### Assessment and Interventions with Potentially Suicidal Patients

**A Guide for Primary Care Professionals**

**High Risk**
- Patient has a suicide plan with preparatory or rehearsal behavior

**Moderate Risk**
- Patient has suicidal ideation but limited suicidal intent and no clear plan; may have had previous attempt

**Low Risk**
- Patient has thoughts of death only; no plan or behavior

#### Handout B: Assessment and Interventions with Potentially Suicidal Patients: A Pocket Guide for Primary Care Professionals

<table>
<thead>
<tr>
<th>Risk Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Risk</td>
<td>Patient has suicidal ideation or any past attempt(s) within the past two months. See right for risk factors and back for assessment questions.</td>
</tr>
<tr>
<td>Moderate Risk</td>
<td>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.</td>
</tr>
<tr>
<td>Low Risk</td>
<td>Patient has thoughts of death only; no plan or behavior.</td>
</tr>
</tbody>
</table>

**High Risk**
- 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
- Encourage social support, involving family members, close friends and community resources. If patient has a 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.

**Low Risk**
- Patient has thoughts of death only; no plan or behavior.
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).

PROTECTIVE FACTORS
- **Internal**: ability to cope with stress, religious beliefs, frustration tolerance.
- **External**: responsibility to children or pets, positive therapeutic relationships, social supports.

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 (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?
- 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).

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.