
Suicide Prevention Toolkit for Rural Primary Care: *Module 4 – Suicide Risk Assessment*

A Primer for Primary
Care Providers

Western Interstate Commission
for Higher Education (WICHE)
Mental Health Program

and

Suicide Prevention Resource
Center (SPRC)



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Module 4: Suicide Risk Assessment

About 3% of adults (and a much higher percentage of youths) are entertaining thoughts of suicide at any given time; however, there is no certain way to predict who will go on to attempt suicide.^{i ii}

Key components of a suicide risk assessment

1. Assess risk factors
2. Suicide Inquiry: thoughts/plan /intent/access to means
3. Assess protective factors
4. Clinical judgment
5. Document

1. Risk Factors

Suicidal behavior is associated with many different types of events, illnesses, and life circumstances.ⁱⁱⁱ

The strongest predictor of suicide is one or more previous attempts; however, most people who die by suicide die on their first attempt.

There are many factors that increase risk for suicide. A greater number of identified risk factors is suggestive of greater risk.^{iv}

Individual Risk Factors

- Previous suicide attempt
- Major physical illnesses, especially with chronic pain
- Central nervous system disorders, including TBI
- Mental disorders, particularly mood disorders, schizophrenia, anxiety disorders (e.g., PTSD), and certain alcohol and other substance use disorders; personality disorders (such as Borderline PD, Antisocial PD, and Obsessive-Compulsive PD). In youths: ADHD and conduct disorders (antisocial behavior, aggression, impulsivity)
- Psychiatric symptoms/states of mind: anhedonia, severe anxiety/panic, insomnia, command hallucinations, intoxication, self-hate
- Impulsive and/or aggressive tendencies
- History of trauma or abuse
- Family history of suicide
- Precipitants/triggering events leading to humiliation, shame, or despair (e.g., loss of relationship, health or financial status—real or anticipated)

Social/Environmental Risk Factors

- Chaotic family history (e.g., separation or divorce, change in caretaker, change in living situation or residence, incarcerations)

- Lack of social support and increasing isolation
- Easy access to/familiarity with lethal means (e.g., guns, illicit drugs, medications)
- Local clusters of suicide that have a contagious influence
- Legal difficulties/contact with law enforcement/incarceration
- Barriers to accessing health care, especially mental health and substance abuse treatment

Societal Risk Factors

- Certain cultural and religious beliefs (for instance, the belief that suicide is a noble resolution of a personal dilemma)^v
- Exposure to, including through the media, and influence of others who have died by suicide

2. Suicide Inquiry

- If any suicide warning signs are evident or if significant risk factors are present, an initial suicide inquiry is warranted. Patients will generally not spontaneously report suicidal ideation, but 70% communicate their intentions or wish to die to significant others. **Ask patients directly about suicide and seek collateral information** from other clinicians, family members, friends, EMS personnel, police, and others.^{vi} How you ask the question affects the likelihood of getting a truthful response. **Use a non-judgmental, non-condescending, matter-of-fact approach.**
- **NEVER ask leading questions like:**
“You’re not thinking of suicide, are you?”
- **Practice questions several times prior to a clinical encounter;** asking about suicide for the first time may be harder than you think.



Thoughts of Suicide

Ask patients you suspect may be feeling suicidal about thoughts or feelings related to suicide. The sample questions below will help you ease into the subject in a non-threatening way.

Sample questions to uncover suicidal thinking:^{vii}

- Sometimes, people in your situation (describe the situation) lose hope; I’m wondering if you may have lost hope, too?
- Have you ever thought things would be better if you were dead?
- With this much stress (or hopelessness) in your life, have you thought of hurting yourself?
- Have you ever thought about killing yourself?

- **Prior Attempt**

A history of a prior attempt is the strongest predictor of future suicidal behavior. Always ask if the patient has attempted suicide in the past, even if there is no evidence of recent suicidal thinking.

Sample question to assess prior attempt:

- Have you ever tried to kill yourself or attempt suicide?

- If your questioning reveals no evidence of suicidal ideation, you may end the inquiry here and document the finding.
- If your patient initially denies suicidal thoughts but you have a high degree of suspicion or concern due to agitation, anger, impaired judgment, etc., ask as many times as necessary in several ways until you can reconcile the disagreement about what you see and what the patient says.
- If your patient is having suicidal thoughts, ask specifically about frequency, duration, and intensity.

Sample questions to assess suicidal ideation:

- When did you begin having suicidal thoughts?
- Did any event (stressor) precipitate the suicidal thoughts?
- How often do you have thoughts of suicide? How long do they last? How strong are they?
- What is the worst they have ever been?
- What do you do when you have suicidal thoughts?
- What did you do when they were the strongest ever?

Plan

After discussing the character of suicidal thoughts, providers should inquire about planning.^{viii} **Ask whether the patient has a plan and, if so, get the specifics.**

Sample questions to assess suicidal planning:

- Do you have a plan or have you been planning to end your life? If so, how would you do it? Where would you do it?
- Do you have the (drugs, gun, rope) that you would use? Where is it right now?
- Do you have a timeline in mind for ending your life? Is there something (an event) that would trigger the plan?

Intent

Determine the extent to which the patient expects to carry out the plan and believes the plan or act to be lethal vs. self-injurious. Also explore the patient's

reasons to die vs. reasons to live. Inquire about aborted attempts, rehearsals (such as tying a noose or loading a gun), and non-suicidal self-injurious actions, as these are indicators of the patient's intent to act on the plan.^{ix} Consider the patient's judgment and level of impulse control. Administer mental status exam if in doubt about mental status.

Sample questions to assess intent:

- What would it accomplish if you were to end your life?
- Do you feel as if you're a burden to others?
- How confident are you that this plan would actually end your life?
- What have you done to begin to carry out the plan?
For instance, have you rehearsed what you would do (e.g., held the pills or gun, tied the rope)?
- Have you made other preparations (e.g., updated life insurance, made arrangements for pets)?
- What makes you feel better (e.g., contact with family, use of substances)?
- What makes you feel worse (e.g., being alone, thinking about a situation)?
- How likely do you think you are to carry out your plan?
- What stops you from killing yourself?

Look for disagreement between what you see (objective findings) and what the patient tells you about their suicidal state (subjective findings). When possible, and always with adolescents, seek to confirm the patient's reports with information from a family member, spouse, or close friend. **Patients are more likely to tell a family member than a PCP that they are suicidal.**^x It may also be helpful to explore the patient's cultural and/or religious beliefs about suicide and death.^{xi}

3. Protective Factors

While protective factors provide a poor counterbalance to individuals who are high-risk for attempting suicide (i.e., someone with strong ideation, intent, a plan, preparatory behaviors, and impaired judgment), **protective factors can mitigate risk in a person with moderate to low suicide risk.** Strengthening protective factors can be a part of safety planning, which will be discussed in Module 5.

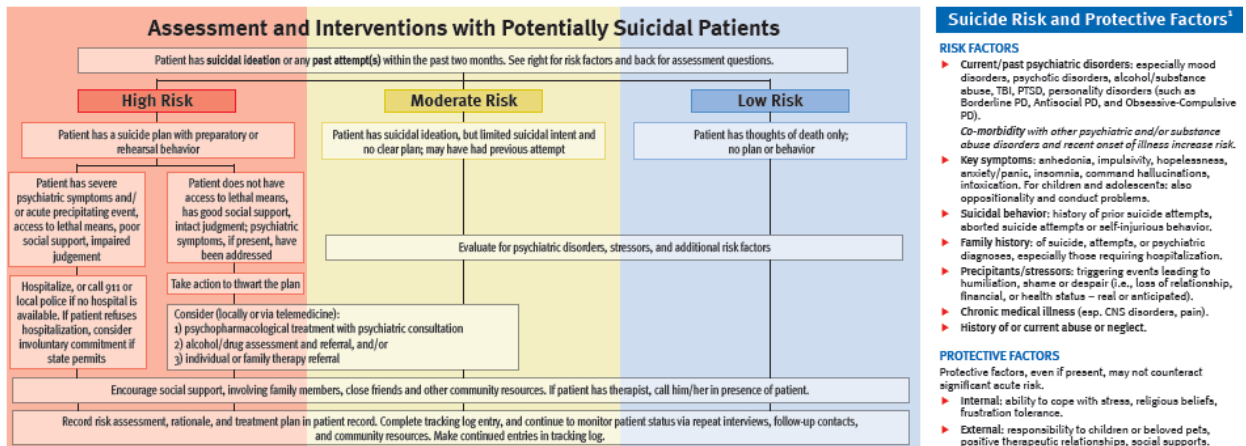
Some important protective factors are:^{xii}

- Sense of responsibility to family
- Life satisfaction
- Social support; belongingness

- Coping skills
- Problem-solving skills
- Strong therapeutic relationship
- Reality testing ability
- Religious faith

4. Clinical Judgment of Suicide Risk

Assessing suicide risk in primary care is complex when patients have medical illnesses, mental health and substance abuse problems, and myriad family, contextual and environmental risk and protective factors. At the low end of the risk spectrum are patients with thoughts of death or wanting to die, but without suicidal thoughts, intent or a plan. Those with highly specific suicide plans, preparatory acts or suicide rehearsals, and clearly articulated intent are at the high end. **Impaired judgment (intoxication, psychosis, TBI, impulsiveness) further exacerbates that heightened risk.** There is no screening tool or questionnaire that can accurately predict which patients from among the many with suicidal risk will go on to make a suicide attempt, either fatal or non-fatal. The decision tree below is a snapshot of the pocket guide developed by the WICHE Mental Health Program and Suicide Prevention Resource Center for use by primary care professionals in assessing suicide risk and determining appropriate interventions (covered in Module 5). The copy of the pocket guide is also available as a separate document/tool for reference.



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