Mount Sinai Health Partners

PROVIDER'S GUIDE TO SUICIDE RISK ASSESSMENT

STRATEGIES TO ASSESS AND TREAT PATIENTS AT RISK FOR SUICIDALITY

The Goal of this Guide

Asking a patient whether they are having thoughts of suicide is the first step in an important, and potentially life-saving, conversation to help the patient stay safe and connect with necessary care. Contrary to a commonly held myth, asking patients about whether they experience thoughts of suicide, does not put the thought in their mind. In fact, it typically opens the door for the patient to share their thoughts, and lets them know that you are open to listening and supporting them. This guide offers you strategies to assess and treat patients at risk for suicidality; this is the crucial first step to determine the nature of the risk, and plan for the patient's safety.

WHAT'S INSIDE

Beginning a Suicide Inquiry

1. **Assess the frequency and intensity of the patient's suicidal thoughts.**
2. **Ask the patient:**
   - about passive and active suicidal ideation
   - when they last had these thoughts and how often they have them
   - if they have a history of suicide attempts (and if so, when, and did they tell anyone)
   - if they are currently having thoughts of wanting to die or to kill themselves, *and* if they have a plan and what the plan is
   - if they have thoughts of hurting themselves with no desire to die
3. **Assess the patient's idea of what would happen if they followed through with their plan**

START THE CONVERSATION

You may be anxious to ask directly about suicidal ideation. By starting the conversation, providing support, and directing help to those who need it, we can prevent suicides and save lives. **Asking about suicide does not encourage suicidal thoughts.** Remember, patients are often ambivalent, do not necessarily want to end their lives, but may see no other way out of their pain.

Treat the interview as an exploration and engender confidence that there are alternatives. Be calm and reflect empathy and concern. Get collateral information from the medical record and friends/family when possible.

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Documenting Suicide Risk in an Objective Manner

KEY QUESTIONS

1. **Did the patient want to die?**
2. **What did the patient expect to happen, and what was the outcome?**

THINK OF THESE BEHAVIORS AS BEING ON A CONTINUUM

NSSIB (non suicidal self injurious behavior) has strong correlations with completed suicides and is often minimized if providers assess them as attention-seeking behavior. **NSSIB may be a gateway to enable individuals to acquire the capability and capacity for suicide.**

Past suicidal behavior is highly correlated with future suicidality.

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Risk and Protective Factors for Suicide

BIOLOGICAL, PSYCHOLOGICAL, AND SOCIAL RISK FACTORS*

- Previous suicide attempt
- Mood disorders and certain personality disorders
- Alcohol and substance abuse disorders
- History of trauma or abuse
- Adverse childhood experiences
- Bullying
- Family history of suicide
- Hopelessness
- Impulsive and/or aggressive tendencies
- Some major physical illnesses

ENVIRONMENTAL RISK FACTORS*

- Job or financial loss
- Relational or social loss
- Legal trouble
- Easy access to lethal means
- Local clusters of suicide that have a contagious influence
- Stigma associated with help-seeking behavior
- Barriers to accessing health care
- Certain cultural and religious beliefs
- Exposure to the influence of others who have died by suicide

* Source: https://suicideprevention.nv.gov/Adult/Risk/ or https://www.cdc.gov/suicide/factors/index.html

PROTECTIVE FACTORS**

- Coping and problem-solving skills
- Cultural and religious beliefs that encourage connecting and help-seeking, discourage suicidal behavior, or create a strong sense of purpose or self-esteem
- Connections to friends, family, and community support
- Supportive relationships with care providers
- Availability of physical and mental health care
- Limited access to lethal means among people at risk
- Feeling connected to family and community support

** Source: https://afsp.org/risk-factors-protective-factors-and-warning-signs or https://www.cdc.gov/suicide/factors/index.html

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Determining Suicide Risk and Interventions

CONTINUUM OF RELATIVE RISK FOR SUICIDE

Suicidality is complex and requires holistic assessment. **Patients often do not fit into one category or level of risk.** Moreover, **risk for suicide is not static, and may shift dynamically along a continuum** based on a number of factors, including acute and chronic stressors, environmental factors, etc. The risk stratification levels noted in this guide are not intended to override your own clinical judgment of your patient's wellbeing, but rather offer some suggested interventions based on commonly observed patterns.

RISK LEVEL	RISK/PROTECTIVE FACTORS	SUICIDALITY	POSSIBLE INTERVENTIONS
LOW	• Risk factors are modifiable or mostly distal/chronic • None or minimal acute/proximal risk factors or warning signs • Strong protective factors, including reason for living • Good social supports	• May have thoughts of death or even active suicidal thoughts without plan or intent • No recent history of suicidal behavior	• Consider outpatient behavioral health treatment • Safety plan, including an emergency and crisis plan • Medication management • Give emergency/crisis numbers
MODERATE	• Multiple risk factors, but more distal/chronic than proximal/acute (suicide attempt in the distant past, psychiatric diagnoses, trauma history) • Few or weak protective factors • More intact problem solving or coping skills • Has social supports that may be able to assist in maintaining safety	• Suicidal ideation with plan but no intent • No recent suicidal behavior • Can anticipate a possible precipitant in the near future but none is imminent • No immediate access to means, but may be able obtain them	• Possible inpatient admission • Safety plan, including an emergency and crisis plan • Structured follow-up and monitoring • Outpatient behavioral health treatment • Give emergency/crisis numbers
HIGH	• Many acute/proximal risk factors and warning signs that outweigh protective factors • Psychiatric disorders with severe symptoms	• Suicidal ideation with intent and plan, especially if plan is imminent or lethal • Recent suicidal behavior (attempt, interrupted/aborted attempt, or preparatory behaviors) • Persistent ideation that feels uncontrollable, strong or intensely fluctuating intent, or suicidal rehearsal • History of prior attempts with lethal method or impulsive attempts with little planning, especially if circumstances around prior attempts resemble current or anticipated triggers • Has access or could easily obtain access to lethal means • Recent or anticipated acute precipitating events (such as trauma or loss)	• Inpatient psychiatric admission or intensive • Outpatient care followed by outpatient treatment • Other suicide precautions such as involving friends and family to create a social support safety net for close monitoring • Safety plan • Structured follow up and monitoring • Give careful consideration to patient risk factors, level of distress (in relation to their baseline), patient resources, protective factors, and coping skills, and anticipated future events, past precipitating events, and responses to the latter.

Chart adapted from SAMHSA SAFE-T Protocol; see appendix. This chart is intended to represent a range of risk levels and interventions, not actual determinations.

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Determining Suicide Risk and Interventions (cont.)

Effective safety planning encourages individuals to call on a range of strategies to delay acting on suicidal urges.

Ask about suicidal ideation, intent, and behaviors at each visit and watch for warning signs. Increase contact when a patient is in crisis. With the patient's permission, involve members of the individual's support network to create a safety net.

PATIENTS AT IMMINENT RISK

- Medications are not immediately effective in patients at imminent risk
- Medications are not always effective in extinguishing persistent suicidal thoughts
- When the risk is immediate, a safe environment is the most effective protective factor

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Conceptualizing Risk and Planning Intervention

PRACTICE SCENARIOS

JANE

Jane is a 32 year old cis-female who identifies as bisexual. She has a history of childhood trauma and attempted suicide when she was 15 years old. She is diagnosed with depression and is engaged in talk therapy, where she mentioned that she occasionally has passive thoughts of death, but no plan or intent. She generally finds her life fulfilling and has strong social supports in the LGBTQ community.

What risk factors are present for Jane?

- Mood disorder (depression)
- History of childhood trauma
- Previous suicide attempt

What protective factors are present for Jane?

- Connections to community support
- Supportive relationship with care provider
- Availability of mental health care

What would be some appropriate interventions for this patient?

- Discuss pharmacological therapy and its risks and benefits with the patient
- Safety plan, including an emergency and crisis plan
- Continue talk therapy

HARRISON

Harrison is 65 year old retired cis-male who lives alone after his wife passed last year. He misses his wife terribly and often makes comments about joining her again. He is not engaged in any behavioral health treatments. He denies suicidal ideation and has no attempts, but his daughter expressed her concerns to you that he may try to end his life.

What risk factors are present for Harrison?

- Relational/social loss

What protective factors are present for Harrison?

- Connections to family

What would be some appropriate interventions for this patient?

- Outpatient behavioral health treatment, including medication management and talk therapy
- Safety plan, including an emergency and crisis plan
- Structured follow up and monitoring

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Conceptualizing Risk and Planning Intervention (cont.)

ZEKE

Zeke is a 20 year old trans man who was not able to transition until he moved out of his parents' house at 18. He has few friends or social supports and he no longer speaks to his parents. He has persistent thoughts of death and a plan, but denies intent and does not have access to his choice of means. He has yet to receive a formal diagnosis, but he scored a 17 on the PHQ-9.

What risk factors are present for Zeke?

- Potential mood disorder
- Childhood trauma
- Relational loss

What protective factors are present for Zeke?

- No access to choice of lethal means

What would be some appropriate interventions for this patient?

- Possible inpatient admission or outpatient behavioral health treatment, including medication management and talk therapy
- Safety plan, including an emergency and crisis plan
- Structured follow up and monitoring
- Involve friends to create a social support safety net for close monitoring

This content was developed in collaboration with Amy Bennett-Staub, R.N., MPA, Behavioral Health Director of Safety and Quality, Mount Sinai Health System.

Appendix: SAMHSA SAFE-T Protocol

Suicide assessments should be conducted at first contact, with any subsequent suicidal behavior, increased ideation, or pertinent clinical change; for inpatients, prior to increasing privileges and at discharge.

1. RISK FACTORS

- **Suicidal behavior:** history of prior suicide attempts, aborted suicide attempts, or self-injurious behavior
- **Current/past psychiatric disorders:** especially mood disorders, psychotic disorders, alcohol/substance abuse, ADHD, TBI, PTSD, Cluster B personality disorders, conduct disorders (antisocial behavior, aggression, impulsivity) Co-morbidity and *recent onset of illness increase risk*
- **Key symptoms:** anhedonia, impulsivity, hopelessness, anxiety/panic, global insomnia, command hallucinations
- **Family history:** of suicide, attempts, or Axis 1 psychiatric disorders requiring hospitalization
- **Precipitants/stressors/Interpersonal:** triggering events leading to humiliation, shame, or despair (e.g, loss of relationship, financial or health status—real or anticipated). Ongoing medical illness (esp. CNS disorders, pain). Intoxication. Family turmoil/chaos. History of physical or sexual abuse. Social isolation
- **Change in treatment:** discharge from psychiatric hospital, provider or treatment change
- **Access to firearms**

2. PROTECTIVE FACTORS

Protective factors, even if present, may not counteract significant acute risk

- **Internal:** ability to cope with stress, religious beliefs, frustration tolerance
- **External:** responsibility to children or beloved pets, positive therapeutic relationships, social supports

3. SUICIDE INQUIRY

Specific questioning about thoughts, plans, behaviors, intent

- **Ideation:** frequency, intensity, duration—in last 48 hours, past month, and worst ever
- **Plan:** timing, location, lethality, availability, preparatory acts
- **Behaviors:** past attempts, aborted attempts, rehearsals (tying noose, loading gun) vs. non-suicidal self injurious actions
- **Intent:** extent to which the patient (1) expects to carry out the plan and (2) believes the plan/act to be lethal vs. self-injurious. Explore ambivalence: reasons to die vs. reasons to live.
  * **FOR YOUTHS:** ask parent/guardian about evidence of suicidal thoughts, plans, or behaviors, and changes in mood, behaviors, or disposition
  * **HOMICIDE INQUIRY:** when indicated, esp. in character disordered or paranoid males dealing with loss or humiliation. Inquire in four areas listed above

4. RISK LEVEL/INTERVENTION

- **Assessment of risk** level is based on clinical judgment, after completing steps 1–3
- **Reassess** as patient or environmental circumstances change

RISK LEVEL	RISK/PROTECTIVE FACTORS	SUICIDALITY	POSSIBLE INTERVENTIONS
HIGH	Psychiatric diagnoses with severe symptoms or acute precipitating event; protective factors not relevant	Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal	Admission generally indicated unless a significant change reduces risk. Suicide precautions
MODERATE	Multiple risk factors, few protective factors	Suicidal ideation with plan, but no intent or behavior	Admission may be necessary depending on risk factors. Develop crisis plan. Give emergency/crisis numbers
LOW	Modifiable risk factors, strong protective factors	Thoughts of death, no plan, intent, or behavior	Outpatient referral, symptom reduction. Give emergency/crisis numbers

(This chart is intended to represent a range of risk levels and interventions, not actual determinations.)

5. DOCUMENT

Risk level and rationale; treatment plan to address/reduce current risk (e.g., medication, setting, psychotherapy, E.C.T., contact with significant others, consultation); firearms instructions, if relevant; follow-up plan. For youths, treatment plan should include roles for parent/guardian.

Source: Chart adapted from SAMHSA SAFE-T Protocol. This chart is intended to represent a range of risk levels and interventions, not actual determinations.

WE FIND A WAY

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Have questions? We are here to help you.

You may:

- **Contact the Provider Engagement Team**
- **Email us at mshp@mountsinai.org**