

### Screening: uncovering suicidality<sup>2</sup>

- ▶ 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<sup>3</sup>

- ▶ 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:

- <sup>1</sup> SAFE-T pocket card, Suicide Prevention Resource Center & Mental Health Screening. (n/d).
- <sup>2</sup> Stovall, J., & Domino, F.J. Approaching the suicidal patient. American Family Physician, 68 (2003), 1814-1818.
- <sup>3</sup> Gliatto, M.F., & Rai, K.A. Evaluation and treatment of patients with suicidal ideation. American Family Physician, 59 (1999), 1500-1506.

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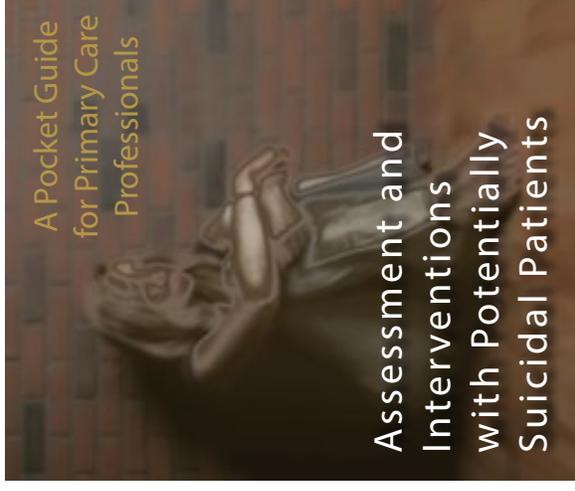
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A Pocket Guide  
for Primary Care  
Professionals



Assessment and  
Interventions  
with Potentially  
Suicidal Patients



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## Assessment and Interventions with Potentially Suicidal Patients

Patient has suicidal ideation or any past attempt(s) within the past two months. See right for risk factors and back for assessment questions.

### 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 judgement

Patient does not have access to lethal means, has good social support, intact judgment; psychiatric symptoms, if present, have been addressed

Take action to prevent the plan

Consider (locally or via telemedicine):  
 1) psychopharmacological treatment with psychiatric consultation  
 2) alcohol/drug assessment and referral, and/or  
 3) individual or family therapy referral

### Moderate Risk

Patient has suicidal ideation, but limited suicidal intent and no clear plan; may have had previous attempt

Evaluate for psychiatric disorders, stressors, and additional risk factors

### Low Risk

Patient has thoughts of death only; no plan or behavior

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

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.

## Suicide Risk and Protective Factors<sup>1</sup>

### 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.