

How to document SUICIDE risk

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Despite the high prevalence of suicide and its impact on society,¹ psychiatric practitioners achieve only modest success at predicting and preventing suicide. With this in mind, evaluating suicide risk when designing a safe treatment plan for a patient admitted with acute suicidal ideation or after a suicide attempt can be daunting. The mnemonic **SUICIDE** can remind you of key elements to include in these patients' charts.

Suicide assessment. Evaluate the patient for suicide risk factors and protective factors.² Key risk factors include previous suicide attempts, family history of suicide, access to lethal means, history of a psychiatric disorder, history of alcohol and substance abuse, recent loss of a loved one, and severe hopelessness. Protective factors can be family and community support, problem-solving skills, and religious beliefs that discourage suicide.

Unpredictable and unpreventable. You are responsible for performing a comprehensive risk assessment, responding appropriately to those risks, and instituting a safe discharge plan. Despite your best effort, you might not be able to avert a suicide, and you must provide the patient and family members with this information and document it.

Interventions. Proceed with biological, psychological, and social treatment options. Review the patient's medications and, when appropriate, consider suicide protective drugs, such as clozapine or lithium.³ Advocate for substance abuse rehabilitation.

Encourage psychotherapy and work with your patient to improve social stressors.

Clear and comprehensive documentation. Detailed, accurate, and thorough daily notes are key. Go beyond reporting "no SI/HI" (suicidal ideation/homicidal ideation). Report what the patient said and how she (he) said it. If the patient denies current suicidal ideation, ask when her (his) last suicidal thought occurred. How did the patient respond to that thought? Why? Avoid using a suicide contract—it is not a substitute for a thorough suicide assessment; it isn't a legal document; it does not protect against legal liability; and it is ineffective.⁴

Intent. Evaluate the lethality of the suicidal attempt or plan. Ask about the means of suicide that were used or considered, whether the patient made provisions to ensure or avoid discovery, and how long she (he) has been planning the attempt.

Discuss the treatment plan with a collateral informant (family, friend, community support, outpatient providers). Facilitate safe discharge by including social support in planning. Request that all methods of self-harm, including guns and old prescriptions, be removed from the patient's home. Help family members and friends identify signs of suicidal ideation.

Educate, engage, and empathize with the patient. Use the Collaborative Assessment and Management of Suicidality (CAMS), which is a structured, evidence-based method of risk assessment and treatment planning. CAMS provides a

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framework to involve the patient in the assessment of her suicidality and to design a suicide-specific treatment plan.⁵

A mnemonic can't prevent all suicides

But using SUICIDE can ensure that the key elements of the evaluation, treatment, and discharge of a patient admitted for acute suicidal ideation or after a suicide attempt are addressed to the best of your ability during an inpatient hospitalization. In doing so, you'll better identify modifiable risk and protective factors that will inform this plan.

Avoid suicide contracts, which are no substitute for a suicide assessment, offer no legal benefit, and are ineffective

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