NATIONAL GUIDELINE CLEARINGHOUSE™ (NGC) GUIDELINE SYNTHESIS

SUICIDAL IDEATION AND BEHAVIOR: RISK ASSESSMENT

Guidelines

1. **American Psychiatric Association (APA)**. Practice guideline for the assessment and treatment of patients with suicidal behaviors. Arlington (VA): American Psychiatric Association; 2003 Nov. 117 p. [846 references]
2. **New Zealand Guidelines Group (NZGG)**. The assessment and management of people at risk of suicide. Wellington (NZ): New Zealand Guidelines Group (NZGG); 2003 May. 72 p. [89 references]

INTRODUCTION:

A direct comparison of the American Psychiatric Association (APA) and New Zealand Guidelines Group (NZGG) recommendations for risk assessment of individuals with suicidal ideation and/or behavior is provided in the tables, below. The APA guideline contains general and specific recommendations for assessment of the patient, psychiatric management, specific treatment modalities and documentation and risk management issues. In addition, it includes an overview of suicide, its natural history, course and epidemiology; a structured review and synthesis of the evidence underlying the APA recommendations; and a summary of areas for which more research is needed to guide clinical decisions. Only recommendations related to assessment of individuals at risk for suicide are addressed in this synthesis. The NZGG guideline replaces a 1993 guideline developed by the New Zealand Department of Health. Its recommendations are intended for use in emergency department and acute psychiatric service settings and therefore focus primarily on crisis and initial management of patients at risk for suicide.

Both guidelines address assessment of suicidality in special populations. The APA guideline considers evaluation in inpatient, outpatient, emergency, long-term care facility, and jail and correctional facility settings. APA also addresses assessment issues concerning the needs of certain cultural groups. The NZGG guideline considers the needs of children and adolescents, the elderly, Māori, Pacific peoples, people of Indian descent, Asian populations and refugee groups. Both guidelines also address the management of individuals with suicidal ideation and/or behavior. This topic, however, is beyond the scope of this synthesis. See the NGC Synthesis Suicidal Ideation and Behavior: Management.

The tables below provide a side-by-side comparison of key attributes of each guideline, including specific interventions and practices that are addressed. The

language used in these tables, particularly that which is used in Table 4, Table 5 and Table 6, is in most cases taken verbatim from the original guidelines:

- Table 1 provides a quick-view glance at the primary interventions considered by each group.
- Table 2 provides a comparison of the overall scope of both guidelines.
- Table 3 provides a comparison of the methodology employed and documented by both groups in developing their guidelines.
- Table 4 provides a more detailed comparison of the specific recommendations offered by each group for the topics under consideration in this synthesis, including:
    - Assessment in Emergency Settings
    - Comprehensive Assessment
    - Assessment in Special Populations
    - Supporting References
- Table 5 lists the potential benefits and harms associated with the implementation of each guideline as stated in the original guidelines
- Table 6 presents the rating schemes used by FMSD and ICSI to rate the level of evidence.

A summary discussion of the areas of agreement and areas of differences among the guidelines is presented following the content comparison tables.

Abbreviations:

- APA, American Psychiatric Association
- GPP, Good Practice Point
- NZGG, New Zealand Guidelines Group

TABLE 1: COMPARISON OF INTERVENTIONS AND PRACTICES CONSIDERED
("✓" indicates topic is addressed)

	APA (2003)	NZGG (2003)
Assessment in emergency settings	✓	✓
Comprehensive psychiatric evaluation	✓	✓
Estimation of suicide risk	✓	✓
Assessment in special populations	✓	✓

TABLE 2: COMPARISON OF SCOPE AND CONTENT

Objective and Scope	
APA (2003)	• To assist psychiatrists in the assessment and care of their patients with suicidal ideation/behaviors • To represent a synthesis of current scientific knowledge and clinical consensus
NZGG (2003)	To guide those working in emergency departments and in acute psychiatric services in the appropriate assessment and early management of suicidal people
Target Population	
APA (2003)	Adult patients with suicidal ideation and/or behaviors
NZGG (2003)	Children, adolescents, adults, and elderly persons in New Zealand who self-harm or attempt suicide or are at-risk for suicide
Intended Users	
APA (2003)	Physicians
NZGG (2003)	Advanced Practice Nurses Allied Health Personnel Emergency Medical Technicians/Paramedics Health Care Providers Nurses Physician Assistants Physicians Psychologists/Non-physician Behavioral Health Clinicians

TABLE 3: COMPARISON OF METHODOLOGY		
	APA (2003)	**NZGG (2003)**

Methods Used to Collect/Select the Evidence	• *Hand-searches of Published Literature (Primary Sources)* • *Searches of Electronic Databases* *Described Process:* Relevant literature was identified through a computerized search of PubMed for the period from 1966 to 2002. Key words used were "suicides," "suicide," "attempted suicide," "attempted suicides," "parasuicide," "parasuicides," "self-harm," "self-harming," "suicide, attempted," "suicidal attempt," and "suicidal attempts." A total of 34,851 citations were found. After limiting these references to literature published in English that included abstracts, 17,589 articles were screened by using title and abstract information. Additional, less	• *Hand-searches of Published Literature (Primary Sources)* • *Hand-searches of Published Literature (Secondary Sources)* • *Searches of Electronic Databases* **Note from the National Guideline Clearinghouse (NGC)**: *A systematic literature review was prepared by the New Zealand Health Technology Assessment (NZHTA):* • New Zealand Guidelines Group (NZGG). Search strategy. The assessment and management of people at risk of suicide. Wellington (NZ): New Zealand Guidelines Group (NZGG); 2003 May 2 p. Available from in Portable Document Format (PDF) from the New Zealand Guidelines Group Web site. *Described Process:* A systematic method of literature searching and selection was employed in the preparation of this review. Searches were limited to English language material published from 1990 onwards. The searches were completed in April 2002 using bibliographic databases (MEDLINE, EMBASE, CINAHL, PsychINFO, Current Contents, Science/Social Science Citation, Index New Zealand) and review databases (Evidence-based medicine reviews, Cochrane Database of Systematic Reviews, DARE, NHS Economic Evaluation

	formal literature searches were conducted by American Psychiatric Association (APA) staff and individual members of the work group on suicidal behaviors through the use of PubMed, PsycINFO, and Social Sciences Citation Index. Sources of funding were not considered when reviewing the literature.
	
	Number of Source Documents:
	
	• 34,851 citations
	• 17,589 articles
	
	Number of References: 846
		Database, Health Technology Assessment Database). Hand searching of journals or contacting of authors for unpublished research was not undertaken during the search process.
		
		Study Design and Sample Size:
		
		• Studies employing one of the following designs: systematic review or meta-analysis, randomised controlled trials, cohort study, case-control study
		• Studies contained samples of at least six participants.
		
		Study Exclusion Criteria
		
		The following criteria were used to exclude studies from appraisal:
		
		• study population concerned:
		  • primarily (50% or more) children 12 years of age and under
		  • homicidal people
		  • criminal offenders
		• studies concerned with:
		  • the treatment of people with drug/substance abuse or dependence (that is, treatment directed to their addiction rather than any suicide attempt)
		  • suicide prevention interventions specifically for people with human immunodeficiency virus/acquired

		immune deficiency syndrome (HIV/AIDS) • school-based suicide prevention interventions • economic analysis • studies involving small numbers of case presentations (five or fewer cases) • studies not clearly describing their methods and results or having significant discrepancies • citations which were letters to the editor, comments, editorials, abstract only, or conference proceedings **Search Terms Used** MEDLINE subject terms (Medical Subject Heading [MeSH] terms): suicide, suicide attempted, exp self-injurious behavior, crisis intervention, emergencies, emergency treatment, exp antipsychotic agents, exp psychotropic drugs, exp antidepressive agents, exp tranquilising agents, psychopharmacology. PsychINFO subject terms: suicide, self-destructive behavior, attempted suicide, suicidal ideation, suicide prevention, self-inflicted wounds, self-mutilation, side-effects drug, risk factors, risk analysis, exp drugs, drug therapy. Additional keywords: suicid*, parasuicid*, crisis, crises, psychopharm*. *Number of Source Documents*:

		Not stated *Number of References: 89*
Methods Used to Assess the Quality and Strength of the Evidence	*Expert Consensus (Committee)*	*Weighting According to a Rating Scheme (Scheme Given — refer to Table 6)*
Methods Used to Analyze the Evidence	• *Review of Published Meta-Analyses* • *Systematic Review with Evidence Tables*	• *Review of Published Meta-Analyses* • *Systematic review with evidence tables* **Note from the National Guideline Clearinghouse (NGC)**: *A systematic literature review including evidence tables were prepared by the New Zealand Health Technology Assessment (NZHTA)* *Described Process*: Articles were formally appraised using the checklist schedules and hierarchy of evidence coding system developed by the Scottish Intercollegiate Guidelines Network (SIGN). Validated criteria were used to appraise the studies selected for review. Key facets of the selected studies (including limitations) were documented in the text. Conclusions were drawn based on the study design and the specific problems associated with individual studies. The evidence presented in the selected studies were assessed and classified according to the SIGN grades of guideline recommendation by the suicide prevention guideline group.
Outcomes	• Morbidity and mortality	• Repeat presentations for suicidality

	• Severity of symptoms • Rate of remission, relapse, and recurrence of suicidality	• Repeat suicide attempts • Mortality from suicide
Methods Used to Formulate the Recommendations	• *Expert consensus (refer to Table 6 for rating scheme)* *Described Process*: Once a topic is chosen for guideline development, a work group is formed to draft the guideline. By design, the work group consists of psychiatrists in active clinical practice with diverse expertise and clinical experience relevant to the topic. Policies established by the Steering Committee guide the work of systematically reviewing data in the literature and forging consensus on the implications of those data, as well as describing a clinical consensus. These policies, in turn, stem from criteria formulated	• *Expert Consensus (Refer to Table 6 for rating scheme)*

	by the American Medical Association to promote the development of guidelines that have a strong evidence base and that make optimal use of clinical consensus.	
Financial Disclosures/Conflicts of Interest	Potential financial conflicts of interest: This practice guideline has been developed by psychiatrists who are in active clinical practice. In addition, some contributors are primarily involved in research or other academic endeavors. It is possible that through such activities some contributors have received income related to treatments discussed in this guideline. A number of mechanisms are in place to minimize the potential for producing biased recommendations due to conflicts of interest. The guideline has been extensively reviewed by members of the American Psychiatric	Declaration of Competing Interests: Pete Ellis has accepted support from Janssen-Cilag to attend a recurring scientific meeting in New Zealand as a presenter and part organiser. Brian Craig has received travel support to attend an overseas conference from Janssen-Cilag.

	Association (APA) as well as by representatives from related fields. Contributors and reviewers have all been asked to base their recommendations on an objective evaluation of available evidence. Any contributor or reviewer who has a potential conflict of interest that may bias (or appear to bias) his or her work has been asked to notify the APA Department of Quality Improvement and Psychiatric Services. This potential bias is then discussed with the work group chair and the chair of the Steering Committee on Practice Guidelines. Further action depends on the assessment of the potential bias.	

TABLE 4: COMPARISON OF RECOMMENDATIONS FOR ASSESSMENT OF INDIVIDUALS WITH SUICIDAL IDEATION AND/OR BEHAVIOR
Assessment in Emergency Settings

APA (2003)	**Emergency Settings** Regardless of the patient's presenting problem, the suicide assessment is an integral part of the psychiatric evaluation in an emergency setting. As the suicide assessment proceeds, the psychiatrist should be alert for previously unrecognized symptoms of trauma or toxicity resulting from ingestions. Ambivalence is a key element in individuals presenting with suicidality, and individuals may simultaneously seek help yet withhold information about recent ingestions or self-induced trauma. Thus, in addition to initially assessing the patient's vital signs, the psychiatrist should investigate any changes in the patient's physical condition or level of consciousness that may develop during the course of the evaluation. For patients who are administered medications in the emergency area or who have concomitant alcohol or substance use, serial monitoring of vital signs is important to detect adverse events or signs of substance withdrawal. Simultaneous presentation with intoxication and suicidality is common in emergency settings and requires some modification in the assessment process. Depending on the severity of the intoxication, medical intervention may be needed before psychiatric assessment begins. Also, it is often necessary to maintain the patient in a safe setting until the intoxication resolves and a thorough suicide assessment can be done. In this regard, some institutions find it helpful to quantify the level of intoxication (with serum alcohol levels or breath alcohol measurements), since some individuals may not show physical symptoms of intoxication despite substantially elevated blood alcohol concentrations. At some facilities, short-term observation beds are available in the emergency area or elsewhere for monitoring and serial assessments of intoxicated individuals who present with suicidality. At other facilities, such observation may need to be carried out in a more typical medical or psychiatric inpatient setting. Although obtaining collateral information is useful with all suicidal individuals, in the emergency setting such information is particularly important to obtain from involved family members, from those who live with the patient, and from professionals who are currently treating the patient. Patients in emergency settings may not always share all of the potentially relevant aspects of their recent symptoms and their past psychiatric history, including treatment adherence. In addition, most psychiatrists who evaluate patients in emergency settings do not have the benefit of knowing and working with the patient on a longitudinal basis. Corroboration of history is particularly important when aspects of the clinical picture do not correspond to other aspects of the patient's history or mental state. Examples include patients who deny suicidal ideas and request discharge yet who made a highly lethal suicide attempt with clear

	suicidal intent or those who request admission on the basis of command hallucinations while seeming relaxed and jovial and without appearing to respond to internal stimuli. The process by which the patient arrived at the emergency department can provide helpful information about his or her insight into having an illness or needing treatment. Typically, individuals who are self-referred have greater insight than those who are brought to the hospital by police or who reluctantly arrive with family members. For individuals who are brought to the emergency department by police (or as a result of a legally defined process such as an emergency petition), it is particularly important to address the reasons for the referral in estimating suicide risk.
NZGG (2003)	**Risk Factors** **D** Anyone who talks about suicide needs to be taken seriously. People who die by suicide have often expressed suicidal thoughts or displayed warning signs to families or health professionals. **GPP** All people who report self-harm or suicidal intent should be treated as being in a state of potential emergency until clinicians are convinced otherwise. **Assessment of Suicide Risk** **D** Anyone who seeks assistance from an emergency department following an act of deliberate self-harm, irrespective of intent, or who is expressing suicidal ideation, should be further evaluated by a suitably trained mental health clinician. **GPP** Culturally appropriate services should be involved with assessment, crisis management, and service liaison where possible, and if agreed to by the suicidal person. **GPP** A suicide assessment should be conducted in a separate interview room that allows the person privacy when disclosing sensitive material. **GPP** There is no evidence to suggest that directly asking about the presence of suicidal ideation or intent creates the risk of suicide in people who have not had suicidal thoughts or worsens the risk in those who have. It is more likely that a calm and matter-of-fact approach discussion of suicidality may allow people to disclose their previously "taboo" thoughts. **<u>Assessment of Suicidality by Emergency Departments</u>** **Triage**

Anyone seeking assistance from an emergency department should be triaged by an emergency department nurse who should be specifically trained and experienced in the process of triage. Pre-hospital information provided by paramedics, caretakers or referring doctors should also be utilized by staff, wherever available, to determine the severity of the physical or mental condition. This will enable emergency staff to prepare appropriately to receive and mange the person's symptoms.

GPP No person who has attempted deliberate self-harm or who is expressing suicidal ideation should be categorised to triage category 5 (i.e., waiting beyond one hour to be seen by a doctor). Refer to Table 1 in the original guideline document for details of emergency department mental health triage.

General Assessment Principles

C Case notes should be augmented with structured assessments.

C Training in suicide assessments should be provided to all appropriate staff.

- People should be asked to hand over objects of potential self-harm such as sharp objects, belts, sheets or cords. Medications should be removed. If the person has a dangerous weapon that they are not willing to relinquish the police should be called. All District Health Boards should have specific protocols in place that outline procedures for searching people and removing their possessions. [4]
- The person should be placed in a special room where there is no access to potentially injurious material and where safe observation is possible. [4]
- People may need monitoring and observation for their physical condition in an acute area. Even so, they may still need to have someone sitting watch beside them. [4]
- The assessment should occur as quickly as possible. If the person makes to leave prior to the assessment being completed, and attempts to calm them and persuade them to remain are unsuccessful, a decision should be made regarding the use of restraint. [4]
- Accompanying friends and relatives of the person need to be supported by staff. [4]
- Appropriate medical treatment should be initiated. [4]
- Where transfer to a psychiatric facility is to follow, appropriate arrangements need to be made to complete any further required medical procedures. [4]
- If the person is being held by the police, or has been brought into the emergency department by the police, they should still be followed up by mental health services. [4]
- Anyone who talks about suicide should be taken seriously. People who die by suicide have often previously expressed

suicidal thoughts or displayed warning signs to families or health professionals. [2++/3]

- Case notes should be augmented with structured assessments. Clinicians have often been shown to overlook key information when recording their suicide assessments in case notes. This can be avoided by augmenting case notes with structured assessments. [2-] The information should include the following if the person has been assessed for suicide risk:
    - relevant suicide risk assessments
    - Whānau/family members' concerns
    - previous psychiatric history
    - previous treatment received
    - risk/benefit assessments of key clinical decisions.
- Training in suicide assessments can improve the performance of all staff in assessing, documenting and making appropriate referrals for people with suicidal ideation. [3]

Medical Clearance

D Emergency department staff are encouraged to use the triage protocol described (see page 12 in the original guideline document) and the Rapid Assessment of Patients in Distress (RAPID) assessment tool (Appendix 1 in the original guideline document) to assess the urgency of need for mental health referral and security measures.

GPP Clinicians should maintain a high index of suspicion when a person arrives following an overdose. People will often under-report quantities consumed.

Sedation

C Acute sedation with medication may be necessary if the person shows violent or agitated behaviour or symptoms of psychosis. Consider prescribing an antipsychotic (such as haloperidol) or a short- to medium-term benzodiazepine (such as lorazepam which has a short half-life, or clonazepam which is presently the only intra-muscular benzodiazepine available). A full assessment must then be resumed.

Assessment of Intoxicated People

GPP People who present to emergency departments with suicidal ideation or following a suicide attempt whilst intoxicated should be provided with a safe environment until they are sober. Assessment should focus on their immediate risk (whilst they are still intoxicated). Enduring risk cannot be judged until the person is sober.

GPP People at risk of suicide should be strongly advised to stop

	using alcohol or illicit drugs due to their potential disinhibiting effects. Whānau/family members should also be told of this. **Referral to Mental Health Services** **GPP** Mental health services should at least be contacted (or existing management plan consulted) by the assessing emergency department clinician whenever suicidal ideation, intent, or a suicide attempt or self-harm is present. **Use of Screening Measures** **B** The Beck Hopelessness Scale has the best generic application for screening for suicide risk amongst adults, adolescents, inpatients, outpatients, and people seeking assistance from emergency departments.
Comprehensive Assessment	
APA (2003)	**Suicide Assessment** The psychiatric evaluation is the essential element of the suicide assessment process **[I]**. During the evaluation, the psychiatrist obtains information about the patient's psychiatric and other medical history and current mental state (e.g., through direct questioning and observation about suicidal thinking and behavior as well as through collateral history, if indicated). This information enables the psychiatrist to 1) identify specific factors, signs, and symptoms that may generally increase or decrease risk for suicide or other suicidal behaviors and that may serve as modifiable targets for both acute and ongoing interventions, 2) address the patient's immediate safety and determine the most appropriate setting for treatment, and 3) develop a multiaxial differential diagnosis to further guide planning of treatment. The breadth and depth of the psychiatric evaluation aimed specifically at assessing suicide risk will vary with setting; ability or willingness of the patient to provide information; and availability of information from previous contacts with the patient or from other sources, including other mental health professionals, medical records, and family members. Although suicide assessment scales have been developed for research purposes, they lack the predictive validity necessary for use in routine clinical practice. Therefore, suicide assessment scales may be used as aids to suicide assessment but should not be used as predictive instruments or as substitutes for a thorough clinical evaluation **[I]**. Table 1 of the original guideline document presents the important domains of a suicide assessment, including the patient's current

presentation, individual strengths and weaknesses, history, and psychosocial situation. Information may come from the patient directly or from other sources, including family members, friends, and others in the patient's support network, such as community residence staff or members of the patient's military command. Such individuals may be able to provide information about the patient's current mental state, activities, and psychosocial crises and may also have observed behavior or been privy to communications from the patient that suggest suicidal ideation, plans, or intentions. Contact with such individuals may also provide opportunity for the psychiatrist to attempt to fortify the patient's social support network. This goal often can be accomplished without the psychiatrist's revealing private or confidential information about the patient. In clinical circumstances in which sharing information is important to maintain the safety of the patient or others, it is permissible and even critical to share such information without the patient's consent **[I]**.

When communicating with the patient, it is important to remember that simply asking about suicidal ideation does not ensure that accurate or complete information will be received. Cultural or religious beliefs about death or suicide, for example, may influence a patient's willingness to speak about suicide during the assessment process as well as the patient's likelihood of acting on suicidal ideas. Consequently, the psychiatrist may wish to explore the patient's cultural and religious beliefs, particularly as they relate to death and to suicide **[II]**.

It is important for the psychiatrist to focus on the nature, frequency, depth, timing, and persistence of suicidal ideation **[I]**. If ideation is present, request more detail about the presence or absence of specific plans for suicide, including any steps taken to enact plans or prepare for death **[I]**. If other aspects of the clinical presentation seem inconsistent with an initial denial of suicidal thoughts, additional questioning of the patient may be indicated **[II]**.

Where there is a history of suicide attempts, aborted attempts, or other self-harming behavior, it is important to obtain as much detail as possible about the timing, intent, method, and consequences of such behaviors **[I]**. It is also useful to determine the life context in which they occurred and whether they occurred in association with intoxication or chronic use of alcohol or other substances **[II]**. For individuals in previous or current psychiatric treatment, it is helpful to determine the strength and stability of the therapeutic relationship(s) **[II]**.

If the patient reports a specific method for suicide, it is important for the psychiatrist to ascertain the patient's expectation about its lethality, for if actual lethality exceeds what is expected, the patient's risk for accidental suicide may be high even if intent is low **[I]**. In general, the psychiatrist should assign a higher level of risk

to patients who have high degrees of suicidal intent or describe more detailed and specific suicide plans, particularly those involving violent and irreversible methods **[I]**. If the patient has access to a firearm, the psychiatrist is advised to discuss with and recommend to the patient or a significant other the importance of restricting access to, securing, or removing this and other weapons **[I]**.

Documenting the suicide assessment is essential **[I]**. Typically, suicide assessment and its documentation occur after an initial evaluation or, for patients in ongoing treatment, when suicidal ideation or behaviors emerge or when there is significant worsening or dramatic and unanticipated improvement in the patient's condition. For inpatients, reevaluation also typically occurs with changes in the level of precautions or observations, when passes are issued, and during evaluation for discharge. As with the level of detail of the suicide assessment, the extent of documentation at each of these times varies with the clinical circumstances. Communications with other caregivers and with the family or significant others should also be documented **[I]**. When the patient or others have been given specific instructions about firearms or other weapons, this communication should also be noted in the record **[I]**.

Estimation of Suicide Risk

The statistical rarity of suicide also makes it impossible to predict on the basis of risk factors either alone or in combination. For the psychiatrist, knowing that a particular factor (e.g., major depressive disorder, hopelessness, substance use) increases a patient's relative risk for suicide may affect the treatment plan, including determination of a treatment setting. At the same time, knowledge of risk factors will not permit the psychiatrist to predict when or if a specific patient will die by suicide. This does not mean that the psychiatrist should ignore risk factors or view suicidal patients as untreatable. On the contrary, an initial goal of the psychiatrist should be to estimate the patient's risk through knowledgeable assessment of risk and protective factors, with a primary and ongoing goal of reducing suicide risk **[I]**.

Some factors may increase or decrease risk for suicide; others may be more relevant to risk for suicide attempts or other self-injurious behaviors, which are in turn associated with potential morbidity as well as increased suicide risk. In weighing risk and protective factors for an individual patient, consideration may be given to 1) the presence of psychiatric illness; 2) specific psychiatric symptoms such as hopelessness, anxiety, agitation, or intense suicidal ideation; 3) unique circumstances such as psychosocial stressors and availability of methods; and 4) other relevant clinical factors such as genetics and medical, psychological, or psychodynamic issues **[I]**.

Once suicide risk and protective factors are identified, the

	psychiatrist can determine if these factors are modifiable. Past history, family history, and demographic characteristics are examples of nonmodifiable factors. Financial difficulties or unemployment can also be difficult to modify, at least in the short term. While immutable factors are important to identify, they cannot be the focus of intervention. Rather, to decrease a patient's suicide risk, the treatment should attempt to mitigate or strengthen those risk and protective factors that can be modified **[I]**. For example, the psychiatrist may attend to patient safety, address associated psychological or social problems and stressors, augment social support networks, and treat associated psychiatric disorders (such as mood disorders, psychotic disorders, substance use disorders, and personality disorders) or symptoms (such as severe anxiety, agitation, or insomnia).
NZGG (2003)	**Establishing a Therapeutic Alliance** **GPP** A key component to working with anyone who presents in a state of distress following a suicide attempt or expressing suicidal ideation is the conscious attempt to establish rapport with that person. This facilitates their disclosure of information and may serve as a protective factor by encouraging a sense of hopefulness and connectedness. **Involving Whānau/Family Support People of the Suicidal Person** **GPP** Whenever possible clinicians should involve Whānau/family/support people/carers of the suicidal person when working with that person. This is equally true for the assessment component, crisis management, and subsequent treatment. At any time families can give information to the clinician without it compromising the person's privacy. **GPP** If a person who is considered acutely suicidal declines involvement of others, the clinician may override that refusal in the interest of keeping the person safe. **Detailed Suicide Assessment/Assessment by Mental Health Services** **Key Components of a Psychiatric/Psychosocial Assessment** The aims of a comprehensive psychiatric/psychosocial assessment carried out by a mental health clinician are to enable the best preventive efforts to minimise risk of future suicide. To do this, clinicians should: • Identify all acute and chronic co-morbid conditions • Evaluate all factors and motivations associated with the attempt

or threat
- Identify significant interpersonal problems and conflicts
- Identify social stressors and concerns such as unemployment and illness
- Identify patterns of dysfunctional thinking and behaviour
- Adequately consult with Whānau, family and friends where possible
- Assess short-term and continuing risks of suicide and deliberate self-harm
- Assess for factors that contribute to long-term risk
- Conduct the assessment within the context of a multidisciplinary team, under psychiatric supervision

B When conducting an assessment of suicide risk always be mindful of the presence of concomitant mental illness, particularly the following diagnoses, which are associated with increased risk.

- Major depression - acute risk factors: severe anhedonia, insomnia, anxiety, substance abuse.
- Substance abuse - acute risk factors: comorbid depression, recent interpersonal loss or disruption.
- Schizophrenia - acute risk factors: age <40, chronicity of illness with frequent exacerbations, awareness of deterioration and poor prognosis, depression.
- Borderline Personality Disorder or Antisocial Personality Disorder - acute risk factors: comorbid Axis I disorders, particularly depression.

Mental State Examination

A key part of any assessment is a Mental State Examination. A clinician can infer a lot of clinically useful information from the appearance of a person and their account of themselves. Particular attention should be paid to factors such as an increase in their distress, an increase in feelings of self-dislike, hopelessness [2] (nothing will change) and/or helplessness (I can't change), evidence that they are denigrating themselves or their circumstances, and evidence of an increased preoccupation with escape and suicide as the only option. [4] Appendix 3 in the original guideline document outlines key aspects of conducting a Mental State Examination.

Information from Whānau/Family/Friends

If possible, corroberative sources should be asked about whether they have seen anything that would suggest suicidal intent, about any stressors that the person has recently been under and any changes in the way they normally act.

Physical Illness

	A general medical history with attention to recent diagnoses and the presence of any chronic illness should also be undertaken. **Formulating Risk** **GPP** Mental state and suicidal ideation can fluctuate considerably over time. Any person at risk should be re-assessed regularly, particularly if their circumstances have changed. Assessment of risk represents an integration of the following factors: • Intent • Lethality • Means • Presence of risk factors (e.g., mental illness, hopelessness, anxiety and depression, impulsivity/recklessness) • Psychosocial triggers • Lack or presence of protective factors Refer to Table 2 in the original guideline document for a listing of risk factors.
Assessment in Special Populations	
APA (2003)	**Suicide Assessment** When communicating with the patient, it is important to remember that simply asking about suicidal ideation does not ensure that accurate or complete information will be received. Cultural or religious beliefs about death or suicide, for example, may influence a patient's willingness to speak about suicide during the assessment process as well as the patient's likelihood of acting on suicidal ideas. Consequently, the psychiatrist may wish to explore the patient's cultural and religious beliefs, particularly as they relate to death and suicide **[II]**. **Estimate Suicide Risk** *Race, Ethnicity, and Culture* Racial and ethnic differences in culture, religious beliefs, and societal position may influence not only the actual rates of suicide but also the views of death and suicide held by members of a particular group. For some groups, suicide can be considered a traditionally accepted way of dealing with shame, distress, and/or physical illness. In addition, cultural values about conveying suicidal ideas may differ; in some cultures, for example, suicidal ideation may be considered a disgraceful or private matter that should be denied. Cultural differences, particularly in immigrants and in Native Americans and Alaska Natives, may generate acculturative stresses

that in turn may contribute to suicidality. Thus, knowledge of and sensitivity to common contributors to suicide in different racial and ethnic groups as well as cultural differences in beliefs about death and views of suicide are important when making clinical estimates of suicide risk and implementing plans to address suicide risk.

Assessment of Patients with Suicidal Behaviors

Children and Adolescents

Since the approach to assessment does vary to some degree in the assessment of suicidal children and adolescents, the psychiatrist who evaluates youths may wish to review the American Academy of Child and Adolescent Psychiatry's *Practice Parameter for the Assessment and Treatment of Children and Adolescents With Suicidal Behavior.*

Additional Considerations When Evaluating Patients in Specific Treatment Settings

Inpatient settings

It is important to conduct a suicide risk assessment, as discussed earlier, when individuals are admitted for inpatient treatment, when changes in observation status or treatment setting occur, when there are significant changes in the patient's clinical condition, or when acute psychosocial stressors come to light in the course of the hospitalization. For patients with repeated hospitalizations for suicidality, each suicidal crisis must be treated as new with each admission and assessed accordingly.

Outpatient Settings

An initial evaluation of a patient in an office-based setting should be comprehensive and include a suicide assessment. The intensity and depth of the suicide assessment will depend on the patient's clinical presentation. In following outpatients over time, the psychiatrist should be aware that suicidality may wax and wane in the course of treatment. Sudden changes in clinical status, which may include worsening or precipitous and unexpected improvements in reported symptoms, require that suicidality be reconsidered. Furthermore, risk may also be increased by the lack of a reliable therapeutic alliance, by the patient's unwillingness to engage in psychotherapy or adhere to medication treatment, or by inadequate family or social supports. Again, however, the frequency, intensity, and depth of the suicide assessment will depend on the patient's clinical state, past history, and other factors, including individual strengths, vulnerabilities, and stressors that will simultaneously influence risk. These factors will also be important in judging when family members or other significant support persons may need to be contacted.

	Long-term Care Facilities When evaluating patients in long-term care facilities, psychiatrists and staff should be aware of the varied forms that suicidality may take in such settings. In particular, it is important to recognize that indirect self-destructive acts are found among both men and women with chronic medical conditions and are a common manifestation of suicide in institutional settings. When treating individuals in long-term care facilities, the psychiatrist should be mindful of the need for follow-up assessments, even when initial evaluation does not show evidence of depression or increased risk for suicide or other self-injurious behaviors. To facilitate early intervention, safety and suicide risk should be reassessed with significant changes in behavior, psychiatric symptoms, medical status, and/or level of functional disability. *Jail and Correctional Facilities* In jails, prisons, and other correctional facilities, most initial mental health assessments are not done by psychiatrists; however, psychiatrists are often asked to perform urgent suicide assessments for individuals identified as being at risk. The importance of identification and assessment of individuals at increased risk for suicide is underscored by the fact that suicide is one of the leading causes of death in correctional settings.
NZGG (2003)	**Assessment and Crisis Management with Special Populations** *Children and Adolescents* **D** The assessment of suicidal young people should be carried out by a clinician who is skilled in interviewing and working with children and adolescents whenever possible. **D** Self-harm among children is rare and should be treated very seriously. **GPP** Risk assessments should draw on information from multiple sources, including the young person, their teachers/guidance counselors, parents etc. *The Elderly* **GPP** Any elderly person who is expressing suicidal ideation or has presented following an attempt should be treated very seriously. The clinician should consider whether the symptoms could be related to

self-neglect or reflect a passive death wish.

GPP Clinicians should treat symptoms of depression in an older person assertively. If depression and/or suicidality is suspected, physical causal factors need to be ruled out.

GPP Assessments should also draw on information from relatives or friends who can comment on whether the person is different from "their usual self."

Mäori

GPP Assessment of Mäori people requires consideration of their cultural context and meaning associated with their identity as Māori. Specialist Māori input is important when cultural issues or issues of identity arise among tāngata whaiora. Māori people who are suicidal should be offered the input of specialist Māori mental health workers.

GPP People's preference should be sought and respected for involving whānau or support of others in assessment and developing a treatment/management plan.

Pacific Peoples

GPP Assessment of Pacific peoples requires consideration of their Pacific cultural contexts and beliefs. Specialist Pacific input is important when cultural issues or issues of breaches of protocol are present among Pacific peoples. Pacific peoples who are suicidal should be offered the input of specialist Pacific mental health workers.

GPP Pacific peoples' preference should be sought and respected for involving family or support of others (e.g., church leaders, traditional healers) in assessment and developing a treatment/management plan.

GPP Language barriers may be an issue for some Pacific peoples. Care must be taken in ensuring confidentiality when interpreters are used due to the small size of Pacific communities and the shame associated with suicide and attempted suicide among Pacific peoples.

People of Indian Descent

GPP Indian people come from many diverse cultures, and assessment should acknowledge their specific cultural contexts and beliefs.

GPP Indian people consider family roles and obligations of primary importance, and assessment should acknowledge their needs within

	the context of their family. **GPP** Problem-solving, psycho-education, and the use of trusted intermediaries can help counter some of the shame or "loss of face" associated with mental illness. *Asian Populations* **GPP** Cultural values and beliefs vary depending on the person's subculture and degree of acculturation to Western values. Even if the person identifies themselves as a New Zealander, it is still important to check the cultural values of their family and significant others, as a gap in views can be a source of stress. **GPP** Language barriers may be an issue for some Asian people. Care must be taken in ensuring confidentiality when interpreters are used due to the small size of Asian communities. **GPP** When working with someone from an Asian community the clinician should consult culturally appropriate services to assist in intervening in helpful ways. *Refugee Groups* **GPP** Refugees are most likely to have been victims of some level of trauma. They may be distrustful of official agencies and health systems. Clinicians need to proceed respectfully and carefully, explaining the intention behind any action and potential consequences for the person. Clinicians should not push for accounts of past trauma experiences, and may need to focus more on the "here and now." **GPP** If an interpreter is needed, care must be taken over confidentiality issues as many of the communities are small and people may know each other. **GPP** Serious consideration should be given to referring refugees with mental health difficulties to specialist agencies such as Refugees as Survivors. **Assessment and Management of Chronically Suicidal People** **C** Detailed management plans that list both chronic and acute symptoms should be developed with the person. This assists clinicians in determining whether a person is presenting with new/greater risk than their ongoing risk. All services working with this person should have a copy of these plans, and they should be regularly reviewed and updated. **C** Emergency departments should always contact mental health

	services (even if only by phone) when a chronically suicidal person presents. Care must be taken not to downplay the seriousness of attempts. **D** When a person who is well-known to the service arrives at the emergency department, it is crucial that their file is obtained, their management plan consulted, and ideally their case manager or therapist contacted in case they are now suffering from additional stressors or a significant change in their mental illness(es). **D** Inpatient admission or referral to high support services (such as crisis respite) may be necessary when the person's suicidality is exacerbated by an acute life stressor, or if they also develop an Axis I disorder.

Selected Supporting References
Note from NGC: Bolded references are cited in both guidelines. Refer to the original guideline documents for a complete listing of supporting references.

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TABLE 5: BENEFITS AND HARMS	
Benefits	
APA (2003)	• Increased understanding of suicide risk and intervention by psychiatric professionals • Decreased rates of suicide • Decreased rates of suicide attempts • Improved control of symptoms related to suicidal ideation and behaviors Refer to the original guideline document for the evidence synthesis related to specific interventions.
NZGG (2003)	Appropriate management and intervention with people who have made a suicide attempt with the intent (or partial intent) of ending their lives and those who are at risk of taking their own lives
Harms	
APA (2003)	Not stated
NZGG (2003)	Not stated

TABLE 6: EVIDENCE RATING SCHEMES AND REFERENCES	
APA (2003)	Each recommendation is identified as falling into one of three categories of endorsement, indicated by a bracketed Roman numeral following the statement. The three categories represent varying

	levels of clinical confidence regarding the recommendation: [I] Recommended with substantial clinical confidence [II] Recommended with moderate clinical confidence [III] May be recommended on the basis of individual circumstances **TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS** The recommendations are based on the best available data and clinical consensus with regard to a particular clinical decision. The summary of treatment recommendations is keyed according to the level of confidence with which each recommendation is made (see the "Major Recommendations" field). In addition, the following coding system is used to indicate the nature of the supporting evidence in the references: [A] *Randomized, double blind clinical trial* A study of an intervention in which subjects are prospectively followed over time; there are treatment and control groups; subjects are randomly assigned to the two groups; both the subjects and the investigators are "blind" to the assignments [A--] *Randomized clinical trial* Same as above but not double blind [B] *Clinical trial* A prospective study in which an intervention is made and the results of that intervention are tracked longitudinally; study does not meet standards for a randomized clinical trial [C] *Cohort or longitudinal study* A study in which subjects are prospectively followed over time without any specific intervention [D] *Case-control study* A study in which a group of patients and a group of control subjects are identified in the present and information about them is pursued retrospectively or backward in time [E] *Review of secondary analysis* A structured analytic review of existing data, e.g., a meta-analysis or a decision analysis [F] *Review* A qualitative review and discussion of previously published literature without a quantitative synthesis of the data [G] *Other* Textbooks, expert opinion, case reports, and other reports not included above
NZGG (2003)	**Levels of Evidence**

	1++ High quality meta-analyses/systematic reviews of randomised controlled clinical trials (RCTs), or RCTs with a very low risk of bias **1+** Well-conducted meta-analyses/systematic reviews, or RCTs with a low risk of bias **1-** Meta-analyses/systematic reviews, or RCTs with a high risk of bias **2++** High quality systematic reviews of case-control or cohort studies High quality case-control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal **2+** Well-conducted case-control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal **2-** Case-control or cohort studies with a high risk of confounding or bias and a significant risk that the relationship is not causal **3** Non-analytic studies (e.g., case reports). Case series **4** Expert opinion Qualitative material was systematically appraised for quality, but was not ascribed a level of evidence. **Grades of Recommendations** **A**

	At least one meta-analysis, systematic review, or randomised, controlled clinical trial (RCT) rated 1++ and directly applicable to the target population or A body of evidence consisting principally of studies rated as 1+, directly applicable to the target population, and demonstrating overall consistency of results **B** A body of evidence consisting principally of studies rated as 2++, directly applicable to the target population, and demonstrating overall consistency of results or Extrapolated evidence from studies rated as 1++, or 1+ **C** A body of evidence consisting principally of studies rated as 2+, directly applicable to the target population, and demonstrating overall consistency of results or Extrapolated evidence from studies rated as 2++ **D** Evidence level 3 or 4 or Extrapolated evidence from studies rated as 2+ Additionally, **Good Practice Points** are recommended as the best practice based on the clinical experience of the guideline development team.

GUIDELINE CONTENT COMPARISON

The American Psychiatric Association (APA) and the New Zealand Guidelines Group (NZGG) present recommendations for risk assessment of individuals with

suicidal ideation and/or behavior and provide explicit reasoning behind their judgments, ranking the level of evidence for each major recommendation.

There are important differences in the general focus of the guidelines. The APA guideline is directed at psychiatrists and other physicians and includes considerable detail concerning assessment and both initial and long-term management of the person at risk for suicide. In contrast, the NZGG guideline primarily addresses assessment and initial management in acute care settings such as emergency departments and acute psychiatric services settings, with referral to mental health services for further assessment and management as appropriate. The NZGG guideline only minimally addresses long-term management of the patient at risk for suicide.

Guideline Development Methodology

Both organizations performed a systematic review of the literature that included applying quality criteria to published studies to select those suitable for evidence review and guideline formulation. A description of the methods used to collect and search the literature (e.g., search strategies and search terms) is included for both organizations. NZGG also provides inclusion/exclusion criteria, APA and NZGG both describe relevant information about the electronic databases they searched and the time range over which data were obtained. A systematic literature review was prepared by the New Zealand Health Technology Assessment (NZHTA) for the NZGG guideline.

With regard to the review of the evidence, APA presents its arguments and rationale, along with references to supporting evidence, in a narrative format. APA also includes an executive summary of recommendations (also in narrative format) at the beginning of the guideline. NZGG includes recommendation statements both at the beginning and throughout the guideline, supported by narrative discussion with references to the evidence. Both groups performed a Review of Published Meta-Analyses and a Systematic Review with Evidence Tables as methods of analyzing the evidence.

Both groups provide reference lists (846 references for APA, 89 for NZGG), and both groups cite the supporting evidence in their narrative discussions, rather than linking it directly to the recommendation statements. For both groups, the strength of each recommendation statement is graded accorded to a rating scheme. Also using a rating scheme, NZGG denotes the quality of the supporting evidence in the narrative discussion. Although APA does not employ a rating scheme for the strength of evidence, it uses a coding system to indicate the nature of the supporting evidence in the list of references.

APA and NZGG both present potential conflicts of interest.

Suicidal Ideation and Behavior: Comparison of Recommendations Between the APA and NZGG Guidelines

APA (2003)	NZGG (2003)
• Recommends a risk assessment upon presentation to an emergency setting, with medical intervention as necessary to facilitate assessment	• Recommends a risk assessment upon presentation to an emergency setting, with medical intervention as necessary to facilitate assessment
• After assessment in emergency setting (if applicable), APA recommends a comprehensive psychiatric assessment including an estimation of suicide risk	• After assessment in emergency setting (if applicable) NZGG recommends a comprehensive psychiatric assessment including an estimation of suicide risk
• Provides assessment information for the following special populations: selected cultural groups, inpatient settings, outpatient settings, long-term care facilities, jail and correctional facilities	• Provides assessment information for the following special populations: children and adolescents, the elderly, Māori, Pacific peoples, people of Indian descent, Asian populations, refugee groups, intoxicated individuals, chronically suicidal individuals

Areas of Agreement

Assessment

The APA and NZGG guidelines are in general agreement regarding the components of a comprehensive assessment of individuals at risk for suicide. APA notes that an assessment should be comprehensive in scope and integrate specific risk factors, clinical history, and interaction with the clinician. NZGG states that the key to diagnosis and management is a fully comprehensive psychiatric/psychosocial assessment and an evaluation of both short and longer-term risk factors. Assessment should include a psychiatric evaluation, determination of whether concomitant mental illness is present, inquiry about suicidal thoughts and behaviors, and estimation of suicide risk based on a number factors. Relevant risk factors noted by both guidelines include history of mental illness, history and lethality of previous suicide attempts, precipitating factors (e.g., loss of employment, recent bereavement), perpetuating factors (e.g., mood disorders, hopelessness, substance abuse) and degree of suicidality (e.g., degree of suicidal ideation, presence of a suicide plan), among other factors.

Both guidelines note the importance of gathering information from family members, health professionals, or other individuals who can provide information

about the patient's mental state, history of suicide attempts, and current psychosocial situation. APA and NZGG agree that when suicide assessment instruments are used to ascertain risk, they should not be used in place of a thorough examination of the patient's mental state. The guidelines differ concerning the utility of such instruments and these differences are discussed below.

According to APA, the estimation of suicide risk is the "quintessential clinical judgment", as no study has identified a specific risk factor or set of risk factors that predict suicidal behavior. Similarly, NZGG states that because there are no absolute markers for suicide risk, risk assessment ultimately requires sound clinical judgment.

Areas of Differences

Assessment

The guidelines differ somewhat in their view of the utility of suicide assessment scales. According to APA, suicide assessment scales have been developed for research purposes and lack the predictive validity necessary for use in routine clinical practice. In contrast, NZGG states that the Beck Hopelessness Scale has robust reliability and strong positive predictive power when administered to clinical samples of adults and recommends it as the best generic application for screening for suicide risk amongst adults, adolescents, inpatients, outpatients, and people seeking assistance from emergency departments.

Conclusion

Both guidelines recommend initial assessment in emergency settings focused on patient safety, followed by a comprehensive psychiatric evaluation to determine suicide risk, subsequent treatment setting, and a treatment plan.

This Synthesis was prepared by ECRI on October 29, 2006. It has not yet been reviewed by the guideline developers.

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