Condensed Clinical Practice Guideline
Assessment and Treatment of Patients with Suicidal Behavior

I. Key Points
   a. Suicide is defined as self-inflicted death with evidence that the person intended to die
   b. Suicide attempt is defined as self-injurious behavior with a nonfatal outcome accompanied by evidence that the person intended to die
   c. The psychiatric evaluation is the essential part of the suicide assessment process
      i. Current presentation of suicidality
      ii. Psychiatric illnesses
      iii. History
      iv. Psychosocial situation
      v. Individual strengths and vulnerabilities
   d. Documentation of the assessment is essential
   e. Patients with suicidal thoughts, plans, or behaviors should be treated in the setting that is least restrictive but most likely to be safe and effective
   f. Suicide prevention contract is not considered a substitute for a careful clinical assessment
   g. Psychotherapies play an important role in the treatment of individuals with suicidal thoughts and behaviors

II. Assessment of Patients with Suicidal Behaviors
   a. Conduct a thorough psychiatric evaluation
      i. Identify specific psychiatric signs and symptoms
      ii. Assess past suicidal behavior, including intent of self-injurious acts
      iii. Review past treatment history and treatment relationships
      iv. Identify family history of suicide, mental illness, and dysfunction
      v. Identify current psychosocial situation and nature of crisis
      vi. Appreciate psychological strengths and vulnerabilities of the individual patient
   b. Specifically inquire about suicidal thoughts, plans, and behaviors
      i. Elicit the presence or absence of suicidal ideation
      ii. Elicit the presence or absence of a suicide plan
      iii. Assess the degree of suicidality, including suicidal intent and lethality of plan
      iv. Understand the relevance and limitations of suicide assessment scales
   c. Establish a diagnosis
   d. Estimate Suicide Risk (See Table 4 in the Clinical Practice Guideline document page 25)
   e. Specific psychiatric symptoms/factors that increase risk for suicide
      i. Anxiety
      ii. Hopelessness
      iii. Command hallucinations

iv. Impulsiveness and aggression
v. Alcohol intoxication
vi. Past suicide attempts
vii. History of childhood physical/sexual abuse
viii. History of domestic partner violence
ix. Past history of treatment/hospitalization
x. Early in course of psychiatric illness and severe symptoms
xi. Presence of physical illness
xii. Family history of suicide

f. Psychosocial Factors that increase risk for suicide
    i. Unemployment
    ii. Absence of strong religious faith
    iii. Lack of psychosocial support
g. Psychosocial protective factors
    i. Reasons for living, including children in the home
    ii. Healthy and well developed coping skills
h. Degree of Suicidality
    i. Presence, extent, and persistence of suicidal ideation
        1. It is important to determine the presence, magnitude, and persistence of current and past suicidal ideation
    ii. Presence of suicide plan and availability of method
        1. The formation of suicide plan can precede a suicidal act
        2. Assess access to firearms and other methods with potential for lethality
    iii. Lethality and intent of self-destructive behavior
        1. Suicidal intent refers to the patient's subjective expectation and desire to die as a result of a self-inflicted injury
        2. Factors separating suicide attempters who go on to make future fatal vs. nonfatal attempts
            a. Initial attempt with high intent
            b. Having taken measures to avoid discovery
            c. Having used more lethal methods that resulted in physical injuries

III. Psychiatric Management
a. Establish and maintain a therapeutic alliance
b. Attend to the patient's safety
c. Determine a treatment setting (See Table 8 in the Clinical Practice Guideline document page 53)
d. Develop a treatment plan
    i. A plan that integrates a range of biological and psychosocial therapies may increase the likelihood of successful outcome
    ii. Goals of treatment should include a comprehensive approach with the major focus directed at reducing risk; not eliminate suicide risk
    iii. Address substance use disorders when relevant

e. Coordinate care and collaborate with other clinicians
f. Promote adherence to the treatment plan
    i. Establish physician-patient relationship
    ii. Collaboratively develop the plan
    iii. Reassess the treatment plan on a regular basis
g. Provide education to the patient and family
    i. Patients and family members can benefit from an understanding of the role of psychosocial stressors as well as available treatment options
h. Reassess safety and suicide risk
i. Monitor psychiatric status and response to treatment
    i. Clinical observations suggest there may be an early increase in suicide risk as depressive symptoms lift but before they are fully resolved
j. Obtain consultation, if indicated

IV. Specific Treatment Modalities

a. Somatic therapies
    i. Antidepressants
        1. Mainstay of treatment of patients with suicidality experiencing acute, recurrent, and chronic depressive illness
        2. Successful in treating patients with suicidality with accompanying depression and substance abuse disorders
        3. Limited evidence that they reduce risk of suicide
    ii. Lithium
        1. Strong, consistent evidence for reductions in risk of both suicide completion and attempts in patients with reoccurring bipolar disorder and major depressive disorder
    iii. Mood-stabilizing anticonvulsant agents
        1. No established evidence of reduced risk of suicidal behavior
    iv. Antipsychotic agents
        1. Mainstay of somatic treatment of patients with suicidality with psychotic disorders
        2. Potential effects in limiting suicidal risk in patients with psychotic symptoms are unknown
    v. Antianxiety agents
        1. May have potential to decrease suicide risk
    vi. ECT
        1. Evidence suggests that ECT reduces short-term suicidal ideation
b. Psychotherapies
    i. Preliminary evidence that cognitive and behavioral psychotherapy may reduce incidence of suicide attempts in depressed outpatients
    ii. Few rigorous studies have directly examined whether interventions reduce suicide morbidity, clinical consensus suggests that interventions are of benefit to patients with suicidality

iii. Dialectical behavior therapy may be effective in reducing suicide attempts when applied over longer time frames, especially for patients with personality disorders

V. Documentation

a. General risk management
    i. Documentation of patient care is essential to risk management (See Table 9 in the Clinical Practice Guideline Document Page 67)

b. Suicide Contracts
    i. No studies have shown their effectiveness in reducing suicide
    ii. Studies of suicide attempters and of inpatients who died by suicide have shown that a significant number had a prevention contract in place at the time of their suicidal act

References

Jacobs, D.G. et al., (2004). Practice Guideline for the Assessment and Treatment of Patients With Suicidal Behaviors. *American Journal of Psychiatry, 161* (4).