Screening: uncovering suicidality[2]

Transition Question: Confirm Suicidal Ideation

Have you had recent thoughts of killing yourself? Is there other evidence of suicidal thoughts, such as reports from family or friends? **(Note: the transitional question is not part of scoring.)**

1. **Thoughts of carrying out a plan.** Recently, have you been thinking about how you might kill yourself? **If yes, consider the immediate safety needs of the patient.**
2. **Suicide intent.** Do you have any intention of killing yourself?
3. **Past suicide attempt.** Have you ever tried to kill yourself?
4. **Significant mental health condition.** Have you had treatment for mental health problems? Do you have a mental health issue that affects your ability to do things in life?
5. **Substance use disorder.** Have you had four or more (female) or five or more (male) drinks on one occasion in the past month or have you used drugs or medication for non-medical reasons in the past month? Has drinking or drug use been a problem for you?
6. **Irritability/agitation/aggression.** Recently, have you been feeling very anxious or agitated? Have you been having conflicts or getting into fights? Is there direct evidence of irritability, agitation, or aggression.

Scoring: Score 1 point for each of the Yes responses on questions 1-6. If the the answer to the transition question and any of the other six items is "Yes", further intervention, including assessment by a mental health professional, is needed.

Assess suicide ideation and plans[3]

- 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 strong are the thoughts of suicide?
  - What is the worst they have ever been?
  - What do you do when you have suicidal thoughts?
- 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?
- 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)?

Endnotes:

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

[2] *Caring for Adult Patients with Suicide Risk: A Consensus Guide for Emergency Departments*. Suicide Prevention Resource Center. Newton, MA. http://www.sprc.org/sites/default/files/EDGuide_quickversion.pdf.

[3] 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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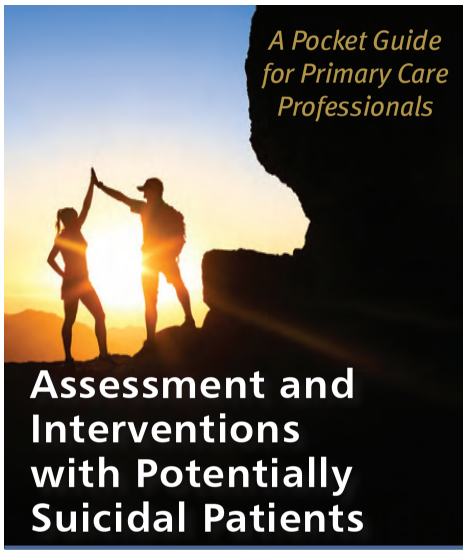

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Assessment and Interventions with Potentially Suicidal Patients

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

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

Patient has good social support, intact judgment; psychiatric symptoms, if present, have been addressed

Take action to prevent the plan

Safety planning

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

Safety planning

Low Risk

Patient has thoughts of death only; no plan or behavior

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 to evidence based treatment

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. Continue to monitor patient status via repeat interviews, follow-up contacts, and collaboration with other providers.

Suicide Risk and Protective Factors[1]

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.