



Magellan Clinical Practice Guideline for Assessing and Managing the Suicidal Patient

Magellan Practice Guideline Task Force Membership

Lawrence J. Nardozi, M.M.M., M.D., D.F.A.P.A., C.P.E.

J. Andrew Burkins, M.D.

Robert Ciaverelli, M.D.

Gary Henschen, M.D.

Kathleen K. Frampton, R.N., B.S.N., M.P.H.

Timothy T. Stock, M.D.

Charles Wadle, R.Ph., D.O., F.A.P.A.

TABLE OF CONTENTS

I.	INTRODUCTION.....	4
II.	SUICIDE STATISTICS: DEMOGRAPHICS AND EPIDEMIOLOGY	5
III.	ASSESSING SUICIDE LETHALITY.....	7
	A. GENERAL QUESTIONS.....	7
	B. ASSESSING SUICIDAL IDEATION	7
	C. ASSESSMENT TOOLS	9
	D. ASSESSING RISK FACTORS	10
	E. SPECIAL POPULATIONS	17
	F. CULTURAL FACTORS.....	21
IV.	MANAGING THE SUICIDAL PATIENT.....	23
	A. DO I MANAGE MY PATIENT BASED ON THE THEORY OF SUICIDE?.....	23
	B. GENERAL RECOMMENDATIONS	23
	C. GENERAL TREATMENT STRATEGIES	24
	D. SPECIFIC TREATMENT STRATEGIES	24
	E. WHEN DOES SUICIDALITY REQUIRE HOSPITALIZATION?.....	25
	F. SHOULD CONTRACTS FOR SAFETY BE USED?.....	27
	G. PREVENTION	27
	H. MEDICATION	29
	I. ELECTRO-CONVULSIVE THERAPY (ECT)	31
	J. PSYCHOTHERAPY	32
	K. COMBINED TREATMENT.....	32
	L. RISK MANAGEMENT.....	34
	M. POST PREVENTION	35
V.	BIBLIOGRAPHY.....	37

I. INTRODUCTION

The assessment of suicidality is among the most important functions exercised by mental health professionals. The imperative of keeping the patient safe constitutes not only the most important clinical objective, but the core of good risk management as well. The principles outlined in this document represent Magellan Health Services' (Magellan's) best practice guidelines with regard to assessing and managing the patient who presents with suicidal potential. It is expected that clinicians who are members of Magellan's provider network and Magellan care managers incorporate these recommendations in their own systematic approach to this aspect of clinical practice. Ultimately, clinical judgment used consistently with the standards of good clinical practice will result in effective suicide assessment and management. The guidelines presented here are not meant to replace the clinician's good clinical judgment in light of the individual patient's clinical status and the best available assessment and treatment options.

The guideline principles that follow are drawn from the scientific literature. In the preparation of the 2000 and 2002 guidelines, a thorough literature review was conducted including a review of guidelines on schizophrenia, major depression, substance abuse, and bipolar disorder. In the preparation of the 2004, 2006 and 2008 revisions, another thorough review of more recently published scientific literature, along with available practitioner input, was conducted. These guidelines continue to constitute a living document to be improved and refined in light of new clinical knowledge and technology. Accordingly, practitioners' comments are welcomed.

The Magellan Clinical Practice Guideline for Assessing and Managing the Suicidal Patient represents an overview of essentials and nuances to complement the American Psychiatric Association 2003 Practice Guideline for the Assessment and Treatment of Patients With Suicidal Behaviors.¹ As such, the reader should become familiar with the APA document for more detail regarding any particular topic herein.

At the present time, mental health professionals cannot predict with certainty which patients are going to attempt suicide. Despite vast literature on the subject, there is no "gold standard" and no single test or method of assessment that identifies the patient most at risk. The basic goal of the assessment, therefore, is to identify, characterize, quantify, and manage those factors that constitute clinical risk. Along with proper documentation, such activities constitute the backbone of safe practice patterns. It should be recognized, however, that safety is a relative concept and risk is inherent in health care. As pointed out in the American Psychiatric Association Practice Guideline for the Assessment and Treatment of Patients With Suicidal Behaviors,¹ in working with suicidal patients, one must balance the "competing goals of encouraging the patient's independence yet simultaneously addressing safety."

It should also be noted that many suicide screening tests have been developed, primarily based on studies of completed suicides, but to date none have proven adequate predictors in the individual case. Attempts to screen the general population based on such data identify both false positive and false negative cases. While psychometric tests have value, especially with regard to quantifying and tracking depression, the severity of depression and the specific diagnostic category of depression do not predict suicide.

This being the case, clinical guidelines for assessing and managing the suicidal patient must be directed toward those who *might* attempt suicide rather than those who *will* attempt suicide. It is hoped that understanding of and adherence to a guideline such as this will help decrease the likelihood of completed or attempted suicide, although it is also understood that the goal of complete suicide eradication, even within the context of optimal psychiatric practice, is not presently attainable. It is in this spirit that these guidelines are presented.

II. SUICIDE STATISTICS: DEMOGRAPHICS AND EPIDEMIOLOGY

Rates and Ratios

- Based on 2001 National Institute of Mental Health (NIMH) data, the suicide rate in the U.S. has remained relatively constant at approximately 11 suicides per 100,000 people. This amounts to approximately 30,622 deaths per year. Of these, about 2,000 are adolescents.²
- The suicide rate among the young (under 25 years of age), however, has dramatically increased. Suicide is the third leading cause of death for this age group, following unintentional injuries and homicide. This finding is linked to increases in substance abuse and depression among this population.
- A new five-year analysis on the nation's death rates recently released by the federal Centers for Disease Control and Prevention (CDC) found that the suicide rate among those age 45 to 54 increased 19.5 percent from 1999 to 2004, far outpacing the changes in nearly every other age group. For women ages 45 to 54, the rate increased to 31 percent. The suspected reasons for these findings may be the increased use and abuse of prescription drugs.⁷⁴
- The rate is highest among older adults (65 and older, and especially Caucasian males). The rate for white men ages 85 and older is 54 per 100,000, almost 5 times the rate of the general population.²
- Native American and Native Alaskan youth have higher rates of suicide in their respective age groups. This may partly explain why the suicide rates in the U.S. are highest in the western states and Alaska.
- The suicide ratio of men to women is 4:1, although in 20 to 24 year olds, it is 7:1.²

Profiles

- Attempters are primarily female, suffering from a high rate of personality disorders, and make repeated suicide attempts.
- Completers are primarily male, suffering from a major Axis I mental disorder, and often (more than 60 percent) make a single suicide attempt. Male suicide attempters are at high risk for eventual completion.
- Although most deaths from suicide occur in the community setting, some patients commit suicide while hospitalized in psychiatric and medical settings.

- It has been estimated that there may be from eight to 25 attempted suicides for every one completed suicide.²

Methods

- Suicide by firearms is the most common method for men and women, accounting for 60 percent of all suicides in 2001.² Eighty percent of all firearm suicide deaths occur in Caucasian males. The second most common method for men is hanging; for women, it is self-poisoning, including drug overdose.²
- 16 percent of suicides in females ages 15-24 are due to ingestion, while only 2 percent of suicides among males in this age group are due to ingestion.²

Risk Factors

The APA guidelines contain a table with a comprehensive list of factors associated with increased risk for suicide; the reader is referred to that table for additional information¹ Among salient trends:

- More than 90 percent of suicides are associated with a mental disorder.
- The strongest risk factors for suicide are depression, alcohol abuse, cocaine use, and separation or divorce.²
- A previous suicide attempt is more predictive in males.
- Violence within the past year indicates an increased risk of suicide.³
- Homosexual youth, bisexual youth, and victims of child abuse are at greater risk for suicide attempts.
- Being diagnosed with HIV-AIDS increases suicide risk, particularly just after testing positive and disclosing to friends.⁴

It is generally believed that those who attempt suicide (“attempters”) represent a different population from those who complete suicide (“completers”). As noted above, attempters are primarily females suffering from a high rate of personality disorders who make repeated suicide attempts. Conversely, completers are primarily males suffering from a major Axis I mental disorder, 60 percent of whom make a single suicide attempt. Male attempters are at a higher risk for eventual completion than female attempters.

There are differences between those who complete suicide in the first year after contact with the health care system and those who complete suicide after a longer period of time. The first group is characterized by acute turmoil, high levels of psychic as opposed to somatic anxiety, and profound biological disturbance, such as global insomnia, anhedonia, and impaired concentration. Patients who are discharged from hospitals appear to fall into this short-term risk group, with high rates of suicide during the ensuing year, especially for those patients admitted due to a suicide attempt or ideation.⁵ The risk is especially high in the month following discharge from a mental health facility.

The latter, long-term risk group is comprised of predominantly patients with chronic mental disorders associated with high levels of hopelessness and despair.

III. ASSESSING SUICIDE LETHALITY

A. General Questions

The following four general questions are provided for consideration in formulating a consistent and salient approach to effectively assess suicidal lethality.

1. Who should receive a suicide assessment?

A suicide assessment should be conducted on any new patient who meets DSM-IV criteria for mental or substance use disorder, or any patient who otherwise has any other identified potential risk factors. Patients with psychiatric disorders have significantly higher rates of suicide attempts when compared to the general community, 29 percent compared to 5 percent.⁶

2. What are the components of a suicide assessment?

There are two components to a suicide assessment:

- The elicitation and elaboration of suicidal ideation, and
- The identification and quantification of risk factors for completed suicide.

3. At what point(s) should such an assessment take place?

Ordinarily a suicide assessment should occur at the point of entry into treatment (i.e., at the initial visit with a mental health professional) and periodically thereafter, as indicated by the patient's symptomatology. If, at the time of the initial assessment, a patient meets criteria for a major psychiatric disorder and/or manifests any degree of suicidal risk, then the patient should be monitored for suicidal risk at each session thereafter.

4. How should such assessment be documented?

The clinical record should reflect that the suicide risk assessment has taken place, what the findings are, and what intervention plans are in place to contain, manage, or mitigate the identified suicidal risk. The ideation and risk, along with the positive and negative findings, should be noted in the clinical record, either in the mental status exam section or in a clinical note.

B. Assessing Suicidal Ideation

Kaplan et al.⁷ notes that although there is a high level of correlation in a patient's responses to suicide-related questions between a self-administered questionnaire and the same questions posed in a face-to-face interview, there are often discrepancies on questions concerning current suicidal ideation. The authors found that patients tended to admit current suicidal ideation on self-administered tools more so than in a face-to-face interview.

It is surmised that perhaps the patient fears that a positive response to this question might have “unwanted” consequences, such as hospitalization. The authors suggest that during an initial evaluation, patients may feel more comfortable responding to basic questions regarding suicidal ideation and behaviors on a self-administered questionnaire, more so than with an interviewer. Another study supports this conclusion.⁸

The assessment of suicidal ideation proceeds along a gradient, from least to most severe, with a specific line of inquiry as part of the assessment of mental status:

- Beginning with general questions about the consideration of self harm, the interviewer should ask whether thoughts of death or suicide have occurred; if so, how often and how persistently. Are they fleeting, periodic, or constant? Do they occur under specific circumstances? Are they increasing, decreasing or remaining constant?
- Thoughts should be characterized as passive (e.g., “I would be better off dead”) or active (e.g., “Sometimes, when I am driving my car, I get the impulse to drive into other cars.”)
- Any thoughts noted should then be elaborated upon using the patient’s own language. Specifically, what are the thoughts?
- The patient should be asked whether there have been suicidal impulses, whether there is current intent, and if so, is there a plan? Details of the plan (method, time and place) should be reviewed and documented in the clinical record. The patient should be asked about whether any rehearsal (mental or through action) has taken place and whether there have been any attempts made thus far.
- Past history of similar thoughts, wishes, impulses, plans or attempts should be obtained.
- The patient with a plan should be asked about the availability of means and/or whether there is a plan/intent to obtain any means (e.g., plan to purchase a gun).
- As part of the evaluation, the interviewer should make a determination about the patient’s attitude toward suicide, which may range from acceptance of its inevitability or desirability (ego syntonic) to ambivalence or rejection (ego dystonic).
- The patient should be asked about barriers to suicide. What are the reasons for living and those for dying? How has the patient managed to evade the act of suicide thus far?
- Is there anything different now or anticipated to be different in the near future?
- Has the suicidal ideation been shared with anyone else besides the therapist? Who is or could be helpful in managing the ideation? This calls for the involvement of family and/or significant others. Family and/or significant others can assist in obtaining data about the patient and provide containment and feedback during treatment. Sometimes, suicidal communications may be made to family and/or significant others rather than to a health care professional. Optimally, as part of the safety plan, such collaboration should be with the patient’s permission.

C. Assessment Tools

1. Suicide Intent Scale (SIS)

The literature offers some helpful suicide assessment tools. Mieczkowski et al. and Spirito et al. reported their findings on suicide attempters by using the Suicide Intent Scale (SIS).^{9,10} The SIS is designed to evaluate various factors pertinent to suicidal intent associated with a previous suicide attempt. The SIS elicits both the subjective and objective aspects of suicide intent.

Mieczkowski et al. reported that SIS scores of Lethal Intent were often at the highest end of the scale for suicide attempters who made serious suicide attempts. Additionally, those who completed suicide were found to have a higher score on the Objective Planning section of the SIS than those who attempted suicide. The authors indicated that Lethal Intent and Objective Planning sub-scales may be useful assessment tools for defining distinct components of intent.

Spirito et al.'s research revealed three factors noteworthy of consideration in assessing adolescent attempters:

- The purpose, expectation of lethality, seriousness, ambivalence about living, and the concept of reversing the attempt,
- The patient's isolation, timing, precautions against being discovered, and acting to gain help, and
- The degree of premeditation and planning.

The authors explain that an adolescent's suicidal intentions "are not adequately explained by the SIS." The authors suggest it may be useful to consider the subjective factors (expected outcome) and objective factors (planning activities), which have been shown to be specific to the adolescent population versus a total score when conducting assessments on adolescent suicide attempters.

2. Chronological Assessment of Suicide Events (CASE)

Shea¹¹ set out to reduce the number of poorly done suicide assessments by developing the Chronological Assessment of Suicidal Events (CASE) interviewing strategy. The strength of the interview strategy is that it is reliable regardless of how tired or overwhelmed the clinician may be, or how hectic the clinical environment. In the CASE interview, the clinician explores the following four regions in this order: 1) the presenting ideation and suicidal behavior; 2) any recent ideation and behaviors (over the preceding 8 weeks); 3) past suicidal ideation and behaviors; and 4) immediate ideation and plans for the future.

The clinician is invited to alter the format to meet the needs of the patient. The CASE approach is not characterized as a complete interview and should be used in conjunction with some other clinical interview, such as an initial or emergency room assessment.

3. Beck's Scales

Further assessment tools were outlined by Beck et al.¹², who identified three scales for assisting in the assessment for potential suicidality:

- *Scales for Suicide Ideation-Current (SSI-C)*, which attempts to measure current suicidal ideation,
- *Scales for Suicide Ideation-Worst (SSI-W)*, which attempts to measure suicidal ideation at its worst point in the patient's life, and
- *Beck Hopelessness Scale (BHS)*, which attempts to measure the patient's level of hopelessness.

The SSI-C is a 19-item scale used to evaluate the current intensity of the patient's attitudes, behaviors and suicidal plans. The SSI-W evaluates the level of suicidality at a given point in time of a patient's life. The interviewer is instructed to ask the patient to recall the approximate date and circumstances when they experienced the most intense suicidal ideation. The patient is asked to keep this experience in mind as he/she answers the 19-item scale. Beck reported that the SSI-C and SSI-W have moderately high internal consistency and good concurrent and discriminant validity for psychiatric outpatients. The BHS is a scale of 20 true-false statements designed to assess the extent of positive and negative beliefs about the future. Beck notes that in developing an instrument to measure suicidality, the test's sensitivity is more important than the specificity. In Beck's study, the SSI-W was found to be a significant predictor of eventual suicide.

Although not as powerful as the SSI-W, Beck reports that when hopelessness is assessed over time, it may be a more accurate assessor than current hopelessness. Beck concludes that outpatients with high SSI-W scores who do not respond to therapy and have consistently high BHS scores are a particularly high-risk group for suicide.

Beck's study provides examples of evaluation tools designed to assist the clinician in better assessing the degree of suicide risk. It is extremely important to note that no screening tool is an absolute determinant for suicide risk. At best, evaluation tools assist the clinician in the risk assessment of an individual patient. A key conclusion from Beck is that "the evaluation of a patient's risk for suicide should never be based on a score of a single scale."

4. Columbia Classification Algorithm of Suicide Assessment (C-CASA)

The Columbia Classification Algorithm of Suicide Assessment (C-CASA) is a classification system that utilizes a definition of suicidality derived from empirical findings on the phenomenology of suicidality and identified predictive and risk factors.⁷⁵ In order to enhance interpretability of pediatric antidepressant trial data to be used in their risk analysis, the Food and Drug Administration (FDA) commissioned a study by Columbia University/New York State Psychiatric Institute investigators to classify all events that could represent suicidality. The C-CASA tool was developed for this purpose and was

subsequently used as the standardized suicidal rating system that provided data for the pediatric suicidal risk analysis of antidepressants conducted by the FDA.

The C-CASA tool has eight categories that distinguish suicidal events from non-suicidal events and indeterminate or potentially suicidal events and are grouped as follows:

- Suicidal events – completed suicide, suicide attempt, preparatory acts toward imminent suicidal behavior and suicidal ideation
- Non-suicidal events – self-injurious behavior, no suicidal intent and other, no deliberate self-harm
- Indeterminate or potentially suicidal events – self-injurious behavior, suicidal intent unknown

The strength of the suicide classification system is in its ability to comprehensively identify suicidal events while limiting the over-identification of suicidal behavior. As a research-based classification, it has been redesigned to a prospective version as the Columbia-Suicide Severity Rating Scale (C-SSRS) for use in both clinical settings and during clinical research trials.⁷⁶ In January 2008, the FDA notified drug makers that they would be required to study whether patients become suicidal during clinical trials. The FDA has adopted the C-SSRS for use by pharmaceutical companies in the systematic administration of a tool designed to track suicidal adverse events across a treatment trial in an effort to obtain better safety monitoring information and to avoid inconclusive results.⁷⁷

D. Assessing Risk Factors

There is no certain way of predicting who will commit suicide. The assessment and weighing of risk factors alerts the clinician to those patients who should be monitored. In addition, the determination that a patient is at risk, whether or not ideation is present, shapes the treatment by introducing the objective of risk reduction. The following section details general risk factors and those associated with specific diagnoses.

1. General risk factors

The presence of more than one risk factor increases the risk of suicide. The presence of a mental disorder may be regarded as a necessary factor, in that more than 90 percent of completed suicides are associated with the presence of such a disorder. Factors that may add increased risk for any patient with a mental disorder include:

- The presence of depression;
- Recent or impending loss, such as a job or an interpersonal relationship (including that with a therapist);
- Recent loss of a child, especially if child has committed suicide and/or dies during early childhood¹³;
- The presence of substance or alcohol abuse;

- Access to guns;
- A psychiatric hospitalization within the past year, especially for patients admitted due to a suicide attempt or ideation;⁵ A history of impulsive or dangerous behavior, especially self-destructive behavior;
- Previous suicidal behavior or attempts; One study suggests that when an individual has made a deliberate act of self harm their risk of death by suicide is as high as 66 times that of the general population in the first year after the act, and that the elevated risk continues over an extended period of time for as long as 20 years after the act.¹⁴
- A history of physical or sexual abuse;
- A family history of suicide;
- Social isolation; or
- The presence of a concurrent medical disorder characterized by chronicity, poor prognosis, poor physical functioning, and/or persistent pain.

2. High-risk diagnoses

Four diagnoses particularly associated with the risk of completed suicide are: 1) depression (primarily major depression, unipolar or bipolar, but including also the full range of depressive disorders listed in the DSM-IV); 2) alcohol or other substance abuse or dependence; 3) schizophrenia (all forms, including schizophreniform disorders); and 4) borderline personality disorder.

With the exception of alcoholism, suicides tend to occur early in the course of most psychiatric disorders.¹ The risk factors associated with these disorders appear to vary with the diagnosis. They should be assessed as part of the treatment planning process.

a. Depression

The most commonly associated diagnosis with suicide is depression. It is present in more than 60 percent of completed suicides (probably an underestimation of the true frequency). It is estimated that 15 percent of patients with major depression will eventually die by suicide. Counter intuitively, the severity of depression and the presence or absence of psychosis may not be good indicators of suicidal risk. Therefore, patients with any type of depressive disorder should be assessed for suicidal risk. The following factors have been found to increase risk and should be systematically queried and the response documented:

- 1) The concurrent presence of anxiety
 - Anxiety, especially psychic (as opposed to somatic) forms

- Agitation and specific anxiety syndromes (obsessive-compulsive symptoms, though not necessarily meeting criteria for diagnosis of obsessive-compulsive disorder)
- Turmoil (called by some “perturbation,”) especially when defensive breakdown is indicated

The physical symptom of akathisia, occurring either alone or as a side effect of certain medications, which may be characterized as a sense of inner agitation as well as motor restlessness. When present, such anxiety should be treated. It is this side effect that is postulated to be connected to *de novo* suicidal behavior due to antidepressants, if that indeed occurs, or a worsening of already present suicidal behavior.¹⁵

2) Concurrent substance abuse or dependence

- Alcohol problems in depression are associated with a worse depression course, an increased risk for relapse and decreased likelihood of recovery from depression, increased suicide/death risk, worsening social function and increased health care utilization.⁷⁹
- Current use or abuse, whether or not these appear to constitute self-medication.
- Use of substances that promote disinhibition, which may increase the risk of impulsive acts or undermine judgment and restraint. Concurrent substance abuse in bipolar patients has been identified as a risk factor for attempts.¹⁶

3) Command hallucinations

- Hallucinations may be present in psychotic states and are thought to increase risk, though this has not been proven conclusively.
- The evaluator should ask whether the patient has received any signals or messages regarding self-harm.

4) Rapid shifts in mood

- Ask about fluctuations and lability of mood (e.g., from sadness to euphoria, irritability, and anger).
- There is some suggestion that patients with bipolar II disorders, with hypomania alternating (or co-existing with) depression, and patients with rapid cycling bipolar disorder, may be at a higher risk.¹⁶
- Irritability or anger associated with impulsivity may indicate a patient especially prone to take (self-destructive) action.

5) Certain aspects of the depressive diagnostic criteria appear ominous

- Severe insomnia, especially global insomnia, along with states of severe hopelessness, may increase risk. Research has postulated that instead of hopelessness per se, it may be the elements of pessimism, a factor combining negative outlook with less reason for living, and the presence of aggressive/impulsive traits that may increase risk for a future suicide attempt. Therefore, psychotherapeutic techniques targeting pessimism may lower risk.⁶
- Ask about these two symptoms in detail when they are present. Severe insomnia should be treated.

6) The presence of or access to a firearm

- Ask about access to firearms routinely. If a firearm is present, take steps to remove access during the episode of treatment and assess who is a safe person to restrict the patient's access to the gun(s).
- Many suicides are impulsive, and national statistics indicate that more than half of all suicides are committed with guns, especially handguns.
- Guns are especially likely to be associated with suicide in the young (adolescents) and in the elderly.

7) Medication History

- There is evidence suggesting that lithium discontinuation, especially if abrupt, leads to an increase in suicidal behavior, at least in the first year following lithium discontinuation.^{17,18}
- There is also very suggestive evidence that in patients with bipolar disorder, maintenance lithium treatment is associated with a sustained reduction in suicidal acts.^{17,19}

8) History of past attempt

A two-year prospective study of patients entering treatment with major depressive disorder revealed that the three strongest risk factors predicting a future suicide attempt were a history of a suicide attempt, cigarette smoking, and the patient's subjective rating of the severity of their depression, as opposed to the clinician's objective rating of the severity of their depression.⁶

b. Alcohol/substance abuse or dependence

Individuals who carry a primary diagnosis of alcohol abuse, with a pattern of drinking over many years, and have a degree of suicidality, are generally considered a chronic rather than acute suicidal risk. However, as many as half of completed suicides (and probably many events characterized as "accidents," which may be covert suicides) involve drinking at the time of death.

1) Alcohol/drug use as self medication

It has been found that alcohol use is often related to suicide and suicide attempts through its use as a self-medication for the relief of depression. Alcohol is thought to disinhibit impulses to suicide.²⁰ Therefore, the clinician should routinely ask about substance abuse and depression as part of any suicide risk evaluation. In addition, inquiries about jeopardy with regard to important relationships and job, threats of incarceration or detention, or severe financial or other losses should be conducted. Positive and negative findings should be noted in the record. The presence of multiple risk factors in a given patient is highly significant.

2) Unrecognized withdrawal

Dlugacz et al. reviewed 17 attempted or completed suicides by inpatients in the North Shore-Long Island Jewish Health System and noted that unrecognized or under-treated alcohol withdrawal on medical units was the single most common precipitant for the suicidal behavior.²¹ Thus, both the disinhibiting effect of intoxication and the agitation and anxiety of withdrawal can contribute to suicidality.

3) Cigarette smoking

Another interesting finding being demonstrated in the literature is the finding of cigarette smoking heightening the risk of future suicide attempts in high-risk patients, e.g., patients with major depression.⁶ Although the reasons for this remain unknown, it has been demonstrated that cigarette smokers have lower serotonergic functioning and more aggressive/impulsive traits, two factors that may mediate this heightened risk.

c. Schizophrenia

Between 20 and 40 percent of patients with schizophrenia attempt suicide at some point in their lives. While it has been widely reported over the last 30 years that this disorder carries a lifetime suicide rate of approximately 10 percent, recent adjustment after meta-analysis currently estimates that 4.9 percent of schizophrenics will commit suicide.⁸⁰ Also, recent data analyzing standardized mortality ratios (SMR) for people with schizophrenia show that of all specific-cause SMRs, suicide was associated with the highest estimate: 12 times greater than the general population.⁸¹ The risk for suicide is highest early in the onset of the illness. Suicide is most likely to occur in the young patient with schizophrenia who has experienced a great decline in performance and, therefore, diminished expectations with regard to the future.

Suicide often takes place during periods of remission, especially following hospitalization, rather than during acute psychotic states. A pattern of repeated exacerbations and remissions, and especially the occurrence of depressive symptoms, carries high risk. The clinician should be alert to the presence of

subtle or covert thought disorder and should ask patients with schizophrenia about:

- 1) Dangerous behavior, perhaps under the influence of features of persisting delusions; e.g., overestimation of abilities, poor judgment in protecting self, and excessive risk-taking. Noncompliance with medication may represent one form of such behavior. A study published in 2003 appears to support this latter risk factor.²²
- 2) Concurrent substance abuse (it may be important to ask others, as well as the patient).
- 3) The presence of depression, which may center on the individual's response to having schizophrenia, as well as the family's response of disappointment and/or anger. Highlighting the importance of this aspect of the assessment is a Canadian study that noted poor ascertainment of depressive symptoms in the mental health records of many patients with schizophrenia who eventually committed suicide.²³

One study found that in those patients who had previously attempted suicide, current command suicide hallucinations were a significant risk factor for a subsequent attempt.²⁴

d. Borderline personality disorder

This over-inclusive diagnosis is most likely to be associated with parasuicidal rather than suicidal acts, but approximately 10 percent of patients who are diagnosed as borderline personality disorder eventually commit suicide, usually after many previous suicidal or para-suicidal acts. Those who commit suicide most commonly qualify for a concurrent Axis I diagnosis (depression, substance abuse) at the time of suicide. The fact that such patients often use suicide as a manipulative threat and tend to be litigious, accounts for a great many hospitalizations. For these patients, hospitalization should be considered for short-term stabilization rather than for a prolonged stay. According to Paris²⁵, many of these hospitalizations may be counter-therapeutic, in that they may divert focus from developing new coping mechanisms for exacerbations of chronic suicidality. Paris thus suggests that structured programs, such as partial hospital programs, may be a more appropriate level of care for many of these patients, to both address safety issues and allow for the development of new coping strategies. The APA Suicide Practice Guideline also notes that "For some patients, treatment in...an inpatient unit may foster dependency and a regressive, vicious cycle of intensifying suicidal thoughts requiring ever more restrictive care."²¹

Suicide attempts are very common and may occur in an estimated 60 to 70 percent of patients with borderline personality disorder.⁸² Risk factors for suicidal behavior in patients with borderline personality disorder are as follows:

- Prior suicide attempts

- Co-morbid mood disorder
- High levels of hopelessness
- Family history of completed suicide or suicidal behavior
- Co-morbid substance abuse
- History of sexual abuse
- High levels of impulsivity and/or antisocial traits.

In a published clinical review of treatment, Oldham notes that despite the ability to identify meaningful risk factors in patients with borderline personality disorder, we cannot with certainty predict future suicidal behavior in an individual patient. This is a problem that confronts clinicians in the treatment of all patient populations with potential suicide risk.⁸² As discussed in Section III, Assessing Suicide Lethality, use of the newly developed Columbia-Suicide Severity Rating Scale (C-SSRS) should assist providers in evaluating self-injurious behavior and in distinguishing suicide attempts from non-suicide events in patients.⁷⁵

Despite these observations, the clinician should take suicidal threats in such patients seriously and develop a plan for containment, if indicated, and be mindful of the increased risk for the first month following discharge.⁵

A two-year prospective study examined the specific borderline personality diagnostic criteria that were most associated with *suicidal behavior*, defined in this study as any suicidal acts regardless of intent, and with *suicide attempts*, defined in this study as any suicidal behavior with any intent to die and at least some mild medical threat.²⁶ The findings indicate that affective instability was the borderline criterion most associated with both suicidal behavior and suicide attempts. DSM-IV-TR describes affective instability as “intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days.”²⁷

Other criteria found to be risk factors for suicidal behaviors were identity disorder and impulsivity. Interestingly, the study also found that a history of childhood sexual abuse was a risk factor for suicide attempts, but not suicidal behavior. This led the authors to suggest that this nosology and differentiation between behavior and attempts is useful and may lead to identification of risk factors that are specific for attempts only. A major recommendation from these authors is that affective instability in borderline personality disorder patients should be assessed for and treated if present.

E. Special Populations

1. Age groups

a. Adolescents

When assessing adolescent patients, the following information may prove useful.

1) Rates

There is a vast amount of information available on adolescent suicide. An excellent review of this material can be found in the *Practice Parameter for the Assessment and Treatment of Children and Adolescents With Suicidal Behavior*, published by the American Academy of Child and Adolescent Psychiatry in July of 2001.²⁸ Here it is noted that suicide attempts before adolescence are rare, but a sharp increase occurs between 13 and 18 years of age. In addition, the lifetime rate of some kind of suicide attempt or gesture for high-school-aged children is 3 percent to 15 percent. It is also noted that suicide is the third leading cause of death among 15 to 24-year-olds. The suicide rate peaks in the 20 to 24 age range, particularly in males. As in adults, the rate of completed suicide is greater in adolescent males, and the rate of suicide attempts is two to three times greater in female adolescents than in male adolescents.

2) Risk factors

Major depression is the most significant risk factor in girls, with some studies indicating a 20-fold increase in risk. The next most significant risk factor is a previous attempt. In boys, a previous attempt is the leading risk factor, followed by depression, substance abuse, and disruptive behavior. Stressful psychosocial life events and low levels of communication between parents and children appear to be significant risk factors.

Personality characteristics associated with increased risk include poor self-esteem or feelings of inferiority, underestimating one's own competence, and a sense of responsibility for negative events.²⁹ A family history of suicide also increases risk. Additionally, children with a history of physical and/or sexual abuse are at greater risk. Although not firmly established as a risk factor, self-mutilation frequently occurs in adolescent suicide attempters, and therefore should be assessed.³⁰

3) Protective factors

Some factors mitigating against suicidal behavior in adolescents include:

- Fear of social disapproval
- Positive survival beliefs, e.g., beliefs about one's purpose in life and ability to persevere
- Having a reason for living.

4) Suicide attempters

Management of adolescents who have recently attempted suicide is critically important since a prior suicide attempt is a strong predictor for eventual suicide completion.³¹ Adolescents often experience ongoing stress following a suicidal crisis, which can culminate in another suicide attempt. An essential aspect of the evaluation is reviewing the recent attempt thoroughly. An evaluation of the degree of impulsivity in the past attempt versus the degree of significant planning can be helpful in guiding the focus of treatment from targeting impulsivity to targeting underlying depression and hopelessness. Additionally, one cannot be reassured by a previous attempt with low lethality since the adolescent may have had a high expectation of death with significant intent to die. Stressors or precipitants should be identified and most often are found to be difficulties in interpersonal relationships with parents and/or friends.

It is recommended that management include more frequent evaluations of ideation, intent and plans, since the presence of these factors in the context of continuing depression and hopelessness would present significant risk. One therapeutic technique that can aid the management process can be re-framing the suicide attempt as unsuccessful problem-solving, which leads to working with the adolescent and family to develop more effective problem-solving skills. Additionally, parents should be given psycho-education about suicide and be counseled to increase supervision, take suicidal statements seriously, and limit access to any lethal means. The article that discusses these points includes a list of risk and protective factors as well as a sample information sheet for parents.³¹

b. Elderly

The National Institute of Mental Health reported that the elderly, particularly older white males, have the highest suicide rate among all populations. Among white males ages 65 and older, risk goes up with age. White males ages 85 and older have a suicide rate six times that of the overall national rate.

Reviewing the suicide risk of the elderly population, Conwell et al.³² found that older age was a significant indicator of more determined and planful self-destructive acts, less violent methods, and fewer warnings of suicidal intent. The authors report that intervention in the midst of a suicidal crisis may be more difficult in the elderly because they are less likely to give warning to others, being less likely to speak to anyone about their plans.

However, since it has also been reported that somatic illness is a risk factor in the old elderly (ages 75 and older) and that over 70 percent of suicidal elderly see their primary care physician shortly before committing suicide, primary care physicians have a unique opportunity to detect suicidality in this age group. Particular attention should be paid to those old elderly who are both depressed and have somatic complaints, especially impaired vision.³³ It also is reported that family conflict and loneliness are independent risk factors in the old elderly. Depression is not only under-detected in this age group, but under-treated as compared to the young elderly.

In addition to the somatic complaints factor already mentioned, depression in the elderly is associated with specific physical illnesses, especially respiratory conditions, malignancy, diabetes, and neurological conditions, such as stroke. Significantly, one study found that 78 percent of suicide completers were newly diagnosed with medical problems, such as malignancy, prostatitis, or stroke, or had a need for surgery.³⁴ Pain was also considered a major factor affecting life and comfort. These findings underscore the opportunity primary care physicians and other medical specialists have for early detection of depression.

2. Occupations

a. Physicians

Numerous studies over the last 50 years have reported a higher incidence of suicide in physicians than in the general population. The risk ratio relative to the general population for male physicians has been reported to range from 1.1 to 3.4, and for female physicians from 2.5 to 5.7. These gender-based relative risk ratios lead to equalization of the actual suicide rate in physicians between males and females. This is in contrast to the general population, which has a higher rate for males to females of 4:1.

One large study reviewed self-report data from women physicians in the United States and found that women physicians did not have a higher rate of suicide attempts than the general female population.³⁵ However, findings from a Finnish study indicated that Finnish female physicians have a higher completed suicide rate than the general female population.³⁶ Due to these somewhat different findings, it is clear that this area requires further research.

Factors commonly blamed for a higher incidence of suicide in physicians, such as long working hours and demanding patients, do not seem to contribute as much as the reluctance of doctors to seek care for themselves. One of the reasons for this is their concern about the impact on their practice of being labeled with a psychiatric diagnosis. Some states, many hospitals, and malpractice insurance carriers ask about a history of psychiatric diagnosis as a proxy for impairment or instability. Physicians should be encouraged to seek appropriate treatment, and bureaucratic or organizational barriers to care should be removed.³⁷

b. Dentists

There has long been a belief that dentists have a higher rate of suicide than many other professionals. One article cites the American Dental Association studies from the 1970s calling this conclusion into question. The author highlights a need for newer and less flawed research to quantify whether a higher relative risk exists for dental practitioners.³⁸

c. Police Officers

A study was published in 2002 that sought to validate the hypothesis that New York City police officers have a higher suicide rate than the general population.

After analyzing data on police deaths in New York City between 1977 and 1996, it was found that the rate in police officers was actually lower than in the general population.³⁹ This may be related to the routine psychological screening of police candidates. An important exception to this finding was that female police officers were four times more likely to commit suicide than their female general population counterparts. This statistic loses some strength since the absolute numbers were small. Risk factors for female officers included marital problems, job suspension, and alcoholism. Suggestions by the authors were for counseling programs and education to begin early in police training and to repeat them periodically throughout police officers' careers. This is seen as a way to overcome the stigma and other barriers standing in the way of police officers seeking counseling programs.

F. Cultural Factors

It is of utmost importance that clinicians be educated, knowledgeable, and sensitive to cultural differences among patients. Research is available regarding suicide risks associated with specific ethnic groups. Some key findings are provided here with respect to the Asian-American, Native American, and African-American communities, to assist clinicians in being attentive to these risks.

1. Asian-American

Purcell studied suicide in the elderly Asian population. Key risk factors for this population are depression, physical illness, and loss. Results from the study showed that the mean age for suicide was 75 years, with the highest completion rate in the 80 years and older category.³⁴

The predominant method was hanging, followed by jumping, use of a firearm, and poisoning. Almost half of the sample had seen a health care provider within six months of death. Seventy-nine percent of the sample committed suicide at home or on the surrounding property.

Active depression was the most common psychiatric illness. Only 15 percent had contact with a mental health provider within one month of death. Fifty-eight percent had a history of suicidal behavior. Fifty-three percent made one or more active attempts.

Only 45 percent of the subjects who were prescribed antidepressants showed evidence of taking medication in the toxicology reports. In findings consistent with other literature, the authors found that males tended to use more violent means (hanging, firearm, jumping) than females.

In Lester's article on Chinese-American suicidal behavior, the author found that Asian-Americans have a relatively low suicide rate compared to Caucasians.⁴⁰ For example, in 1980 the figures were 13.2 per 100,000 for Caucasians compared to 8.3 per 100,000 for Chinese-Americans. Asian-Americans used hanging much more often than Caucasians and firearms less often. Lester concluded that gender and age patterns seem to be affected strongly by

ethnicity (older males more likely to suicide than females). The suicide rates and methods are also affected by the nation in which the Chinese live.

Finally, in the Asian population, under-reporting is a distinct possibility, since suicide is viewed as “shameful.”

2. Native American

Conversely, in the Native-American culture, suicides have often been honored. The concern is that today’s youth may seek attention and acceptance in their own suicides. Acculturation is a factor thought to contribute to the suicide rate. Resulting pressure from the dominant culture leads to a variety of changes in the non-dominant culture.

Native Americans who attempted or completed suicide reveal influential factors such as grief over loss, and quarrels with relatives and friends.⁴¹ Rarely is cultural conflict mentioned. Problems related to acculturation may raise the stress level so much that additional stressors now precipitate suicide.

3. African-American

Research on African-American suicide has yielded some information about cultural-specific suicide risk factors. The combination of male gender, early adulthood, and substance abuse may be associated with a greater risk for suicide among African-Americans. Additional precipitants identified were depression, family dysfunction, interpersonal discord/marital conflict, acting out/delinquency, psychiatric disorders, and homosexuality/AIDS.⁴²

Conversely, the combination of strong religious beliefs, social supports, and ethnic neighborhoods is purported to help reduce the effects of aging and poverty, thus reducing the suicide risk. In contrast to Caucasians, African-Americans tend to under-report suicidal ideation. This suggests that clinicians should use caution when relying on patient self-reports of depression and suicidal ideation as predictors of suicidal behavior in African-American youth.

4. Hispanic

The overall rate of suicides among Hispanics is about half that of the U.S. population as a whole (6/100,000 versus 11/100,000). The majority of suicide deaths among all Hispanics occurs in men aged 85 or older, followed by men ages 80 to 84, and those aged 75 to 79. For Hispanic women, most suicide deaths occur in the 50 to 54 age range, followed by 45 to 49 and then 15 to 19.²

Hispanic subpopulations differ in suicidal behavior. The majority of suicides in Hispanics occurs in Mexican-American populations, followed respectively by persons of unknown Hispanic, Central and South American, Puerto Rican, and Cuban origin.⁴³ Suicide attempt rates are highest among those of Puerto Rican ethnicity and lowest among those of Cuban ethnicity.⁴³

There is evidence that adolescent Hispanic populations have a higher rate of suicide attempts than comparable non-Hispanic white populations.⁴¹ Risk

factors for suicidal ideation and attempts in adolescent Hispanics are negative self-concept, derogation from parents and teachers, low social integration, and low social support.⁴¹

Hispanic adolescent females appear to have twice the prevalence of suicide attempts compared to African-Americans or white non-Hispanic females.⁴⁴ It has also been observed that suicide rates for these females are higher in the United States than in their countries of origin, suggesting a role for acculturation issues. It has also been observed that suicide attempts in this population typically occur in the context of progressively intense conflicts with the girl's parents over her romantic involvements in particular.

Other risk factors cited include having families with absent or under-involved fathers, low cohesiveness, pervasive familial/marital conflict and violence, and low parental support and warmth.

Among all Hispanic populations, culturally-based protective factors may operate to keep suicide attempts and completions at lower rates than the overall population.⁴⁵ Specifically, moral objections to suicide, beliefs about responsibility to family, and mores regarding survival and coping may protect against suicide ideation, attempts, and completions.⁴⁵ In addition, among Mexican-Americans, being Mexican-born appears to protect against suicidal ideation and attempts compared with Mexican-Americans born in the United States.¹

IV. MANAGING THE SUICIDAL PATIENT

A. Do I manage my patient based on the theory of suicide?

At present, there are two distinct theories of causation:

- Suicide derives from an individual's potential, evoked by the development of a mental disorder, especially depression. This hypothesis, which is not proven, is based on data suggesting certain common neurotransmitter and other biochemical features of successful suicides; or
- Suicide is a symptom of a mental disorder, and the disorder is causative.

The best answer at present is that neither biological nor genetic markers are of everyday clinical use, so the clinician should instead direct attention to the treatment strategies indicated in the following sections.

B. General Recommendations

An important distinction exists between the acute risk and the eventual risk of suicide. The presence of pervasive anxiety with depression, thought disorder with persecutory delusions, and/or command hallucinations with schizophrenia should alert the clinician to the need for rapid symptom reduction and containment whether or not suicidal ideation is acknowledged.

It is also significant, in the therapeutic relationship, to work to establish a strong therapeutic alliance between the patient and clinician. Developing and establishing this alliance could enhance the therapeutic engagement between clinician and patient thus enabling for the clinical intervention to reduce suicidal risk.

C. General Treatment Strategies

- Conduct a thorough assessment;
- Take steps to mitigate or eliminate identified risk factors;
- Strengthen barriers to suicide; and
- Treat the associated disorder.

D. Specific Treatment Strategies

Suicide appears to occur when a mental disorder is present, intent develops, and means become available. Additionally, help from mental health professionals, family, or significant others, is unavailable or rejected. Specific treatment strategies that fall into the general categories noted above include the following:

1. Arrange for the removal of the patient's access to weapons, especially guns. Assess, identify and work with a family member, friend, or authorities in assuring that the weapon is removed.
2. Address the abuse of substances in order to restore the patient to normal restraint and inhibition.
3. Assist with the strengthening of social resources through active involvement of family/significant others in containment.
4. Vigorously treat anxiety or agitation associated with depression and/or thought disorder, if present.
5. Assist the patient in planning and taking steps to stabilize job and family situations that are in jeopardy.
6. Identify and address dangerous behavior that may represent suicidal intent.
7. Make lethality an acknowledged and targeted issue.
8. Evidence can be found in the literature supporting the particular efficacy of specific psychotherapies for suicidal patients, such as cognitive-behavioral therapy (CBT), interpersonal psychotherapy (IPT), and dialectical behavioral therapy (DBT). It is, however, generally acknowledged that most forms of psychotherapy may be useful, providing the therapist develops a strong therapeutic alliance with the patient and conveys a sense of optimism and activity.
9. Inform and involve the patient's primary care physician and other clinicians to increase coordination of care across settings.

10. Employ family intervention to enhance effective family problem-solving and conflict resolution.
11. Be aware that time-limited, home-based interventions have limited efficacy for children and adolescents without major depressive disorder.⁴⁶

E. When does suicidality require hospitalization?

The benefits of hospitalization should be compartmentalized and the question divided into two parts. First, is containment necessary? Second, are the unique medical resources of a hospital necessary to provide the treatment? When both severity and imminence of suicidal risk are present, a hospital is usually required to provide safe treatment. This situation is usually an emergency requiring immediate containment and intensive psychiatric treatment with close observation.

If hospitalization is selected as the safest and most appropriate level of care, it is important that discharge and aftercare planning be initiated quickly and that an outpatient follow-up visit is scheduled prior to the patient's discharge.⁴⁷

However, hospitalization by itself does not end the suicidal threat. One study of completed suicides in a hospital setting revealed that one common contributing factor was poor communication of the severity of the suicidality between the emergency or admitting department and the treatment unit.²¹ For hospitalization to achieve optimal containment and safety, it requires ongoing good clear communication between hospital units and between nursing shifts on each unit.

When severity is present without imminence, such as when the patient is ambivalent or rejecting of suicide as an option, and help is accepted and supports are present, other forms of containment may be considered (psychosocial, chemical, and/or structural). The APA Suicide Practice Guideline advises that "patients should be treated in the setting that is least restrictive yet most likely to prove safe and effective," and "the benefits of hospitalization must be weighed against possible negative effects."¹ The APA suicide guideline contains a table, reprinted in this document, that outlines criteria for consideration when deciding about appropriate levels of care for patients with suicide risk. ¹ For a detailed discussion of how the intensity and site of service should be determined, the clinician is referred to Table 1 in this document and to the Magellan Medical Necessity Criteria.⁴⁸

It is important to note that risk may fluctuate during an episode of care and such decisions call for continual review and updating. The patient must be aware that ongoing reassessment is available, even on an ongoing emergency basis. The patient needs to be instructed on how to access these services in a timely fashion.

Table 1. Guidelines for Selecting a Treatment Setting for Patients at Risk for Suicide or Suicidal Behaviors*

<p><u>ADMISSION GENERALLY INDICATED</u></p>
<p>After a suicide attempt or aborted suicide attempt if:</p> <ul style="list-style-type: none"> Patient is psychotic Attempt was violent, near-lethal, or premeditated Precautions were taken to a void rescue or discovery Persistent plan and/or intent is present Distress is increased or patient regrets surviving Patient is male, older than age 45 years, 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 <p>In the present of suicidal ideation with:</p> <ul style="list-style-type: none"> Specific plan with high lethality High suicidal intent
<p><u>ADMISSION MAY BE NECESSARY</u></p>
<p>After a suicide attempt or aborted suicide attempt, except in circumstances for which admission is generally indicated</p> <p>In the presence of suicidal ideation with:</p> <ul style="list-style-type: none"> Psychosis Major psychiatric disorder Past attempts, particularly if medically serious Possibly contributing medical condition (e.g., acute neurological disorder, cancer, infection) Lack of response to or inability to cooperate with partial hospital or outpatient treatment Need for supervised setting for medical trial or ECT 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 clinical-patient relationship or lack of access to timely outpatient follow-up <p>In the absence of suicide attempts or reported suicidal ideation / plan / intent but evidence from the psychiatric evaluation and/or history from others suggests a high level of suicide risk and a recent acute increase in risk</p>
<p><u>RELEASE FROM EMERGENCY DEPARTMENT WITH FOLLOW-UP RECOMMENDATIONS MAY BE POSSIBLE</u></p>
<p>After a suicide attempt or in the presence of suicidal ideation / plan when:</p> <ul style="list-style-type: none"> Suicidality is a reaction to precipitating events (e.g., exam failure, relationship difficulties), particularly if the patient's view of the situation has changed since coming to 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
<p><u>OUTPATIENT TREATMENT MAY BE MORE BENEFICIAL THAN HOSPITALIZATION</u></p>
<p>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</p>

*Reprinted with permission from American Psychiatric Association. (2003). Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors. ¹

F. Should contracts for safety be used?

Contracts for safety should not be used in the absence of a strong alliance with the patient, or in settings that do not provide the opportunity to monitor the patient over time (e.g., single session emergency care.) Contracts should never substitute for developing a safety plan. Contracts run the risk of communicating to the patient that the therapist does not want to hear about suicidal ideation or wishes primarily to protect him/herself against liability. The risk under such circumstances is that the patient will interpret the contract as a form of rejection.

Contracts may be useful with some patients however, following a thorough evaluation and if based on evidence that the patient may be relied upon to honor them, as part of a general strategy of risk sharing. It should be noted that the routine use of contracting may create a false sense of security for the clinician and/or the patient.

Shea reminds clinicians that safety contracts are no guarantee of safety.¹¹ Safety contracts can act best as deterrents when there is a powerful bond between the patient and the clinician. The more concrete the contract (written versus oral), the more likely it is to serve as a powerful deterrent. The sense of commitment and trust in a long-standing relationship between patient and clinician may cause the patient to hesitate in breaking his/her word. However, the deterrent power of a safety contract made with a first-time patient is significantly less.

Shea notes that it is best to avoid safety contracting with patients who exhibit agitated, psychotic, or impulsive behavior, are intoxicated, or have characteristics that could increase the likelihood that the patient will be manipulative with regard to the safety contract, e.g., borderline and passive-aggressive personality characteristics.

G. Prevention

Although a primary purpose of this guideline is to assist with suicide prevention, this section reviews several key prevention points.

Depression is a foremost risk factor for suicide. Suicide rates increase with age. Older Caucasian males have a suicide rate up to six times that of the general population. One approach to preventing depression is through grief counseling for widows and widowers. Participation in self-help groups appears to ameliorate depression, improve social adjustment, and reduce the use of alcohol and other drug abuse.

Primary care settings have been targeted to play a significant role in suicide awareness and intervention. Untreated/undiagnosed depression in primary care settings plays a significant role in suicide. As mentioned earlier in this guideline, more than 70 percent of older suicide victims were seen by their primary care physician within a month of their death, many with undetected depressive illnesses. Such data somewhat counters a report from the U.S. Preventive Services Task Force (USPSTF), which indicates a lack of published evidence to demonstrate the efficacy or harm of routine suicide screening in primary care in preventing suicide.⁴⁹ Nonetheless, Magellan believes the preponderance of clinical evidence from preventive medicine indicates the value for enhanced screening and detection of depression and suicidality in the primary care setting. It has been observed that depression training for general practitioners reduces suicide. Also, weighting of risk

factors in suicide prevention may be helpful to identify those persons who would warrant closer monitoring or more in-depth questions as to suicide potential. The APA guideline identifies these risk factors as "...being white male, being single, having a diagnosis of affective disorder, schizophrenia, or alcoholism; having made a previous suicide attempt; or having personality-disorder traits, such as manipulateness and hostility."⁵¹

One study demonstrated the effectiveness of enhancing physician knowledge through treatment guidelines and telephonic or in-person care management in decreasing suicidal ideation and depressive symptomatology in the elderly in primary care.⁵⁰ Detection and treatment strategies are also important for nursing home residents.

A recent systematic review of suicide prevention strategies by Mann et al. provided further support on the effectiveness of primary care physician education in depression recognition and treatment in suicide prevention. This review also revealed findings from studies showing that restricting access to lethal methods reduces suicide rates (e.g., firearms in Canada and Washington, D.C., barbiturates in Australia, domestic gas detoxification in Switzerland and the United Kingdom, and vehicle emissions in England). Educating community and institutional gatekeepers (e.g., clergy, first responders, pharmacists, geriatric caregivers, employees of schools, prisons and the military, etc.) may also be effective in suicide prevention. This study describes gatekeeper education as instruction on suicide risk factors, policy changes to encourage help-seeking, availability of resources and efforts to reduce stigma. Mann noted that study findings to date on gatekeeper education show success in military institutions and therefore, more research is needed to determine its efficacy in other sectors of society.⁸³

Suicide prevention is a much-sought-after therapeutic result. Kessler et al. offer some insight towards this outcome.⁵¹ The authors utilize data on prevalence and risk factors of attempted suicide from the National Comorbidity Survey (NCS). The results indicate the highest risks of initial suicide ideation, plans, and attempters are for individuals in their late teens and early 20s. The progression from ideation to first onset of a plan, from a plan to first attempt, and from ideation to first attempt without a plan, were all highest in the first year after onset of the earlier stage. However, risk of a first-time attempt lacking a plan was limited to the first year after onset of ideation. Risk of a first attempt was substantially higher when a plan was involved. The authors note that risk of an attempt among ideators with a plan was very high in the onset year of the plan and continued for many years.

Co-morbidity was found to be a significant indicator of suicide attempts over the effects of individual disorders. The total number of disorders, rather than the type, was found to be the strongest indicator of suicide risk; however, patients with mood disorders remain at substantially higher risk than patients with any other disorders. The APA guideline presents a fairly detailed discussion of co-morbid disorders in Section B, VI, and the practitioner is referred to the APA guidelines for expanded specific information on the role of co-morbid disorders on suicide risk.¹ A study of 76 completed inpatient suicides, of which there are about 1,600 per year in the United States, pointed out that level of agitation and anxiety was more predictive of acute risk than demographic or prior history predictors or severity of current depressive affect.⁵² Neither suicide "contracts," denials of suicidal ideation, nor 15-minute "checks" were preventive of suicide in this study. The authors recommended close attention to the level of agitation, and line-of-sight observation for severely anxious or agitated patients.

H. Medication

Prescribed medications should be those that are necessary to treat the associated disorder. For guidance, the clinician is referred to Magellan's other adopted guidelines on major depression⁵³, substance use disorders⁵⁴, and schizophrenia⁵⁵ respectively. The APA guideline contains a thorough discussion of the medication, ECT, and psychotherapy management of the suicidal patient (sections A, IV, A-B; and B, VI, D-E.)¹ Additionally, the clinician is referred to the APA guideline for the treatment of bipolar disorder⁵⁶, specifically the sections on treating depressed or mixed states.

As indicated above, anxiety or agitation associated with depression generally should be treated symptomatically. A full discussion of the use of medications or other somatic therapies for the treatment of the disorders associated with suicidality is beyond the scope of these guidelines. However, the following general recommendations are offered:

1. Antidepressants

The choice of antidepressant is based on its scientific support, the unique manifestation of symptoms, and the patient's past response to treatment (when known). Also the patient's current medical condition and associated medications should be considered for their potential impact on pharmacokinetics and pharmacodynamics, as well as to prevent serious side effects or harm to the patient (see Magellan's major depressive disorder guidelines).⁵³

Since suicidal behavior frequently occurs in the context of major depression, following established guidelines for medication regimens for depression is indicated. Conformance with HEDIS-based depression care guidelines, including rapid initiation of antidepressant medication therapy and at least three follow-up outpatient visits within the first 12 weeks of initiation, has been found to improve clinical outcomes.⁵⁷

Several classes of antidepressant medications are available, and the treatment generally begins with a non-MAOI agent.

- a) Selective serotonin reuptake inhibiting drugs (SSRIs), such as fluoxetine (Prozac), sertraline (Zoloft), paroxetine (Paxil), fluvoxamine (Luvox), and citalopram (Celexa), are considered front line for the treatment of major depressive disorders. Because of the lethality of tricyclic antidepressants (TCA) when taken in overdose, TCAs are not recommended as first choices in treating the depressed patient who is suicidal. When depression is associated with bipolar disorder, the first drugs of choice are usually mood stabilizers.

Although SSRIs have been implicated by some studies to increase suicidal ideation, prompting an FDA Advisory on March 22, 2004, studies have not conclusively confirmed a greater risk with this drug or class of drugs.^{58,59, 86, 87} In a large systematic review of randomized controlled trials, Fergusson et al. examined data from 702 trials representing 87,650 patients revealing that patients taking SSRIs were twice as likely to attempt suicide as patients taking placebo in the trials. However, it is important to note that further analysis of these pooled data revealed no increase in risk when only the number of

completed suicides of patients taking SSRIs was compared with those taking placebo. Also, no significant differences were noted in the risk of suicide attempt in patients taking TCAs compared with those taking SSRIs.⁸⁴ In fact, studies demonstrate that suicidality is reduced as depression improves with the use of SSRIs.⁸⁶ The U.S. Surgeon General's Report indicated that in depressed adults, SSRIs were found to reduce suicidal ideation^{60,61} and to reduce the frequency of suicide attempts in patients without major depression who had previously made at least one suicide attempt.⁶² Because of the questions raised, it is advisable to monitor patients closely for the emergence of suicidal ideation or agitation, especially in the initial phases of treatment and at times of dosage change.^{15,63} This may be particularly important in treating children and adolescents.⁶⁴ As with all drugs, it is recommended that patients be observed for side effects and treatment altered accordingly, and that quantities be limited in cases where overdose is a risk.

The psychiatric community has given attention to a recent epidemiological study by Gibbons et al. confirming that in both the United States and the Netherlands, SSRI prescriptions for youths decreased by approximately 22 percent after the FDA and European Medicines Agency issued their warnings about a possible association between antidepressants and suicidal thinking and behavior.^{85, 87} In the Netherlands, the youth suicide rate increased by 49 percent between 2003 and 2005 and shows a significant inverse association with SSRI prescriptions. In the United States, youth suicide rates increased by 14 percent between 2003 and 2004, which is the largest year-to-year change in suicide rates in this population since the Centers for Disease Control and Prevention began systematically collecting suicide data in 1979. Researchers also noted that decreasing the number of SSRI prescriptions did not lead to increases in alternative antidepressant treatments (e.g., newer non-serotonergic-specific antidepressants and tricyclics) as expected.⁸⁷

- b) Atypical antidepressants, such as bupropion (Wellbutrin and Wellbutrin SR), venlafaxine (Effexor and Effexor XR), nefazadone (Serzone), and mirtazapine (Remeron), vary in their action and effect. There is indication that most are effective in the treatment of refractory and/or severe depression. Several have the additional effect of being helpful when anxiety or agitation accompanies depression. They are effective alternatives to SSRIs, and can be used as frontline agents.
- c) For the patient who experiences agitation associated with depression, early and limited use of anxiolytics is indicated. As with all drugs that may produce dependence, the use of benzodiazepines should be avoided in the patient with active chemical dependence and carefully monitored with all patients.

2. Antipsychotics

In the treatment of schizophrenic suicidal patients, the atypical antipsychotics, such as clozapine, risperidone, olanzapine, and ziprasidone, have been shown to be effective in reducing positive and negative symptoms in schizophrenic patients who fail to respond to typical neuroleptics. Meltzer reports that in using clozapine, there is a potential to decrease the mortality rate by as much as 85 percent.^{65,66} It should be

noted that there are also contrary findings in the literature.⁶⁷ The clinician is thus urged to keep abreast of the ongoing literature on this possible risk-lowering effect of clozapine.

3. Lithium

Although there are many medications used to successfully prevent or diminish mood instability in patients with bipolar disorder, studies have noted that lithium treatment significantly reduces the rate of suicides and suicide attempts in such patients.^{18,19, 88} It should also be noted that discontinuing lithium treatment is associated with an increase in suicide morbidity and mortality, particularly in the first 12 months.¹⁷

4. Anti-convulsants

Anti-convulsant drugs may be used as mood stabilizers in bipolar disorder. In January 2008, the FDA published the following Safety Information Alerts:

[Posted 01/31/2008]⁸⁹ FDA informed healthcare professionals that the Agency has analyzed reports of suicidality (suicide behavior or ideation) from placebo-controlled clinical studies of 11 drugs used to treat epilepsy as well as psychiatric disorders, and other conditions. In the FDA's analysis, patients receiving antiepileptic drugs had approximately twice the risk of suicidal behavior or ideation (0.43%) compared to patients receiving placebo (0.22%). The increased risk of suicidal behavior and suicidal ideation was observed as early as one week after starting the antiepileptic drug and continued through 24 weeks. The results were generally consistent among the eleven drugs. **The relative risk for suicidality was higher in patients with epilepsy compared to patients who were given one of the drugs in the class for psychiatric or other conditions.** Healthcare professionals should closely monitor all patients currently taking or starting any antiepileptic for notable changes in behavior that could indicate the emergence or worsening of suicidal thought or behavior or depression. The drugs included in the analyses include (some of these drugs are also available in generic form):

Carbamazepine (marketed as Carbatrol, Equetro, Tegretol, Tegretol XR)

Felbamate (marketed as Felbatol)

Gabapentin (marketed as Neurontin)

Lamotrigine (marketed as Lamictal)

Levetiracetam (marketed as Keppra)

Oxcarbazepine (marketed as Trileptal)

Pregabalin (marketed as Lyrica)

Tiagabine (marketed as Gabitril)

Topiramate (marketed as Topamax)

Valproate (marketed as Depakote, Depakote ER, Depakene, Depacon)

Zonisamide (marketed as Zonegran)

Although the 11 drugs listed above were the ones included in the analysis, FDA expects that the increased risk of suicidality is shared by all antiepileptic drugs and anticipates that the class labeling changes will be applied broadly.

I. Electro-Convulsive Therapy (ECT)

ECT remains a viable option for the seriously depressed suicidal patient. Antidepressant drugs do not work quickly. ECT should be considered in all cases where a rapid response is essential.⁶⁸ This principle continues to be supported in published data from a NIH study (Consortium for Research in ECT Continuation ECT Study) of a large group of severely depressed patients, most of whom were hospitalized, documenting a rapid reduction in expressed suicidal intent in patients treated with ECT. Researchers in this study recommended that evidence-based treatment algorithms for major depressive mood disorder should include dichotomization according to suicide risk, as assessed by interview. For patients at risk, ECT should be considered earlier than at its conventional “last resort” position. Researchers noted that this is particularly important when one considers the risk of suicide and the delayed efficacy of medications in severely depressed patients.⁷⁸

The primary indications for ECT are:

- An urgent need for a rapid response, such as in the instances of imminent suicide, deteriorating physical condition, and/or intolerable suffering;
- Treatment alternatives are riskier than ECT;
- A history of superior response to ECT; and/or
- The patient understanding the risks/benefits of ECT and has expressly requested this treatment.

Secondary indications for ECT are:

- Demonstrable evidence of poor response to adequate pharmacotherapy or intolerable side effects; and/or
- The patient’s condition deteriorating to the point where the primary criteria for ECT are met.

J. Psychotherapy

There is a major role for psychotherapy in most cases of high suicidal risk. An attitude of empathic acceptance and allying with the patient’s pain and sense of desperation may be

regarded as ancillary to other methods of treatment and basic to the establishment of the necessary alliance. The therapist should not try to avoid the issue of suicidality, but rather contain and manage it in conjunction with the patient, significant others, and/or other helpers in his/her life structure, as indicated. It appears to be a significant factor to include family members and key support system people in the overall treatment “team.” Specifically, the family/significant others can be instrumental in limiting access to lethal medication and other means, as well as providing other ongoing support to the individual.

Psychotherapy should focus on the suicide risk itself, as a prelude to reducing it and allowing for other treatment objectives to emerge. Often such therapy may be targeted and brief. These treatment recommendations must be distinguished from questions about the type and role of psychotherapy in the treatment of the underlying disorder.

Depending on the patient’s preferred mode of learning, suicidality may be contained and the patient engaged in the process of recovery from the associated disorder through behavioral, cognitive and psychodynamic forms of focused psychotherapy. It appears that a therapist who conveys a sense of optimism and activity may use most forms of psychotherapy successfully.

K. Combination Treatment – Medication and Psychotherapy

Major depressive disorder has a point prevalence of 5 percent in adolescents and is associated with significant morbidity and family burden, as well as suicidal behavior and completed suicide.⁹⁰ Recent research studies have been conducted to seek improvements in the treatment of depression in adolescents and suggest that combined treatment with medication and psychotherapy for suicidal patients may be beneficial in treating depressed adolescent patients with suicidal risk. However, clinical trials have shown mixed results in the treatment of depressed adolescents using the selective serotonin reuptake inhibitor (SSRI) or serotonin and norepinephrine reuptake inhibitor (SNRI) class of drugs and/or cognitive-behavioral therapy (CBT).

The Treatment for Adolescents with Depression Study (TADS) studied the effects of using fluoxetine (SSRI) or CBT alone or in combination. Combination therapy consistently showed superiority at all follow-up intervals. Suicide ideation decreased with treatment, but less so with fluoxetine therapy than with combination or CBT. Suicidal events were more common in patients receiving fluoxetine therapy (14.7 percent) than combination therapy (8.4 percent) or CBT (6.3 percent).⁹⁰

These findings differed somewhat from two other published reports. Results from the NIH-funded Treatment of SSRI-Resistant Depression in Adolescents (TORDIA) trial revealed that teenagers with difficult-to-treat depression, who do not respond to a first antidepressant medication, were more likely to get well if they were switched to another antidepressant medication with CBT rather than just switching to another antidepressant. These findings showed that for adolescents with depression not responding to an adequate initial treatment with an SSRI, the combination of CBT and a switch to another antidepressant resulted in a higher rate of clinical response than did a medication switch alone. However, a switch to another SSRI was just as efficacious as a switch to the SNRI, venlafazine, and resulted in fewer adverse effects. This study also confirmed that there was no advantage of the combination of CBT and medication over medication alone on

the incidence of suicidal adverse events. Researchers in this particular study noted that suicidality does not necessarily subside when depression does.⁹¹

Related findings also come from a report of a large British clinical trial that showed no difference in the treatment effects of SSRI and specialty clinical care alone than with SSRI and CBT together with specialty clinical care. On average, there was a decrease in suicidal thoughts and self harm. However, there was no evidence of a protective effect of CBT on suicidal thinking or action.⁹²

L. Risk Management

Attention to risk management issues is important since a certain number of suicides will occur despite a clinician providing optimal care and management. According to one estimate, 50 percent of those who die by suicide have seen a mental health provider at some point.⁶⁹ Novice clinicians experience higher rates of suicide among their clients than more seasoned clinicians.⁷⁰ Sound risk management is not only good clinical practice, it can serve as a comfort in the event a practitioner experiences the death by a client to suicide⁷¹ and when documented adequately, as a legal defense against potential malpractice actions.⁷¹

1. Documentation

Clinical records should be a clear indicator of the thought process of the clinician, especially with regard to decisions made about managing lethality. The APA guidelines contain a table that highlights the factors to document in a risk assessment and the critical junctures at which such risk assessment should be documented, and states that risk assessment and documentation of findings is an ongoing process, not an isolated event.¹

The initial assessment provides the first opportunity to demonstrate with the documentation that a complete risk assessment has been conducted and that, if indicated, a safety plan has been developed and implemented.¹¹ In addition to the initial assessment, the documentation should provide clear evidence of the clinician's ongoing assessment of the patient's response to treatment, changes in the treatment plan, safety plan, and/or level of care with the rationale and potential impact on the patient's safety. The record should also include reference to interventions that were considered but not pursued, along with the rationale.

Sound lethality assessments, as described above, including both lethal ideation and risk assessment, are important safeguards against later claims of negligence or lack of care. Contacts with family, other treatment providers, and the patient (phone calls and letters as well as sessions), responses to failed appointments, noncompliance with treatment requirements, and impasses in treatment should all be documented.

2. Collaboration and Issues of Confidentiality

Consultation and/or collaboration with other helpers, as well as with the patient and his/her family/significant others, and communication among principals in treatment are critical elements of good treatment as well as good risk management.

Consultation with a senior colleague is recommended in formulating and supporting an appropriate treatment plan for clients at risk for suicide.¹

Collaboration with the family after obtaining authorization from the patient should be ongoing. If circumstances warrant a breach of confidentiality, the clinician should weigh the risks and benefits of a breach. The clinician can make constructive responses to crisis situations that may not breach confidentiality but may still manage risk to acceptable levels; for example, listening to the patient's family members without making disclosures about the patient. Local and federal law may require disclosure of the patient's status to emergency personnel if necessary to assure the safety of the patient or others, and the clinician should be familiar with applicable laws and regulations.

3. Assessment of Patient Competence and Ability to Collaborate

Patients often fail to inform their therapists about suicidal ideation and behavior. Patients even may actively hide their suicidal intent from their therapists. Interview techniques are available that make it easier to elicit accurate information about suicidal ideation and intent with non-collaborative clients. For example, the therapist can exaggerate symptoms: "How many times this week did you think about suicide, 20 or 30?"⁷² It may be important to review with the patient the subject of suicide risk, and the risks of not keeping the therapist informed.

Also, associated with this strategy should be an assessment of the patient's competence with regard to this issue: i.e., does s/he understand the risks of failing to keep the therapist informed? The result of this process should be documented in the record. When the patient's competence is in question (e.g., actively psychotic patients), other actions may need to be considered (e.g., hospitalization, guardianship).

M. Post Prevention

1. The Family

Following a suicide, it is sound clinical practice to maintain contact with the decedent's family and to offer (at least brief, supportive) services to survivors. When treatment beyond brief support is required, referral to another clinician should be considered. For family members, referral to a specialized support group can be helpful. Since requirements for confidentiality do not cease with the patient's death, the provider should limit the amount of information communicated to family members to only what is necessary.

The brief supportive services should be guided by the need to facilitate grieving and decrease the risk of mood and anxiety disorders in the bereaved family members, particularly prepubertal children. This risk is further heightened in any family members who may have witnessed the suicide or had prior knowledge of the victim's problems and hence develop a degree of guilt. Helping counsel the remaining family members about their increased risk and being vigilant for warning signs is important. Major depressive disorder and post-traumatic stress disorder are two common

disorders occurring in the bereaved and there is some evidence to suggest that the impact on family members can be long-term.

2. The Clinician

According to the American Psychiatric Association, completed suicide is a prevalent occurrence and at least half of psychiatrists can expect to face the death of a patient through suicide with significant impact on the clinician.¹ Clinicians who lose a patient to suicide frequently feel stress akin to that of losing a parent. Reviewing the circumstances leading to the suicide with an attorney and obtaining collegial support, such as consultation or supervision, are recommended to facilitate the clinician's own healing process.

A study surveying therapists after patient suicides revealed that at least one third of the study population experienced severe distress.⁷³ The four factors identified that linked to distress were failure to hospitalize a patient who then died, a treatment decision the therapist felt contributed to the suicide, negative reactions from the therapist's institution, and fear of a lawsuit. Two other notable findings from this study revealed that in retrospect, therapists who experienced distress wished they had involved the patient's family more in the treatment and communicated more with prior or concurrent treatment providers, among other regrets. These two findings underscore the importance of involving family or support system members when treating a patient with suicidal risk, as well as coordinating treatment with past and current providers.

V. BIBLIOGRAPHY

1. American Psychiatric Association. (2003). Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors.
2. National Institute of Mental Health. (2004). Suicide Facts and Statistics www.nimh.nih.gov/suicideprevention/suifact.cfm. Accessed April 26, 2006.
3. Conner KR, Cox C, Duberstein PR, Tian L, Nisbet PA, Conwell Y. Violence, alcohol, and completed suicide: a case-control study. *Am J Psychiatry* 2001;158:1701-1705.
4. Kalichman SC, Heckman T, Kochman A, Sikkema K, Bergholte J. Depression and thoughts of suicide among middle-aged and older persons living with HIV-AIDS. *Psychiatr Serv* 2000;51:903-907.
5. Bostwick JM, Pankratz SV. Affective disorders and suicide risk: a re-examination. *Am J Psychiatry* December 2000;157:1925-1932.
6. Oquendo, MA. Prospective Study of Clinical Predictors of Suicidal Acts After a Major Depressive Episode in Patients With Major Depressive Disorder or Bipolar Disorder. *Am J Psychiatry* 2004; 161:1433-1441.
7. Kaplan ML, Asnis GM, Sanderson WC, Keswani L, De Lecuona J, Joseph S. Suicide assessment: clinical interview vs. self-report. *J of Clin Psychology* March 1994, Vol. 50, No. 2.
8. Brown GS, Jones ER, Betts E, Wu J. Improving suicide risk assessment in a managed-care environment. *Crisis*. 2003;24(2):49-55.
9. Mieczkowski TA, Sweeney JA, Haas GL, Junker BW, Brown RP, Mann JJ. Factor composition of the suicide intent scale. *Suicide and Life-Threatening Behavior* 1993 Spring;23(1).
10. Spirito A, Sterling CM, Donaldson DL, Arrigan ME. Factor analysis of the suicide intent scale with adolescent suicide attempters. *J Pers Assess* 1996 Aug;67(1):90-101.
11. Shea SC. The chronological assessment of suicide events: a practical interviewing strategy for the elicitation of suicidal ideation. *J Clin Psychiatry* 1998, 59 Suppl 20(): 58-72.
12. Beck AT, Brown GK, Steer RA, Dahlsgaard KK, Grisham JR. Suicide ideation at its worst point: a predictor of eventual suicide in psychiatric outpatients. Department of Psychiatry, University of Pennsylvania, Philadelphia, USA. *Suicide Life Threat Behav* 1999 Spring;29(1):1-9.
13. Qin P, Mortensen PB. The impact of parental status on the risk of completed suicide. *Arch Gen Psychiatry* 2003 Aug;60(8):797-802.
14. Hawton K, Zahl D, Weatherall R. Suicide following deliberate self-harm: long-term follow-up of patients who presented to a general hospital. *Br J Psychiatry* 2003 Jun;182:537-42.
15. Culpepper L, Davidson JR, Dietrich AJ, Goodman WK, Kroenke K, Schwenk TL. Suicidality as a possible side effect of antidepressant treatment. *J Clin Psychiatry* 2004 Jun;65(6):742-749.
16. Dalton EJ, Cate-Carter TD, Mundo E, Parikh SV, Kennedy JL. Suicide risk in bipolar patients: the role of co-morbid substance use disorders. *Bipolar Disord* 2003 Feb;5(1):58-61.

17. Baldessarini RJ, Tondo L, Hennen J. Effects of lithium treatment and its discontinuation on suicidal behavior in bipolar manic-depressive disorder. *J Clin Psychiatry* 1999;60 (suppl 2): 77-84.
18. Tondo L, Baldessarini RJ, Hennen J, Gianfranco F, Silvetti F, Tohen M. Lithium treatment and risk of suicidal behavior in bipolar disorder patients. *J Clin Psychiatry* 1998 Aug;59(supp 8):405-414.
19. Tondo L, Baldessarini RJ. Reduced suicide risk during lithium maintenance treatment. *J Clin Psychiatry* 2000, 61(suppl 9): 97-104.
20. Gruenewald PJ, Ponicki WR, Mitchell PR. Suicide rates and alcohol consumption in the United States, 1970-89. Prevention Research Center, Berkeley, CA 94704, USA. *Addiction* 1995 Aug;90(8):1063-75.
21. Dlugacz YD, Restifo A, Scanlon KA, Nelson K, Fried AM, Hirsch B, Delman M, Zenn RD, Selzer J, Greenwood A. Safety strategies to prevent suicide in multiple health care environments. *Jt Comm J Qual Saf* 2003 Jun;29(6):267-78.
22. Herings RM, Erkens JA. Increased suicide attempt rate among patients interrupting use of atypical antipsychotics. *Pharmacoepidemiol Drug Saf* 2003 Jul-Aug;12(5):423-4.
23. Burgess P, Pirkis J, Morton J, Croke E. Lessons from a comprehensive clinical audit of users of psychiatric services who committed suicide. *Psychiatr Serv* December 2000;51:1555-1560.
24. Harkavy-Friedman JM, Kimhy D, Nelson EA, Venarde DF, Malaspina D, Mann JJ. Suicide attempts in schizophrenia: the role of command auditory hallucinations for suicide. *J Clin Psychiatry*. 2003 Aug; 64(8): 871-4.
25. Paris J. Chronic suicidality among patients with borderline personality disorder. *Psychiatr Serv* 2002 Jun;53:738-742.
26. Yen S, Shea MT, Sanislow CA, Grilo CM, Skodol AE, Gunderson JG, McGlashan TH, Zanarini MC, Morey LC. Borderline personality disorder criteria associated with prospectively observed suicidal behavior. *Am J Psychiatry* 2004 Jul;161(7):1296-8.
27. Diagnostic and statistical manual of mental disorders. 4th ed, Text revision. (DSM-IV-TR). Washington, DC, American Psychiatric Association, 2000.
28. Practice parameter for the assessment and treatment of children and adolescents with suicidal behavior. *Am Acad Child and Adolescent Psychiatry*. *J Am Acad Child Adolesc Psychiatry* 2001Jul;40(7 Suppl):24S-51S.
29. Goodwin RD, Marusic A. Feelings of inferiority and suicide ideation and suicide attempt among youth. *Croat Med J* 2003 Oct;44(5):553-7.
30. Guertin T, Lloyd-Richardson E, Spirito A, Donaldson D, Boergers J. Self-mutilative behavior in adolescents who attempt suicide by overdose. *J Am Acad Child Adolesc Psychiatry* 2001 Sep;40(9):1062-9.
31. Spirito A, Overholser J. The suicidal child: assessment and management of adolescents after a suicide attempt. *Child Adolesc Psychiatric Clin N Am* 2003;12:649-665.
32. Conwell Y. Suicide among elderly persons. *Psychiatr Serv* 1995; 46:563-564.
33. Waern M, Rubenowitz E, Wilhelmson K. Predictors of suicide in the old elderly. *Gerontology*. 2003 Sep-Oct; 49(5): 328-34.

34. Purcell D, Thrush CR, Blanchette PL. Suicide among the elderly in Honolulu County: a multiethnic comparative study 1987- 1992. Department of Psychiatry, University of Hawaii at Manoa, SA. *Int Psychogeriatr* 1999 Mar;11(1):57-66.
35. Frank E, Dingle AD. Self-reported depression and suicide attempts among U.S. women physicians. *Am J Psychiatry* 1999 Dec;156(12):1887-94.
36. Kubderman S, Laara E, et al. Suicide mortality among medical doctors in Finland: are females more prone to suicide than their male colleagues. *Psycholog Med* 1997;27:1219-1222.
37. Center C, Davis M, Detre T, et al. Confronting depression and suicide in physicians: a consensus statement. *JAMA* 2003 Jun 18;289(23):3161-6.
38. Alexander RE. Stress-related suicide by dentists and other health care workers. *JADA* 2001 Jun;132:786-794.
39. Mazurk PM, Nock MK, Leon AC, Portera L, Tardiff K. Suicide among New York city police officers, 1977-1996. *Am J Psychiatry* 2002 Dec;159:12: 2069-71.
40. Lester D. Part II. Cultural perspectives 6. Suicide in America: a nation of immigrants. Blackwood, NJ 08012, USA. *Suicide Life Threat Behav* 1997 Spring;27(1):50-9.
41. Vega WA, Gil AG, Zimmerman RS, Warheit GJ. Risk factors for suicidal behavioral among Hispanic, African-American, and non-Hispanic white boys in early adolescence. *Ethnicity Disease* 1993;3:229-41.
42. Gibbs JT, African-American suicide: a cultural paradox. School of Social Welfare, University of California at Berkeley 94720, USA. *Suicide Life Threat Behav* 1997 Spring;27(1):68-79.
43. <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5322a5.htm>, accessed April 26, 2006.
44. Zayas L, Kaplan C, Turner S, Romano K, Gonzalez-Ramos G. Understanding suicide attempts in adolescent Hispanic females. *Soc Work* 2000;45:53-63.
45. Oquendo MA, Dragatsi D, Harkavy-Friedman J, Dervic K, Currier D, Burke AK, Grunebaum MF, Mann JJ. *Journal Nervous and Mental Disorders* 2005;438-43.
46. Harrington R, Kerfoot M, Dyer E, McNiven F, Gill J, Harrington V, Woodham A, Byford S. Randomized trial of a home-based family intervention for children who have deliberately poisoned themselves. *J Am Acad Child Adolesc Psychiatry* 1998 May;37(5):512-8.
47. Nelson AE, Maruish ME, Axler JL. Effects of discharge planning and compliance with outpatient appointments on readmission rates. *Psychiatric Services*. 2000;51:885-889.
48. Magellan Health Services, Inc.. Magellan Medical Necessity Criteria. https://www.magellanprovider.com/MHS/MGL/providing_care/clinical_guidelines/MNC.asp.
49. Gaynes BN, West SL, Ford CA, Frame P, Klein J, Lohr KN. Screening for suicide risk in adults: a summary of the evidence for the U.S. Preventive Services Task Force. *Ann Intern Med* 2004 May 18;140(10):822-835.
50. Bruce ML, Ten Have TR, Reynolds III CF, Katz II, Schulberg HC, Mulsant BH, Brown GK, McAvay GJ, Pearson JL, Alexopoulos GS. Reducing suicidal ideation and depressive symptoms in depressed older primary care patients: a randomized controlled trial. *JAMA* 2004;291(9):1081-1091.

51. Kessler RC, Borges G, Walters EE. Prevalence of and risk factors for lifetime suicide attempts in the National Comorbidity Survey. *Arch Gen Psychiatry*. 1999 Jul;56(7):617-26.
52. Busch KA, Fawcett J, Jacobs DG. Clinical correlates of inpatient suicide. *J Clin Psychiatry* 2003 Jan;64(1):14-9.
53. American Psychiatric Association. Practice Guideline for the Treatment of Patients With Major Depressive Disorder. Vol. 157; No. 4, April 2000.
54. American Psychiatric Association. (2003). Practice Guideline for the Treatment of Patients With Substance Use Disorders: Alcohol, Cocaine, Opioids. Vol. 152;No. 11; Nov 1995.
55. American Psychiatric Association. Practice Guideline for the Treatment of Patients With Schizophrenia, Second Edition. Vol. 161; No. 2; Feb 2004.
56. American Psychiatric Association. Practice Guideline for the Treatment of Patients With Bipolar Disorder, Revision. Vol. 159; No. 4; Apr 2002.
57. Rost K, Dickinson LM, Fortney J, Westfall J, Hermann RC. Clinical improvement associated with conformance to HEDIS-based depression care. *Mental Health Services Research* 7(2): 103-112, June 2005.
58. Healy D, Whitaker C. Antidepressants and suicide: risk-benefit conundrums. *J Psychiatry Neurosci* 2003 Sep;28(5):331-7.
59. Lapierre YD. Suicidality with selective serotonin reuptake inhibitors: Valid claim? *J Psychiatry Neurosci* 2003 Sep;28(5):340-7.
60. Letizia C, Kapik B, Flanders WD. Suicidal risk controlled clinical investigations of fluvoxamine. *J Clin Psychiatry* 1996 Sep;57(9):415-21.
61. Wernicke JF, Saylor ME, Koke SC, Pearson DK, Tollefson GD. Fluoxetine and concomitant centrally acting medication use during clinical trials of depression: the absence of an effect related to agitation and suicidal behavior. *Depression Anxiety* 1997;6(1):31-9.
62. Verkes RJ, Van der Mast RC, Hengeveld MW, Tuyl JP, Zwinderman AH, Van Kempen GM. Reduction by paroxetine of suicidal behavior in patients with repeated suicide attempts but not major depression. *Am J Psychiatry* 1998 April;155(4):543-7.
63. Jick H, Kaye JA, Jick SS. Antidepressants and the risk of suicidal behaviors. *JAMA* 2004 Jul 21;292(3):338-43.
64. Gunnell D, Ashby D. Antidepressants and suicide: what is the balance of benefit and harm *BMJ* 2004 Jul 3;329:34-38.
65. Meltzer, HY, Suicide in schizophrenia: risk factors and clozapine treatment. *J Clin Psychiatry* 1998;59(suppl 3):15-20.
66. Meltzer H. Clozapine and suicide. *Am J Psychiatry* 2002 Feb;159:323.
67. Sernyak MJ, Desai R, Stolar M, Rosenheck R. Impact of Clozapine on completed suicide. *Am J Psychiatry* 2001 Jun;158:931-937.
68. American Psychiatric Association. (1990). The practice of electroconvulsive therapy: recommendations for treatment, training, and privileging. Washington, DC.
69. U.S. Dept Health Human Svcs, 1999, Mental Health, A report of the Surgeon General.
70. Bongar Brude 1991, the suicidal patient, clinical and legal standards of care, Washington DC, American Psychological Association.

71. American Academy of Suicidology (2000); <http://www.suicidology.org/displaycommon.cfm?an=1&subarticlenbr=180>, accessed April 26, 2006.
72. Shea SC. The practical art of suicide assessment. 1999. New York: John Wiley & Sons
73. Hendin H, Haas AP, Maltzberger JT, Szanto K, Rabinowicz H. Factors contributing to therapists' distress after the suicide of a patient. *Am J Psychiatry* 2004 Aug;161(8):1442-6.
74. Increases in Age-Group Specific Injury Mortality United States, 1999-2004. *MMWR Weekly* December 14, 2007/56(49);1281-1284.
75. Posner K, Oquendo MA, Gould M, Stanley B, Daview M. Columbia Classification Algorithm of Suicide Assessment (C-CASA): Classification of Suicidal Events in the FDA's Pediatric Suicidal Risk Analysis of antidepressants. *Am J Psychiatry* 164:7, July 2007.
76. Posner K. Suicidality Issues in Clinical Trials: Columbia Suicidal Adverse Event Identification in FDA Safety Analyses. Presented at: Division of Metabolism and Endocrinology Products FDA Advisory Committee, June 13, 2007.
77. Harris G., U.S. requiring suicide studies in drug trials. *International Herald Tribune*. Thursday, January 24, 2008.
78. Kellner CH, Fink M, Knapp R, et al. Relief of Expressed Suicidal Intent by ECT: A Consortium for Research in ECT Study. *Am J Psychiatry* 2005; 162:977-982.
79. Sullivan LE, Fiellin DA, O'Connor PG. Review The prevalence and impact of alcohol problems in major depression: A systematic review. *The American Journal of Medicine* (2005) 118, 330-341.
80. Palmer BA, Pankratz S, Bostwick JM. The Lifetime risk of Suicide in Schizophrenia. A Reexamination. *Arch Gen Psychiatry*/Vol. 62, March 2005.
81. Saha S, Chant JD, McGrath J. A systematic Review of Mortality in Schizophrenia. Is the Differential Mortality Gap Worsening Over Time? *Arch Gen Psychiatry*/Vol. 64 (No. 10). Oct 2007.
82. Oldham JM. Borderline Personality Disorder and Suicidality. *Am J Psychiatry* 163:1, January 2006.
83. Mann JJ, Apter A, Bertolote J, Beautrais A, et al. Suicide Prevention Strategies A Systematic Review. *JAMA* October 26, 2005, Vol 292, No. 16.
84. Fergusson D, Doucette D, Cranley Gleass K, et al. Association between suicide attempts and selective serotonin reuptake inhibitors: systematic review of randomized controlled trials. *BMJ* Volume 330 19 February 2005.
85. Moran M. Suicide Data Prompt Call for Black-Box Review. *Psychiatr News* October 5, 2007 Volume 42, Number 19, page 1.
86. Gibbons RD, Brown CH, Hur K. Relationship Between Antidepressants and Suicide Attempts: An Analysis of the Veteran Health Administration Data Sets. *Am J Psychiatry* 164:7, July 2007.
87. Gibbons RD, Brown CH, Hur K, et al., Early Evidence on the Effects of Regulators' Suicidality Warnings on SSRI Prescriptions and Suicide in Children and Adolescents. *Am J Psychiatry* 2007; 164: 1355-1363.

88. Cipriani A, Pretty H, Hawton K, Geddes JR. Lithium in the Prevention of Suicidal Behavior and All-Cause Mortality in Patients with Mood Disorder: A Systematic Review of Randomized Trials. *Am J Psychiatry* 2005; 162: 1805-1819.
89. January 31, 2008. Healthcare Professional Information Sheet-FDA. Accessed Web site www.fda.gov/medwatch/safety/2008/safety08.htm on February 11, 2008.
90. March JS, Silva S, Petrycki S, Curry J, Wells K, Fairbank J, Burns B, Domino M, McNulty S, Vitiello B, Severe J. The Treatment for Adolescents With Depression Study (TADS): long-term effectiveness and safety outcomes. *Arch Gen Psychiatry*. 2007 Oct;64(10): 1132043.
91. Brent D, Emslie G, Clarke G, et al. Switching to Another SSRI or to Venlafaxine With or Without Cognitive Behavioral Therapy for Adolescents With SSRI-Resistant Depression. The TORDIA Randomized Controlled Trial. *JAMA*. 2008; 299(8): 901-913.
92. Goodyer I, Bernadka D, Wilkinson P, et al. Selective serotonin reuptake inhibitors (SSRIs) and routine specialist care with and without cognitive behaviour therapy in adolescents with major depression: randomized controlled trial. *BMJ* 2007;335; 142-; originally published online 7 Jun 2007.

Other References Used But Not Cited:

93. Adamek M, Kaplan M. Firearm suicide among older men. *Psychiatr Serv* 1996;47:304-306.
94. Akechi T, Okamura H, Yamawaki S, Uchitomi Y. Why do some cancer patients with depression desire an early death and others do not? *Psychosomatics* 2001 Mar-Apr;42(2):141-5.
95. Andrew Edmund Slaby, AE. Treatment of suicidal patients in managed care. *Psychiatr Serv* 2002;53:107-108.
96. Appelbaum P. Legal Liability and Managed Care. *American Psychologist* 1993;48:251-257.
97. Asberg M, Nordstrom P, Traskman-Benda L. Cerebrospinal fluid studies in suicide. *Ann NY Acad Sci* 1987;487:243.
98. Bell CC, Clark DC. Adolescent suicide. *Pediatric Clinics No Am* 45(2) April 1998.
99. Bennett, M. Guidelines for Assessing and Managing the Suicidal Patient, Merit Behavioral Care of California, February 1995.
100. Ferreting WH. Cancer patients' suicide risk tied to physical functioning. *Psych News* May 18, 2001, Volume 36 Number 10 p.18.
101. Bongar B. Effective risk management and the suicidal patient register report 1992;18:2-3 and 21-27.
102. Bongar B. Suicide: guidelines for assessment, management and treatment. New York, Oxford University Press, 1992.
103. Bongar B. The suicidal patient: clinical and legal standards of care. Washington, APA 1991.
104. Brodsky BS, Oquendo M, Ellis SP, Haas GL, Malone KM, Mann JJ. The relationship of childhood abuse to impulsivity and suicidal behavior in adults with major depression. *Am J Psychiatry* November 2001;158:1871-1877.

105. Busch K, Clark D, Fawcett J, Kraits' H. Clinical features of inpatient suicide. *Psych Annals* 1993;23:256-262.
106. Conwell Y, Duberstein PR, Cox C, Herrmann J, Forbes N, Cain ED. Age differences in behaviors leading to completed suicide. *Am J Geri Psych Spring* 1998;6(2):122-126.
107. Coryell W, Classer M. The Dexamethasone suppression test and suicide prediction. *Am J Psychiatry* May 2001;158:748-753.
108. Cox B, Dorenfeld D, Swinson R, Norton G. Suicidal ideation and suicide attempts in panic disorder and social phobia. *Am J of Psychiatry* 1994;151:882-887.
109. Depression Guideline Panel. Clinical Practice Guideline fR5: Depression in Primary Care. Agency for Health Care Policy Research Publication #93-0551; Maryland, U.S. Dept of Health and Human Services 1993.
110. Esposito CL, Clum GA. Psychiatric symptoms and their relationship to suicidal ideation in a high-risk adolescent community sample. *J Am Acad Child Adolesc Psychiatry* 2002 Jan;41(1):44-51.
111. Fawcett J, Clark D, Bush K. Assessing and treating the patient at risk for suicide. *Psych Annals* 1993, 23(5):244-255.
112. Goldston DB, Daniel SS, Reboussin BA, Reboussin DM, Frazier PH, Harris AE. Cognitive risk factors and suicide attempts among formerly hospitalized adolescents: a prospective naturalistic study. *J Am Acad Child Adolesc Psychiatry* 2001 Jan;40(1):91-9.
113. Grunebaum MF, Oquendo MA, Harkavy-Friedman JM, Ellis SP, Li S, Haas GL, Malone KM, Mann JJ. Delusions and suicidality. *Am J Psychiatry* 2001 May;158:742-747.
114. Guthe NT, Bursztajn H, Hamm R, Brodsky A. Subjective data and suicide assessment in the light of recent legal developments. Part 1: malpractice prevention and the use of subjective data. *Int. J Law and Psychiatry* 1983;6:317-329.
115. Gutheil T, Bursztajn H, Brodsky A. The multidimensional assessment of dangerousness: competence assessment in patient care and liability prevention. *Bull Amer. Acad. of Psych Law* 1986;14:123-129.
116. Hillard J. Predicting suicide. *Psychiatr Serv* 1995;46:223-225.
117. Jacobs D. Suicide and clinical practice. Washington, APA Press, 1992.
118. Joe S, Mark S, Kaplan MS. Firearm-related suicide among young african-american males. *Psychiatr Serv* 2002 Mar;53:332-334.
119. King RA, Schwab-Stone M, Flisher AJ, Greenwald S, Kramer RA, Goodman SH, Lahey BB, Shaffer D, Gould MS. Psychosocial and risk behavior correlates of youth suicide attempts and suicidal ideation. *J Am Acad Child Adolesc Psychiatry* 2001 Jul;40(7):837-46.
120. Lambert MT. Seven-year outcomes of patients evaluated for suicidality. *Psychiatr Serv* 2002 Jan;53:92-94.
121. Lewinsohn PM, Rohde P, Seeley JR, Baldwin CL. Gender differences in suicide attempts from adolescence to young adulthood. *J Am Acad Child Adolesc Psychiatry* 2001 Apr;40(4):427-34.
122. Malphurs JE, Eisdorfer C, Cohen D. A comparison of antecedents of homicide-suicide and suicide in older married men. *Am J Geriatr Psychiatry* 2001Feb;9:49-57.

123. Maltzberger T, Buie D. Counter-transference hate in the treatment of suicidal patients. *Arch of Gen. Psychiatry* 1974;30:625-633.
124. National Institute of Mental Health – Frequently Asked Questions About Suicide, December 1999, www.nimh.nih.gov/research/suicidefaq/cfm.
125. National Strategy For Suicide Prevention: Goals and Objectives For Action. Rockville, MD; U.S. Dept. of Health and Human Services, Public Health Service, 2001.
126. Oquendo MA, Ellis SP, Greenwald S, Malone KM, Weissman MM, Mann JJ. Ethnic and sex differences in suicide rates relative to major depression in the United States. *Am J Psychiatry* 2001 Oct;158:1652-1658.
127. Placidi GPA, Oquendo MA, Malone KM, Brodsky B, Ellis SP, Mann JJ. Anxiety in Major depression: relationship to suicide attempts. *Am J Psychiatry* 2000 Oct;157:1614-1618.
128. Remafedi G, French S, Story M, Resnick M, Blum R. The relationship between suicide risk and sexual orientation: results of a population-based study. *Am J Public Health* 1998 Jan;88(1):57-60.
129. Rissmiller D, Steer R, Ranieri W, Rissmiller E, Hogate P. Factors complicating cost containment in the treatment of suicidal patients. *Hosp and Community Psychiatry* 1994;45:782-788.
130. Roy A, Segal NL, Centerwall BS, et al. Suicide in twins. *Arch Gen Psychiatry* 1991;48:22.
131. Shnekiman F. Suicide, lethality and the psychological autopsy. *Inn Psych Clinics* 1969;6:255-250.
132. Soloff PH, Lynch KG, Kelly TM, Malone KM, Mann JJ. Characteristics of suicide attempts of patients with major depressive episode and borderline personality disorder: a comparative study. *Am J Psychiatry* 2000 Apr;157:601-608.
133. Stewart SE, Manion IG, Davidson S, Cloutier P. Suicidal children and adolescents with first emergency room presentations: predictors of six-month outcome. *J Am Acad Child Adolesc Psychiatry* 2001May;40(5):580-7.
134. Szanto K, Mulsant BH, Houck PR, Miller MD, Mazumdar S, Reynolds III CF. Treatment outcome in suicidal vs. non-suicidal elderly patients. *Am J Geriatr Psychiatry* 2001 Aug;9:261-268.
135. Telcher M, Glod C, Cole. Emergence of intense suicidal preoccupation during fluoxetine treatment. *Am J Psychiatry* 1990;147:207-210.
136. Terao T, Whale R. High serum cholesterol and suicide risk. Kitakyushu, Japan. *Am J Psychiatry* 2001 May;158:824.
137. Tondo L, Baldessarini RJ. Suicide: causes and clinical management CME. Post Test and Evaluation link [http:// www. medscape.com/viewprogram/353_index](http://www.medscape.com/viewprogram/353_index).
138. Tondo L, Jamison KR, Baldessarini RJ. Effect of lithium maintenance on suicidal behavior in major mood disorders. *Ann N Y Acad Sci* 1997 Dec 29;836:339-51.
139. Wærn M, Runeson BS, Allebeck P, Beskow J, Rubenowitz E, Skoog I, Wilhelmsson K. Mental disorder in elderly suicides: a case-control study. *Am J Psychiatry* 2002 Mar;159:450-455.
140. Warshaw MG, Dolan RT, Keller MB. Suicidal behavior in patients with current or past panic disorder: five years of prospective data from the Harvard/Brown Anxiety Research Program. *Am J Psychiatry* 2000 Nov;157:1876-1878.

141. Weissman M, Kleman G, Markowitz, Oullette R. Suicidal ideation and suicide attempts in panic disorder and attacks. NEJM 1989;321:1209-1214.