Screening: uncovering suicidality

- Other people with similar problems sometimes lose hope; have you?
- With this much stress, have you thought [are you thinking] of hurting yourself?
- Have you ever thought [are you thinking] about killing yourself?
- Have you ever tried to kill yourself or attempted suicide?

Assess suicide ideation and plans

- Assess suicidal ideation – frequency, duration, and intensity
  - 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 the thoughts of suicide?
  - 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?
- Assess suicide plans
  - 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?

Assess suicide 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 your 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 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?

Endnotes:

1. SAFE-T pocket card. Suicide Prevention Resource Center & Mental Health Screening. (n.d).

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Assessment and Interventions with Potentially Suicidal Patients

**High Risk**
- Patient has a suicide plan with preparatory or rehearsal behavior
- Patient has severe psychiatric symptoms and/or acute precipitating event, access to lethal means, poor social support, impaired judgment

**Moderate Risk**
- Patient has suicidal ideation, but limited suicidal intent and no clear plan; may have had previous attempt
- Patient does not have access to lethal means, has good social support, intact judgment; psychiatric symptoms, if present, have been addressed

**Low Risk**
- Patient has thoughts of death only; no plan or behavior
- Patient has suicidal ideation or any past attempt(s) within the past two months. See right for risk factors and back for assessment questions.

**Suicide Risk and Protective Factors**

**RISK FACTORS**
- **Suicidal behavior:** history of prior suicide attempts, aborted suicide attempts or self-injurious behavior.
- **Family history:** of suicide, attempts, or psychiatric diagnoses, especially those requiring hospitalization.
- **Current/past psychiatric disorders:** especially mood disorders (e.g., depression, Bipolar disorder), psychotic disorders, alcohol/substance abuse, TBI, PTSD, personality disorders (e.g., Borderline PD).
- **Co-morbidity with other psychiatric and/or substance abuse disorders and recent onset of illness increase risk.**
- **Key symptoms:** anhedonia, impulsivity, hopelessness, anxiety/panic, insomnia, command hallucinations, intoxication. **For children and adolescents:** oppositionality and conduct problems.
- **Precipitants/stressors:** triggering events leading to humiliation, shame or despair (i.e., loss of relationship, financial, or health status – real or anticipated).
- **Chronic medical illness** (esp. CNS disorders, pain).
- **History of or current abuse or neglect.**

**PROTECTIVE FACTORS**
- **Protective factors, even if present, may not counteract significant acute risk.**
- **Internal:** ability to cope with stress, religious beliefs, frustration tolerance.
- **External:** responsibility to children or pets, positive therapeutic relationships, social supports.

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**Encourage social support, involving family members, close friends and community resources. If patient has therapist, call him/her in presence of patient.**

**Take action to prevent the plan**

**Evaluate for psychiatric disorders, stressors, and additional risk factors**

**Record risk assessment, rationale, and treatment plan in patient record. Complete tracking log entry, and continue to monitor patient status via repeat interviews, follow-up contacts, and collaboration with other providers. Make continued entries in tracking log.**