MIMIND TOOLS

Assessing Patients for Suicide Risk

Every assessment leads to identifying risk factors, and the modification of those risk factors leads to a reduction in suicide rates. Key points for patient assessment and related tools for providers include:

Every patient at every encounter should be assessed for suicide risk. Clinicians are often adept at assessing suicide risk at intake and then may not thoroughly evaluate risk again unless the patient expresses suicidal thoughts, plan, or intent. Many patients may deny suicide even though they are at risk.

Suicidal ideation, or lack thereof, is not a reliable predictor of suicide. Factors such as suicidal ideation, plan, and intent are risks, but there are many others that are of equal importance including hopelessness, anhedonia (lack of pleasure), substance abuse, and chronic pain, to name a few.

In addition to suicide risk assessment, screening tools also inform risk. It is recommended that clinicians use the Patient Health Questionnaire-9 (PHQ-9) and the Generalized Anxiety Disorder-7 (GAD-7) at *every* clinical visit. Question 9 of the PHQ-9 reviews suicide and has long-term predictive value. Tracking the PHQ-9 and GAD-7 data will help you and the patient measure progress or lack thereof.

- Patient Health Questionnaire (PHQ-9
- Generalized Anxiety Disorder Screening (GAD-7)
- These are available at henryford.com/MIMindtools

The results of a risk assessment drive clinical interventions that are structured to modify the risk factors. Modifications of risk lead to significant prevention of suicide.

These guidelines have four levels of risk: Acute, High, Moderate, and Low. There is no category of "no risk." Every patient who seeks mental health care by definition has a risk of suicide.

An essential intervention to modifying suicide risk is access to an array of psychiatric treatment options including Inpatient, Partial Hospitalization Program (PHP), Intensive Outpatient Programs (IOP), and outpatient visits. In the outpatient arena, the suicide risk level determines how quickly the patient must be evaluated by a psychiatrist:

- Acute risk = Same day
- High risk = Within 48 hours
- Moderate risk = Within a week

Modifications or interventions to change risk must be evidence-based; this is the case for both psychotherapy as well as psychopharmacology. The two major psychotherapies that the literature supports to modify suicide risk are cognitive behavioral therapy (CBT) and dialectical behavioral therapy (DBT). Staff must be proficient in these modalities.

Weapon removal is essential, particularly firearms and stashes of medications to overdose. Availability of lethal weapons increases suicide risk. Guns are the most common method of a lethal attempt with 53% of suicide deaths in Michigan in 2020 being the result of firearms.

- Weapon Safety Protocol), available on henryford.com/MIMindtools, for more information

Family involvement or that of a support person is essential to modify suicide risk. Families/significant others/friends often are the eyes and ears of patient wellness as well as decompensation. Families/significant others/friends must be allies in significantly reducing suicide risk. These tools are available at henryford.com/MIMindtools:

- Understanding and Helping Someone Who is Suicidal
- Preventing Suicide: Tips for Parents
- Involving Loved Ones for Patient Support.

Self-management tools to support the patient on their path to wellness and the development of increased coping strategies is essential to modify suicide risk. A Safety Plan is one essential element of self-management. Other self-management tools may be apps, digital psychotherapy, books, and articles. These tools are available at henryford.com/MIMindtools, and can be web-based or in paper format:

- Provider Protocol for Using Self-management Tools
- Creating a Safety Plan
- Crisis and Suicide Prevention Hotlines
- If you are thinking about suicide, read this first
- Self-help Books

Community involvement is another element to help support the patient and family between appointments and allow the patient to develop support systems outside of the therapy session and in their home. Such interventions can be one tool to modify social factors including isolation.

- Community Mental Health Support Groups, available at henryford.com/MIMindtools

Comfort or caring cards are one of the best-researched and effective strategies that inpatient and outpatient facilities can use to reduce suicide risk during times that patients are statistically at risk: the 7-30 days post inpatient discharge and following missed outpatient appointments are at-risk periods.

- Caring Cards and Letters, available at henryford.com/MIMindtools

Zero Suicide Risk Assessment

At each patient encounter, assess risk and protective factors. The assessment dictates the strategies to modify risk.

Acute Suicide Risk

- [ ] Current uncontrolled mania
- [ ] Current psychosis with command hallucinations and/or severe paranoid delusions
- [ ] Suicidal plan
- [ ] Suicidal intent
- [ ] Severe Hopelessness
- [ ] Suicide attempt within the last 30 days without intervening mental health treatment
- [ ] None

High Suicide Risk

- [ ] History of suicide attempt in the last year
- [ ] Severe anhedonia, or inability to feel pleasure
- [ ] PHQ-9 Question #9 with response of 2 or 3
- [ ] Alcohol abuse/substance abuse within the last month
- [ ] Severe anxiety/panic
- [ ] Acute stressor; particularly real or perceived loss
- [ ] Chronic non-lethal self-injury
- [ ] Global insomnia
- [ ] Mental Health ED visit within last 3 months
- [ ] Severe depression (e.g. PHQ-9>20)
- [ ] Current intoxication with alcohol or substances
- [ ] None

Moderate Suicide Risk

- [ ] Moderate depression
- [ ] Current hypomania
- [ ] Drug use disorder within the last 5 years
- [ ] Moderate anxiety/panic
- [ ] Suicidal ideation or PHQ-9 Question #9 with response of 1
- [ ] History of suicide attempts (> than 1 year ago)
- [ ] Family history of suicide
- [ ] Chronic severe pain
- [ ] LGBTQ+
- [ ] Armed Services: Veteran and active duty
- [ ] Current eating disorder
- [ ] Traumatic Brain Injury within the last year
- [ ] Impatient psychiatric care in last year
- [ ] Opiates abuse within the last year
- [ ] Impulsivity (particularly in teens and young adults)
- [ ] None

Low Suicide Risk

- [ ] Anxiety Disorder (not moderate or severe)
- [ ] Depressive disorder, mild to in remission
- [ ] Bipolar disorder, in remission
- [ ] Psychotic disorder, in remission
- [ ] Multiple chronic medical problems
- [ ] Any other mental health or personality disorder
- [ ] None

Suicide Risk – Protective Factors

Reasons for Living

- [ ] Will not abandon family
- [ ] Reason for living
- [ ] Coping skills
- [ ] Family: Responsible to and would not abandon
- [ ] Parenthood, esp. for mothers
- [ ] Individual meaning of suicide
- [ ] No acceptable method available
- [ ] Spiritual beliefs
- [ ] Presence of support
- [ ] Relationship with treatment team
- [ ] Fear of suicide, death, dying
- [ ] Belief that suicide is immoral or will be punished

Interventions to Reduce Suicide Risk

Level of care:

- [ ] Inpatient Department (IPD)
- [ ] Partial Hospitalization Program (PHP)
- [ ] Intensive Outpatient Program (IOP)
- [ ] Outpatient Department (OPD)
- [ ] Rationale if treatment differs from Zero Suicide Guidelines: _____

Interventions Made or In Place:

- [ ] Safety plan created (available on henryford.com/MIMindtools)
- [ ] Safety plan reviewed
- [ ] Family engaged with care
- [ ] Community resources provided
- [ ] Self-management tools provided (available on henryford.com/MIMindtools)
- [ ] 988 and crisis resources

Weapon Removal

- [ ] None available
- [ ] Discussed but declined
- [ ] Arranged
- [ ] Confirmed

Medical Management

- [ ] Treatment initiated
- [ ] Treatment modified
- [ ] Ongoing and compliant
- [ ] Referral made according to protocol
- [ ] Refused recommendation
- [ ] Not indicated

Psychotherapy

- [ ] Treatment initiated
- [ ] Treatment modified
- [ ] Ongoing and compliant
- [ ] Referral made according to protocol
- [ ] Refused recommendation
- [ ] Not indicated

Risk determines the timeliness and access to care; this includes not only access to a medical psychiatric provider (psychiatrist or advanced practice provider (APP)) but also to a psychotherapist. Any patient with acute, high, or moderate risk should have a psychotherapist involved in their care or documentation as to why such treatment is either not recommended or refused.

Suicide risk mandates a psychiatric evaluation:

- Psychiatric evaluation on the same day if Acute risk.
- Psychiatric evaluation within 48 hours if High risk.
- Psychiatric evaluation within 7 days if Moderate risk with anxiety disorders or mood or psychotic disorders not in remission.
- If Low risk, timing of psychiatric evaluation relates to patient's current needs and response to treatment.
- If a patient is in treatment with a psychiatrist or APP already, the patient's frequency of contact should be dictated by a change in risk level as well as response to treatment.
- A patient who comes to a provider for the first time or for any patient under the care of a behavioral health therapist must be referred to a psychiatrist or APP based on risk level assigned.

Suicide risk mandates a psychotherapy referral:

- Psychotherapist referral on the same day if Acute risk; appointment within 72 hours
- Psychotherapist referral on the same day if High risk; appointment within 5 days
- Psychotherapist referral on the same day if Moderate risk with anxiety disorders or mood or psychotic disorders not in remission; appointment within 7 days.

- If Low Risk referral or need for ongoing psychotherapy relates to the patient's current needs and response to treatment
- If a patient is in treatment with a psychotherapist, the patient's frequency of contact should be dictated by a change in risk level as well as response to treatment