care models, which place mental health services within the primary care setting, also reduce suicidal ideation and depression within primary care populations.[87] These models have been shown to be cost-effective and should be advocated for by primary physicians when possible as they have not been disseminated as widely as evidence would warrant.

PHARMACOLOGIC INTERVENTION

Because over 90% of patients who complete suicide had a mental health diagnosis at their time of death, aggressive, evidence-based treatment of mental health disorders should also be discussed during treatment planning.[88] Despite concerns about increased suicide risk with antidepressant medications, which primarily reflects acute increases in suicidal ideation and attempts in trials of pediatric samples,[89] multiple studies have found them protective against suicidal thoughts, behaviors, and attempts in all age groups, most strongly and consistently in adults, especially older adults, when used to treat mood and anxiety disorders.[90–96] Selective serotonin-reuptake inhibitors (SSRIs) are preferred over tricyclic antidepressants (TCAs) in suicidal patients due to lower risk in overdose. TCAs and other medications with elevated risk in overdose should be prescribed in limited supplies while acute suicide risk remains elevated.[20] When indicated, there is evidence supporting a reduction in risk of suicide for those treated with clozapine or lithium.[97] As with psychotherapy, there is evidence that suicide attempts are increased in the month before treatment, the month after treatment, after discontinuation of medications, and after any dose change. Close follow-up and monitoring are warranted during treatment.[98]

Some pharmacologic interventions may be harmful. After adjusting for mental health diagnoses, a current prescription for any sedative or hypnotic was associated with a four-fold increase in suicide risk, especially in patients greater than 65 years old.[99,100]

DOCUMENTATION

Once a suicide risk assessment and treatment plan have been completed, it is important to document this plan in detail for the protection of both the patient and the healthcare team. Documentation should include:[34]

- Summary of presenting complaints
- Evaluation of current risk factors, protective factors, and warning signs
- Listing of individuals that participated in the evaluation, including patient's family, friends, and any consultants
- Summary of treatment options discussed with the patient, including any suggestions or recommendation for hospitalization, if applicable

- Review of treatment plan agreed upon with the patient, including why this plan provides the safest treatment in the least restrictive environment. Treatment plan may include:

  a. Starting medications and/or therapy

  b. Means restriction (ideally with verification from support system that it will be completed)

  c. Substance use reduction or formal treatment

  d. Safety plan creation (make a copy and scan into medical record)

  e. Referral to mental health provider

  f. Hospitalization

- Include plan for follow-up (next appointment, any follow-up phone calls or other planned out-of-clinic contacts)

The goal of documentation is to clarify the clinical reasoning behind the assessment with a plan that logically follows. From a medicolegal perspective, physicians cannot be expected to predict suicide outcomes, in which high risk individuals may not act and low risk individuals complete suicide.[13,101] While legal standards of care vary, a documented suicide risk assessment that captures the clinical decision makings should suffice.[102] Given the aforementioned need to contextualize the risk assessment within the story of a particular patient, the assessment need not list every risk and protective factor, but can highlight those key risk and protective factors deemed most relevant for the case. Examples of documented suicide risk assessment can be found in Box 1.

EVALUATION AND EDUCATION

Although many primary care providers feel unprepared for assessing and managing suicidal patients, they are often starting with a strong therapeutic alliance that has been independently shown to decrease suicidal ideation in the primary care population.[103] Physician education programs, both through post-graduate training and continuing medical education, can achieve clinical outcomes similar to psychiatrists in the treatment of depression, reduced suicide rates, and increased subjective competency such that providers are more willing to assess and treat suicidal patients.[72,104,105]

FUTURE CONSIDERATIONS/SUMMARY

Suicide risk assessment is distinct from assessing risk for other conditions, such as cardiovascular risk. There are a multitude of factors that must be considered without a clear algorithm that exists or can be developed. This can prove daunting for many clinicians without some template for stratification of risk from which to tailor the appropriate management, but this process is not unlike the many decisions the clinician must make on a daily basis for which clinical judgement is paramount. Suicide risk assessment similarly requires the clinician to exercise their clinical judgement and to weigh the relevance of evidence-based risk and protective factors for the assessment of a particular patient's risk.

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Interventions can have a positive impact[97] and this review is dedicated to the cadres of clinicians willing to make the effort to save the lives of those suffering so profoundly as to take their own, at times not even knowing which lives were spared.

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KEY POINTS

1. Screening tools, including but not limited to the Patient Health Questionnaire -9 (PHQ-9) and the Columbia Suicide Severity Rating Scale (C-SSRS) may identify individuals at risk and in need of further assessment.
2. The suicide risk assessment involves a clinical judgment based on an individualized evaluation of various risk and protective factors for suicide.
3. There exist a variety of interventions for which to target risk of suicide that may be tailored to the individuals risk profile.

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Box 1

Example documented suicide risk assessments

This 30 year-old married female presents with a major depressive disorder and appears to be a low suicide risk. She denies suicidal ideation, has no history of attempts, and is responsible for two children. She has recently started on sertraline and is hopeful about her future. She can be managed safely as an outpatient.

The patient is a 67 year-old married, retired male construction worker who with ischemic cardiomyopathy and recent increased use of alcohol, placing him at a moderate to high risk of suicide. He has no history of suicide attempts and a strong support system. He had a recent hospitalization for a myocardial infarction, during which he developed a depressive syndrome and he appears increasingly hopeless about the future, particularly surrounding his medical bills and debt. While intoxicated last week, he reported having vague and fleeting suicidal thoughts though denies any past or current intent of acting on these thoughts. His wife is not aware of any acute evidence of dangerousness and was willing to secure the patients firearms and excess medications. He was offered hospitalization, but declined. There is insufficient evidence of acute dangerousness to warrant involuntary hospitalization. Patient agrees to quit drinking and engage in close follow-up for his depression with referral to a psychiatrist. He verbalizes intent to seek emergent assistance if feeling unsafe.

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Table 1

Examples of screening questions to identify risk factors for suicide.

Home	Where do you live and who lives with you? How do you get along with each member? Who could you go to if you needed help with a problem?
Education/employment	What do you like about school (or work)? What are you good and not good at? How do you get along with teachers and other students (boss and co-workers)?
Activities	What sort of things do you do in your spare time? Do you belong to any clubs, groups, etc.? What sort of things do you like to do with friends?
Drugs	Many young people at your age are starting to experiment with cigarettes or alcohol. Have you tried these or other drugs like marijuana, injection drugs, or other substances? How much are you taking and how often?
Sexuality	Some young people are getting involved in sexual relationships. Have you had a sexual experience with a guy or a girl or both?
Suicide/safety	What sort of things do you do if you are feeling sad, angry, or hurt? Some people who feel really down often feel like hurting themselves or even killing themselves. Have you ever felt this way? Have you ever tried to hurt yourself? Do you have access to firearms in your home or the home of a friend or family member?

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Table 2

Published guidelines and resources for suicide risk assessment.

Name	Source(s)
Practice Parameter for Assessment and Treatment of Children and Adolescents with Suicidal Behaviors	American Academy of Child and Adolescent Psychiatry
Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors	American Psychiatric Association (APA)
VADOD Clinical Practice Guidelines for Assessment and Management of Patients at Risk for Suicide	Department of Veterans Affairs, Department of Defense
Assessment and Care of Adults at Risk for Suicidal Ideation and Behavior	Registered Nurses' Association of Ontario
Core Competencies for Assessment and Management of Suicide	American Association of Suicidology
National Suicide Prevention Lifeline Suicide Risk Assessment Standards Packet	National Suicide Prevention Lifeline, SAMSHA
Suicide Assessment Five-step Evaluation and Triage (SAFE-T)	SAMSHA
Suicide Prevention: Saving Lives One Community at a Time	American Foundation for Suicide Prevention (AFSP)
Suicide and the Elderly	AFSP
International Association for Suicide Prevention (IASP) Guidelines for Suicide	IASP
Suicide Care in Systems Framework	National Action Alliance for Suicide Prevention, Clinical Care and Intervention Task Force

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Table 3

Summary of suicide risk factors.

Suicide Risk Factors	
Chronic	**Acute**
Prior attempts	Suicidal ideation
Recent hospitalization	Purposelessness
Living alone	Insomnia*
Family history of suicide	Anxiety, agitation*
LBGTQ population	Trapped feeling
Adverse childhood events	Non-adherence to care
Stressful life events	Withdrawal
Mental illness*	Anger, rage, revenge-seeking
Physical illness*	Recklessness
Unemployment	Mood and personality changes
Advancing age	Substance Use*
	Hopelessness*

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Table 4

Protective factors for suicide.

Suicide Protective Factors	
Non-modifiable	**Potentially Modifiable**
Female gender	Interpersonal support
Marriage	Positive coping skills
Children	Life satisfaction
Pregnancy*	
Religion/Spirituality	

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Table 5

Illustration of levels of suicide risk.

Acute Risk Level	Characteristics of Level			Recommended Response
	Protective Factors	**Acute Risk Factors**	**Suicidal Evaluation**	
Mild	Easily identifiable, multiple protective factors.	Few risk factors, mild mood symptoms, evidence of self-control	Ideation limited in frequency, intensity, or duration. No plan or intent	**1** Frequent outpatient follow-up, monitoring for any change in risk. **2** Further evaluation of mood symptoms. **3** Consider psychiatric referral.
Moderate	Some identifiable protective factors.	Baseline chronic risk factors. Minimal mood symptoms. Maintained self-control. Rare acute risk factors.	Frequent suicidal ideation, still limited in intensity and duration. May have plan, but no intent.	**1** Increase frequency/ duration of visits. Repeated evaluation of need for hospitalization. **2** Involve family and support system. **3** Means restriction. **4** Review emergency protocols, such as emergency rooms and crisis services. **5** Control mood symptoms with medications and/or psychotherapy. **6** Frequent follow-up with phone calls or nursing visits (if available). **7** Consider psychiatric referral and/or hospitalization, especially if risk increasing with re-evaluation.
Severe	Minimal protective factors endorsed.	Multiple acute risk factors or high acuity risk factor. Poor self-control, either at baseline or due to substances.	Frequent, intense, persistent suicidal ideation with plans. May discuss intent, but has no gathered means or had rehearsal behaviors	**1** Evaluation for inpatient hospitalization, either by on-site psychiatric professional or through an emergency room. **2** Do not leave patient alone in the office during assessment. **3** Hospitalization may be indicated even if involuntarily. **4** Means restriction for acute period following hospitalization.