

Assessment and Interventions with Potentially Suicidal Patients

A Guide for Primary Care Professionals



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 judgment

Hospitalize, or call 911 or local police if no hospital is available. If patient refuses hospitalization, consider involuntary commitment if state permits

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 Factors¹

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.

Screening: uncovering suicidality²

- ▶ 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 plans³

- ▶ 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).

² Stovall, J., & Domino, F.J. Approaching the suicidal patient. *American Family Physician*, 68 (2003), 1814-1818.

³ Gliatto, M.F., & Rai, K.A. Evaluation and treatment of patients with suicidal ideation. *American Family Physician*, 59 (1999), 1500-1506.

Development of this pocket guide was supported by the Federal Office of Rural Health Policy, Health Resources and Services Administration (HRSA), Public Health Services, Grant Award, U1CRH03713



Western Interstate Commission for Higher Education
3035 Center Green Drive, Suite 200 Boulder, CO 80301-2204
303.541.0200 (ph) 303.541.0291 (fax)
www.wiche.edu/mentalhealth/

Copyright 2011 by Education Development Center, Inc., and the WICHE Mental Health Program. All rights reserved.