

# Suicide Risk Assessment:

## Clinical Care and Risk Management

**STEPHEN E. HALL, M.D.**

THE JEWISH HOME OF SAN FRANCISCO  
UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

---

**ASHLEY HAWN**

MEDICAL INSURANCE EXCHANGE OF CALIFORNIA

# Suicide Risk Assessment Overview

---

- Suicide risk assessment has become part of the standard of care
- What comprises an adequate assessment
- Organizing the assessment
- Techniques and challenges
- Interventions
- Case example and discussion

# Why suicide risk assessment?

---

## Clinician stress and risk management

- 50% of psychiatrists and 25% psychologists will have a patient who completes suicide
- Adverse outcomes associated with assessing and managing suicide risk are common bases for lawsuits
- Appropriate documentation of information gathered and rationale for decision-making is a key element of the assessment

# What is Suicide Risk Assessment?

---

- Obtaining information related to risk factors, protective factors, and warning signs of suicide
- Obtaining information related to the patient's suicidal ideation, planning, intent, and behavior
- Making a clinical formulation of risk based on the information available

# When to do a Suicide Risk Assessment?

---

- Intake evaluation
- Emergency or crisis evaluation
- Abrupt changes in clinical status
- Transitions in care (setting, clinician, observation status, etc.)
- Lack of improvement with treatment
- Onset of physical illness
- Anticipated or new psychosocial stressor

# What is considered adequate?

---

- No widely accepted standard of care
- At a minimum, a clinical encounter where a patient is asked about suicidal thoughts and plans
- Collaborative and therapeutic – UK study showed 40% decrease in suicidal behavior after single MH evaluation in ED
- Responsibilities of the clinician
  - Comprehensive risk assessment (comparable to medical risk stratification)
  - Appropriate response to risks perceived
  - Institution of a reasonable plan
  - Not a prediction of the future; may not be able to anticipate or prevent suicide
  - Inform patient and family of the above

# Specific Goals

---

- Develop a multiaxial differential diagnosis
- Identify specific factors that may increase or decrease the risk of suicide
- Address the patient's immediate safety
- Identify modifiable factors as targets for intervention
- Identify the most appropriate setting for treatment

# Important Risk Factors

---

- Prior attempts
  - Planned v. impulsive
  - Lethality
  - Provisions to avoid discovery
- FH of completed suicide (hereditary aspects, modeling)
- Transition in care (e.g. recent hospital discharge)
- Demographics (gender, age, marital status)
  
- Stressors (bereavement, relationship, work, medical, financial)
  
- Access to lethal means
- Psychiatric disorder (90% of completers)
  - psychosis
  - depression
  - impulsivity
- Alcohol/drug use



# For Consideration

---

Collateral sources

“Protective” factors

Interviewing techniques for challenging patients

Clinical tools

- Rating scales
- Implicit association tests

# Challenge:

## Is the interview reliable in a patient who...

---

- is serious about suicide and withholds this info
- is impulsive and may not be planning suicide
- is ashamed of perceived weakness or immorality
- is unable to describe his emotional state
- is psychotic and speaks abstractly or symbolically, not reflecting intent in recognizable terms
- feels “crazy” and is afraid to reveal these thoughts
- fears being locked up, stigmatized, etc.
- fears loss of confidentiality
- believes no one can help

# Clinical Warning Signs

---

- Acute psychosis
- Agitation
- Anxiety
- Insomnia
- Severe hopelessness
- Anger, aggression
- Withdrawal
- Feeling “trapped”, guilty, or burdensome
- Suicidal ideation / behavior
- Rehearsal behaviors

# Factors to Consider for Management Plan

---

- Future orientation
- Cultural and religious views about suicide
- Presence of external supports
- Likelihood of exposure to ongoing stressors
- Quality of therapeutic relationship
- Quality of problem solving skills
- Access to weapons such as firearms
- Coping skills
- Personality traits
- Past responses to stress
- Capacity for reality testing
- Ability to tolerate psychological pain and satisfy psychological needs

# Potential Interventions

---

- Means restriction
- Somatic
- Psychosocial

# Interventions – Means Restriction

---

- Removal of weapons (usually guns)
  - family, friends, police
- Removal of other lethal means
  - medications, alcohol
- Hospitalization
  - voluntary – important to offer
  - involuntary
  - weak evidence for suicide prevention

# Interventions - Pharmacotherapy

---

- Among antidepressants, lethality of TCAs >> venlafaxine > SSRIs
- Black box warning for antidepressants
  - Increased suicide rates in young people in regions with lower antidepressant treatment rates
  - Need for active monitoring in young people especially
- Lithium
  - evidence for anti-suicide properties from meta-analyses
  - odds ratio 0.13 (0.03-0.66; 95% CI)
- Clozapine
  - approved indication for suicide reduction in schizophrenia
  - RR of S with other neuroleptics = 3.3 (1.7-6.3)
- Anticonvulsants – some evidence as a class
- Anxiolytics
- Ketamine

# Interventions – Electroconvulsive therapy

---

- ECT highly effective treatment for depression
- Rapid resolution of SI
- Unclear longer term effects on SI – generally used in very high risk population



# Interventions - Psychosocial

---

- Psychotherapy
  - CBT, DBT, PST all have studies showing reductions in suicide attempts, but no evidence for reduction in completed suicides
  - Initiation of treatment, or increase in frequency of sessions
  - Online psychotherapies
- Care management
  - TPCs, repeat assessments, letters, outreach for missed appts
  - UK study in CMH showed reduction in completed suicides
    - 14% decrease over one week
    - 11% decrease over one month
- Partial hospitalization program
- Intensive outpatient program

# Case study

---

- 21 y.o. single male patient, brought to psychiatrist by parents for assessment/treatment of depressed mood, anxiety. Symptoms worse in last several months due to academic stressors and disappointments; historically did very well academically but has been struggling. High achieving family; high expectations of patient. Home from college for summer between junior and senior years. Current visit prompted by patient's negative thoughts and statement to older brother of suicidal ideation, had thoughts of jumping from bridge. No overt psychosis.
- History of intermittent anxiety and depression for 5 years with past psychotherapy intervention. No suicide attempts; suicide contemplation 2 years earlier. No medication history. Alcohol use socially; denies alcohol or street drug use/abuse.
- FH unremarkable
- Lives with parents when home from college; siblings live in area, are professionals. Family close. Has had several girlfriends, but no LTR. Home between junior and senior year college. Applied to medical schools, awaiting responses.

# Case study p.2

---

- On exam patient healthy appearing; confirmed past and recent suicidal ideation, but denies current. Patient promised to tell parents, siblings if suicidal ideation worsens and agreed would go to hospital. Appears motivated to address depression. Patient agreed to take clonazepam and sertraline. Authorized discussion with therapist.
- Risk Assessment: Thought to be at low risk for suicide and homicide.
- Clinical Assessment: anxiety, depression with intermittent suicidal ideation without intention for self-harm at time of visit.
- Plan: individual psychotherapy twice weekly with prior therapist, start clonazepam 0.25mg daily start sertraline 12.5mg daily x one week then 25mg; return in 5 weeks. Patient agreed.

# Case study p.3

---

- 2<sup>nd</sup> visit, 60 minutes: 16 days later patient returns for medication evaluation, maintenance follow up care, ongoing psych dysfunction. (One week after the initial visit, patient hospitalized for 2 days at his request). Mother in waiting room. On exam, patient stated anxiety better, tolerating medications well, denied suicidal ideation; has increased appetite, social excursions with friends, going to therapy twice weekly.
- Plan: continue therapy twice weekly; increase clonazepam (0.5 mg daily), continue sertraline (25 mg daily); return in 3 weeks.

# Case study p.4

---

- 3<sup>rd</sup> visit; 60 minutes: Patient returned 1 week later after recent 3 day admission for cutting forearm; friend called police, patient reported continued academic disappointment, feelings of failure. During hospitalization, sertraline changed to mirtazapine 15mg; some dizziness noted. Patient promised to tell family if suicidal, family advised of safety plan, i.e. take to hospital as needed. Patient denied self-mutilation, suicidal or homicidal ideations, impulse, intent or plan. Medication change and collaboration with therapist discussed.
- Assessment: recent admission attributed to academic stress. Cutting was not an intent to kill self.
- Plan: continue individual psychotherapy, taper mirtazapine to 7.5 mg bid, then discontinue. Restart sertraline and continue clonazepam; return in two weeks.
- Patient completed suicide.

Considerations from a risk management standpoint: *Documentation*

# Selected References

---

Bolton JM, Gunnell D, Turecki G, Suicide risk assessment and intervention in people with mental illness. *BMJ* 2015;351:h4978

Ellis TE et al, Impact of a Suicide-Specific Intervention within Inpatient Psychiatric Care: The Collaborative Assessment and Management of Suicidality. *Suicide Life Threat. Behav.* 2015 Jan 12. doi: 10.1111/sltb.12151. [Epub ahead of print]

Francois D, Madva EN, Goodman H, How to document SUICIDE risk. *Current Psychiatry* 2014 October;13(10):33-34.

McNiel DE, Fordwood SR, Weaver CM, Chamberlain JR, Hall SE, Binder RL., Effects of Training on Suicide Risk Assessment. *Psychiatr Serv.* 2008 Dec;59(12):1462-5.

Nock MK, Measuring the Suicidal Mind. Implicit Cognition Predicts Suicidal Behavior. *Psychological Science* April 2010 vol. 21 no. 4 511-517

[Schwartz-Lifshitz M, Zalsman G, Giner L, Oquendo MA, Can we really prevent suicide? \*Current Psychiatry Reports\* December 2012, Volume 14, Issue 6, pp 624-633](#)

Shea SC, Suicide Assessment. *Psychiatric Times* vol. 26 No. 12 December 3, 2009

Stone M, Laughren T, Jones ML, et al. Risk of suicidality in clinical trials of antidepressants in adults: analysis of propriety data submitted to US Food and Drug Administration. *BMJ* 2009;339:b2880.