

APA Practice Guideline Provides Recommendations for Assessing and Treating Patients With Suicidal Behaviors

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Editor's note: This article reviews the American Psychiatric Association Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors. Direct quotations in the article are taken from the guideline. Readers are encouraged to review the complete guideline for a thorough appreciation of its breadth and scope, and to obtain the benefit of the extensive bibliography.

Part A of the guideline was published in 2003. The complete guideline, including Parts A and B, will be published in

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Dr. Jacobs and Ms. Brewer have no industry relationships to disclose.

May 2004 as a compendium and is available at: http://www.psych.org/psych_pract/treatg/pg/pg_suicidalbehaviors.pdf (accessed April 5, 2004).

The American Psychiatric Association (APA) Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors, one of multiple such guidelines, was drafted by a committee of psychiatrists whose work spans clinical practice, research, and academic endeavors, reviewing available evidence and relying on clinical consensus to develop these recommendations for use by clinicians. The draft of the guideline was reviewed extensively by members of the APA and experts in the various topic areas before the publishing of its final version.

Although these recommendations are intended to provide a helpful guide to clinicians in treating adult patients with suicidal behaviors, they are not meant to serve as a standard of care for such treat-

EDUCATIONAL OBJECTIVES

1. Develop processes for accurate psychiatric assessment of patients with suicidal behaviors in various clinical settings.
2. Select appropriate treatment settings for patients with suicidal behaviors based on risk assessment.
3. Identify effective pharmacologic and psychosocial interventions for patients with suicidal behaviors.

ment. Recommendations are given to assist in the process of assessing and treating suicidal patients, but following these recommendations will not ensure a successful outcome for every individual patient. This guideline, although it provides extensive information on a variety of topics related to the assessment and treatment of suicidal patients, does not include every possible appropriate or acceptable method of care. The final judgment regarding assessment

Characteristics Evaluated in the Psychiatric Assessment of Patients With Suicidal Behavior

Current presentation of suicidality

- Suicidal or self-harming thoughts, plans, behaviors, and intent
- Specific methods considered for suicide, including their lethality and the patient's expectation about lethality, as well as whether firearms are accessible
- Evidence of hopelessness, impulsiveness, anhedonia, panic attacks, or anxiety
- Reasons for living and plans for the future
- Alcohol or other substance use associated with the current presentation
- Thoughts, plans, or intentions of violence toward others

Psychiatric illnesses

- Current signs and symptoms of psychiatric disorders with particular attention to mood disorders (primarily major depressive disorder or mixed episodes), schizophrenia, substance use disorders, anxiety disorders, and personality disorders (primarily borderline and antisocial personality disorders)
- Previous psychiatric diagnoses and treatments, including illness onset and course and psychiatric hospitalizations, as well as treatment for substance use disorders

History

- Previous suicide attempts, aborted suicide attempts, or other self-harming behaviors
- Previous or current medical diagnoses and treatments, including surgeries or hospitalizations
- Family history of suicide or suicide attempts or a family history of mental illness, including substance abuse

Psychosocial situation

- Acute psychosocial crises and chronic psychosocial stressors, which may include actual or perceived interpersonal losses, financial difficulties or changes in socioeconomic status, family discord, domestic violence, and past or current sexual or physical abuse or neglect
- Employment status, living situation (including whether or not there are infants or children in the home), and presence or absence of external supports
- Family constellation and quality of family relationships
- Cultural or religious beliefs about death or suicide
- Individual strengths and vulnerabilities

Coping skills

- Personality traits
- Past responses to stress
- Capacity for reality testing
- Ability to tolerate psychological pain and satisfy psychological needs

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and treatment rests with the psychiatrist, based on the clinical information provided by the patient and the treatment options available.

ASSESSMENT PROCESS

The suicide risk assessment includes a number of components that allow the psychiatrist to form a clinical judgment of a patient's risk for suicide and to develop a treatment plan concordant with that risk and with the goal of reducing that risk. These components include an appreciation of the multiple factors that contribute to suicidal behaviors, a thorough psychiatric evaluation, a specific suicide inquiry, determination of level of risk, development of a treatment plan, and relevant documentations.

The psychiatric evaluation serves as the foundation of the suicide assessment. During the evaluation, the psychiatrist must be aware of, appreciate, and seek to identify relevant suicide risk and protective factors. Areas to be evaluated during the assessment include the patient's current and past psychiatric diagnoses, with attention to any comorbidity. Family and personal history of suicide, attempts, and mental illness, as well as individual strengths and vulnerabilities, should also be evaluated, as should acute and chronic life stressors, possible protective factors, and current complaints, symptoms, and mental state. In particular, the presence or absence of any hopelessness, anxiety, and substance use should be assessed. It is useful to evaluate suicidal thoughts, plans, and behaviors through direct questions about current and past suicidal thoughts and actions. If the patient is not forthcoming it may be necessary to seek history from collateral sources.

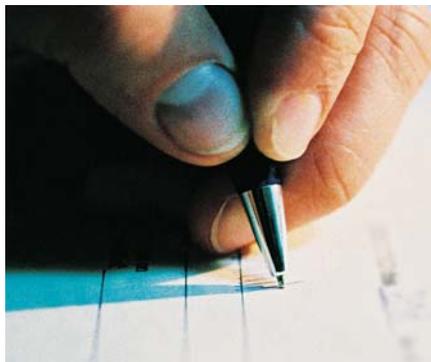
A complete psychiatric history and evaluation is crucial to the assessment process because "the presence of a psychiatric disorder is probably the most significant risk factor for suicide ... [as]

more than 90% of persons who die from suicide satisfy the criteria for one or more psychiatric disorders.” Affective disorders, primarily major depressive disorder or mixed episodes, cluster B personality disorders, schizophrenia, and substance use disorders, carry the highest risk of suicide. Comorbid psychiatric diagnoses, especially those mentioned above, increase suicide risk.

Thus, a suicide risk assessment includes a multi-axial differential diagnosis and an estimation of suicide risk as low, moderate, or high. Estimating the degree of the patient’s suicide risk guides decisions about immediate safety measures and the most appropriate treatment setting. Awareness of specific high-risk diagnoses and modifiable risk factors helps identify treatment targets and clarifies treatment planning in both the short and long term.

The amount of information that can be gathered in a psychiatric evaluation varies with treatment setting and the ability or willingness of the patient and other sources to provide accurate information. In some situations, the psychiatrist’s initial focus may need to be on the areas judged most relevant, leaving further evaluation to be done at subsequent contacts. However, the psychiatrist is advised to obtain sufficient information to determine suicide risk. The extent of information needed will be based upon the psychiatrist’s judgment. Sidebar 1 illustrates important areas of assessment for patients with suicidal thoughts or behavior.

Depending on the clinical situation, information can come from collateral sources such as family, friends, and other healthcare providers. An added benefit of contacting members of the patient’s support system is that it provides the psychiatrist an opportunity to assess that network. Often this can be accomplished simply by listening to the collateral sources, without revealing pri-



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vate or confidential information about the patient. However, when information needs to be shared to maintain the safety of the patient or others, the psychiatrist may have to, and should, breach confidentiality. Documentation of the assessment, including risk level and treatment plan, is essential for risk-management purposes and for conveying important information about the patient’s status and changes in status over time.

Specific Suicide Inquiry

Direct questions about suicide are an essential tool in suicide assessment. The psychiatrist should ask specifically about suicidal thoughts, plans, and behaviors. Simply asking the patient about suicidal ideation and accepting a negative response may not be enough to determine actual suicide risk, however. Inconsistencies between a denial of suicidal ideation and the patient’s presentation or depressive symptomatology may indicate a need for additional questioning or collateral sources of information.

If a patient endorses suicidal ideation, the psychiatrist must obtain information about specific plans for suicide, especially steps taken to enact the plans, such as obtaining a gun or other method, planning time and place, and rehearsing the act. Information concerning plans to prepare for death, including making a will, giving away possessions, and saying goodbye to loved ones, should also be obtained. When a patient indicates considering a specific method, it is important to determine the patient’s expectations of lethality.

“If the patient has developed a suicide plan, it is important to assess its lethality ... through questions about the method, the patient’s knowledge and skill concerning its use, and the absence of intervening persons or protective circumstances. In general, the greater and clearer the intent, the higher the risk for

Guidelines for Selecting a Treatment Setting for Patients at Risk for Suicide or Suicidal Behaviors

Admission generally indicated

After a suicide attempt or aborted suicide attempt if:

- Patient is psychotic
- Attempt was violent, near-lethal, or premeditated
- Precautions were taken to avoid rescue or discovery
- Persistent plan and/or intent is present
- Distress is increased or patient regrets surviving
- Patient is male, older than age 45, especially with new onset of psychiatric illness or suicidal thinking
- Patient has limited family and/or social support, including lack of stable living situation
- Current impulsive behavior, severe agitation, poor judgment, or refusal of help is evident
- Patient has change in mental status with a metabolic, toxic, infectious, or other etiology requiring further workup in a structured setting

In the presence of suicidal ideation with:

- Specific plan with high lethality
- High suicidal intent

Admission may be necessary

- After a suicide attempt or aborted suicide attempt, except in circumstances for which admission is generally indicated

In the presence of suicidal ideation with:

- Psychosis
- Major psychiatric disorder
- Past attempts, particularly if medically serious
- Possibly contributing medical condition (eg, acute neurological disorder, cancer, infection)
- Lack of response to or inability to cooperate with partial hospital or outpatient treatment

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

Release from emergency department with follow-up recommendations may be possible

After a suicide attempt or in the presence of suicidal ideation/plan when:

- Suicidality is a reaction to precipitating events (eg, exam failure, relationship difficulties), particularly if the patient's view of situation has changed since coming to the emergency department
- Plan/method and intent have low lethality
- Patient has stable and supportive living situation
- Patient is able to cooperate with recommendations for follow-up, with treater contacted, if possible, if patient is currently in treatment

Outpatient treatment may be more beneficial than hospitalization

- Patient has chronic suicidal ideation and/or self-injury without prior medically serious attempts, if a safe and supportive living situation is available and outpatient psychiatric care is ongoing

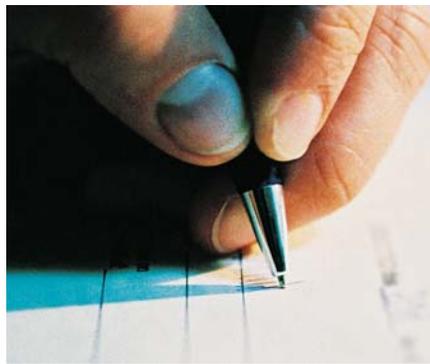
suicide will be. Thus, even a patient with a low-lethality suicide plan or attempt may be at high risk in the future if intentions are strong and the patient believes that the chosen method will be fatal. At the same time, a patient with low suicidal intent may still die from suicide by erroneously believing that a particular method is not lethal.”

During the assessment of suicide plans, it may be important to ask about the patient’s access to firearms. If the patient has access to weapons, a complicated clinical decision must then be made about whether to recommend weapons be removed or the patient’s access to them be restricted. Recommendations may be made to the patient, a significant other, or a treatment team member. As discussed earlier, issues of confidentiality versus safety apply to making recommendations to persons other than the patient.

Past suicide attempts are among the most significant risk factors for suicide, and recent attempts are of particular importance. When the patient presents with a history of suicide attempts, aborted attempts, or other self-harming behavior, the psychiatrist needs to obtain as much information as possible about those events. Specific questions should be asked to determine the detail of past attempts.

“Examples of [aborted attempts] would include putting a gun to one’s head but not firing it, driving to a bridge but not jumping, or creating a noose but not using it. For each attempt or aborted attempt, the psychiatrist should try to obtain details about the precipitants, timing, intent, and consequences as well as the attempt’s medical severity.”

It is also useful to ask about the circumstances surrounding the behavior, especially whether alcohol or substance use was involved, because intoxication may either facilitate impulsive suicidal acts or be part of a suicide plan.



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Estimation of Suicide Risk

Suicide causes enormous personal, social, and economic repercussions, yet suicide is statistically rare, even in high-risk populations. The statistical rarity makes suicide impossible to predict based on risk factors, either alone or in combination. However, psychiatrists can use the estimate of suicide risk to help determine treatment settings and individual treatment plans. “The goal of the suicide risk assessment is to identify factors that may increase or decrease a patient’s level of suicide risk, to estimate an overall level of suicide risk, and to develop a treatment plan that addresses patient safety and modifiable contributors to suicide risk.”

Focus on Modifiable Risk Factors in Treatment Planning

After the patient’s risk factors are identified, clinical attention focuses on those factors that may be modified to reduce suicide risk. According to the guideline, non-modifiable factors include patient history, family history, and demographic characteristics. Financial troubles or unemployment are also difficult to modify. The guideline stresses that treatment planning be focused on those risk factors that can be modified to reduce risk. Intervention should be concentrated on attending to the patient’s immediate safety. The suicide risk associated with psychiatric disorders, such as mood disorders, psychotic disorders, substance use disorders, and personality disorders, may be addressed through appropriate treatment. High-risk symptoms, such as anxiety, agitation, hopelessness, and insomnia, may be specific targets of treatment that can further reduce suicide risk. Protective factors may also be enhanced to reduce suicide risk; for example, the patient’s support system can be strengthened by educating family members or by moving the patient to a higher level of care.

Documentation

Documentation of suicide assessment is essential and is usually included in the treatment planning section of the psychiatric evaluation. Generally, these notes are written just after the assessment is completed. A suicide assessment should be conducted and documented at a patient's initial visit, as well as whenever suicidal ideation or behavior occurs. "On inpatient units, important points of documentation of assessment occur at admission, changes in the level of precautions or observation, transitions between treatment units, the issuance of passes, marked changes in the clinical condition of the patient, and evaluation for discharge."

The psychiatrist should indicate the reasons for the assessment and review the factors that may contribute to increased risk. The documentation should include the basis for the determination of risk, any changes made in the treatment plan, and the rationale for those changes. Any treatment changes that were considered but rejected may also be noted, along with the reason for rejection. The presence or absence of firearms and, if applicable, any measures taken to limit access to or remove suicide methods should also be documented.

The following is an example of a note documenting suicide assessment, levels of risk, and treatment plan.

Case example. This 62-year-old, recently separated man is experiencing his first episode of major depressive disorder. In spite of his denial of current suicidal ideation, he is at moderate to high risk for suicide because of his serious suicide attempt and his continued anxiety and hopelessness. The patient's wish to be treated as an outpatient by his family doctor will not provide adequately for the patient's safety. He has, reluctantly, agreed to be admitted. The plan is to hospitalize with sui-

cide precautions and medications and consider an electroconvulsive therapy (ECT) work-up. Reassessment should be performed the next day.

PSYCHIATRIC MANAGEMENT OF SUICIDAL PATIENTS

Because suicidal thoughts and behaviors may present across the entire spectrum of diagnostic categories, a large variety of therapeutic interventions are included under the broad umbrella of psychiatric management of suicidal patients. The guidelines define psychiatric management as including the determination of a setting for treatment and supervision and attendance to patient safety. In addition, management includes working to establish a cooperative and collaborative physician-patient relationship.

Psychiatric management is more extensive for patients in ongoing treatment. Management for these patients includes "establishing and maintaining a therapeutic alliance, coordinating treatment provided by multiple clinicians, monitoring the patient's progress and response to the treatment plan, and conducting ongoing assessments of the patient's safety, psychiatric status, and level of functioning." In addition, encouraging treatment adherence and providing education to the patient and, when indicated, family members may also be included.

Treatment Setting

In general, treatment should be provided in the least restrictive environment that still provides safe and effective treatment for the patient. The choice of treatment setting will be based on the estimate of suicide risk determined through the psychiatric evaluation and the suicide assessment. "In addition, the benefits of intensive interventions such as hospitalization must be weighed against their possible negative effects

(eg, disruption of employment, financial and other psychosocial stress, social stigma)." Sidebar 2 (see page 376) offers specific guidelines for selecting a treatment setting.

No-suicide Contracts

Although widely used, the no-harm, or suicide prevention, contract must not take the place of a thorough suicide risk assessment. Contracts have not been demonstrated to reduce suicide, and reliance on contracts may reduce staff vigilance about a patient without reducing the patient's suicide risk. The guideline emphasizes patient discharge or hospitalization should not be based on the patient's willingness or reluctance to enter into a suicide prevention contract. No-harm contracts may be useful in opening up conversation on the availability of clinicians and staff for support, however, especially in inpatient settings. The no-harm contract specifically is not recommended for use with new patients, in emergency room settings, or with psychotic or impulsive patients.

SPECIFIC TREATMENT MODALITIES

Both somatic therapies and psychosocial interventions, including psychotherapies, should be considered when developing a treatment plan for a patient with suicidal thoughts and behaviors. The psychiatrist should address the modifiable risk factors previously identified and continue to assess the patient during the course of treatment. Somatic treatments are often focused on acute symptom relief, whereas psychotherapies tend to have broader and longer-term goals related to the patient's psychosocial functioning.

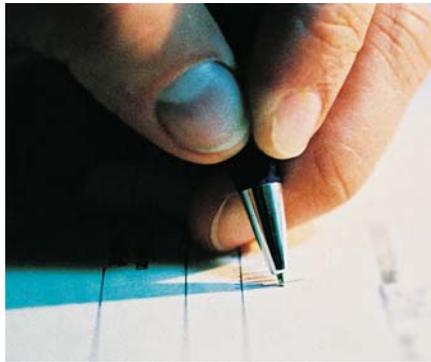
Somatic Interventions

Antidepressants. Antidepressants are a mainstay in the treatment of suicidal patients with acute, recurrent, or

chronic depressive illness. They also may be effective in treatment of anxiety disorders. Surprisingly, there is limited evidence that antidepressants reduce suicide risk. Because depression is one of the most significant risk factors for suicide, however, antidepressants may be essential in the treatment of suicidal patients for depressive-symptom reduction. Prescriptions for suicidal patients should be conservative quantities of antidepressants with low lethality in overdose. Sedating antidepressants may be used to treat prominent insomnia. Psychiatrists should monitor patients closely during the early weeks of antidepressant treatment. Patients should be informed that symptom relief may not occur for a period of days or weeks and be advised that recovery is sometimes uneven and setbacks are possible even when medication is being administered.

Treatment of anxiety. Severe insomnia, agitation, panic attacks, and psychic anxiety are associated with an increased risk of suicide. Benzodiazepines can address these symptoms and may be indicated for short-term symptom reduction. The longer-acting agents are preferred over short-acting agents. The benefits of benzodiazepine treatment should be examined carefully. Their occasional tendency to produce disinhibition and their potential for interactions with other sedatives, including alcohol, must be considered. Agents with sedating effects such as trazodone, some second-generation antipsychotics, and some anticonvulsants may also be used to treat highly anxious and agitated patients. "If benzodiazepines are being discontinued after prolonged use, their doses should be reduced gradually and the patient monitored for increasing symptoms of anxiety, agitation, depression, or suicidality."

Mood stabilizers. Recent studies have shown major reductions in the risk



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of both suicide and suicide attempts associated with long-term maintenance treatment of bipolar disorder with lithium salts. There is moderate evidence for a similar anti-suicide effect of lithium on patients with major depressive disorder. Although certain anti-convulsants have demonstrated effectiveness in treating mania, there is no evidence to date of any associated protection against suicide. The risk-benefit analysis regarding prescription of mood stabilizers must include the anti-suicide effect of lithium but also its potential toxicity in overdose.

Antipsychotic agents. "Antipsychotic medications are an essential treatment for patients with psychotic symptoms and disorders. For highly agitated patients, antipsychotics may reduce suicide risk. The antipsychotic medication that has been shown to decrease suicide risk is clozapine. Clozapine treatment is associated with significant decreases in rates of suicide attempts and perhaps suicide for individuals with schizophrenia and schizoaffective disorder." Anti-suicide benefits need to be weighed against risk of serious side effects, including agranulocytosis and myocarditis, associated with clozapine treatment. Second-generation antipsychotic agents are generally preferred over first-generation agents.

Electroconvulsive therapy. ECT has established efficacy in patients with severe depressive illness with or without psychotic features. ECT is associated with a rapid and robust antidepressant response as well as a rapid reduction of suicidal thoughts. ECT is the treatment of choice for patients with catatonic features, regardless of diagnosis. ECT may also be indicated for suicidal patients for whom medication is not appropriate because of pregnancy or prior treatment failure. Maintenance medication or ECT is necessary for long-term reduction of suicide risk.

PSYCHOSOCIAL INTERVENTIONS AND PSYCHOTHERAPIES

As discussed in the guideline, few studies have directly examined whether psychotherapeutic interventions reduce suicide morbidity or mortality. Clinical consensus suggests, however, that psychosocial interventions and specific psychotherapeutic approaches are beneficial in reducing risk of suicide. Regardless of the theoretical basis or type, the key element in psychotherapy is a positive and sustaining therapeutic relationship. Psychotherapy is especially important in the early stages of a patient's illness to target issues such as denial of symptoms and lack of insight. It is also recommended to help manage hopelessness, anxiety, and other symptoms. Intuitively, the better the therapeutic alliance, the more likely the patient is to be treatment compliant.

Psychotherapy has demonstrated efficacy in treating disorders associated with increased suicide risk, such as depression and borderline personality disorder, and may, therefore, be seen as appropriate treatment for suicidal behaviors. Cognitive behavioral therapy may be useful in addressing such risk factors as hopelessness. "Another form of therapy, dialectical behavioral therapy, has been studied for effects in a narrow range of potentially suicidal patients, particularly chronically suicidal or self-harming women with personality disorders." Overall, research and clinical experience indicate a combination of psychosocial interventions and pharmacotherapy offers the best strategy for reducing suicidal behaviors.

TREATMENT AND MANAGEMENT OF CHRONIC SUICIDALITY

Self-injurious behaviors and suicidality are chronic and repetitive for some patients. These behaviors often result in frequent contacts with the healthcare system. "It is important to recognize that self-injurious behaviors may or may not be associated with suicidal intent. Although self-injurious behaviors are sometimes characterized as 'gestures' aimed at achieving secondary gains (eg, receiving attention, avoiding responsibility through hospitalizations), patients' motivations for such behaviors are quite different."

Behavioral techniques are particularly useful for patients with chronic behavior. Chronic suicidal ideation generally is best treated on an outpatient basis, as long as both a supportive living situation and an ongoing doctor-patient relationship are available. For patients with chronic suicidal behavior who have difficulties with treatment adherence, clinicians should be familiar with local statutes on involuntary outpatient treatment. The guideline cautions psychiatrists to monitor their own feelings, including countertransference reaction, and advises that consultation with a colleague may be helpful.

CLINICAL REALITY AND MANAGEMENT OF SUICIDE IN PRACTICE

The suicide of a patient often has a significant effect on the treating psychiatrist and may result in increased stress and loss of professional self-esteem. Psychiatrists who experience the suicide of a patient may find it helpful to seek support from colleagues and obtain con-

sultation or supervision. Consultation with an attorney or risk manager may also be helpful.

Confidentiality and privacy of medical records continues past the patient's death. Any additional documentation included in the record after the suicide should be contemporaneously dated, not backdated, and previous entries should not be altered. Clinical or professional support may help the psychiatrist continue to treat other patients effectively and respond to the inquiries or needs of the survivors.

Conversations with family members are recommended because they may assist devastated family members in obtaining help after a suicide. "This recommendation is based primarily on humanitarian concerns for survivors, but this approach may also have a powerful, though incidental, risk management aspect." Patients' families may need psychiatric intervention and require help in obtaining it.

SUMMARY

The *APA Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors* may be a useful addition to the psychiatrist's clinical knowledge and practice. It is important to emphasize that there is no "cook-book" approach to suicide assessment. Suicide assessment is the quintessential clinical judgment and is based on a comprehensive psychiatric examination. As the guideline states, "Suicide cannot be predicted and in some cases cannot be prevented, but an individual's suicide risk can be assessed and a treatment plan can be designed with the goal of reducing that risk."