Identifying Patients at Risk of Suicide

Over a third (38%) of the people who attempt suicide saw a health care provider in the week prior to their attempt.[1] Yet rarely will patients voluntarily say that they are thinking of ending their lives.

It is critical that health care staff know what to look for regarding suicide risk. Can you identify a patient who may be at risk of suicide? Do you know what to do if you identify a patient at risk for suicide?

Warning Signs of Suicide

As staff in primary care settings interact with their patients, they may observe many of the common warning signs for suicide, but only if they know what to look for. Warning signs refer to specific behaviors a patient exhibits that may indicate a risk for suicide. Staff need to be able to recognize and appropriately respond to patients who show these signs.

The following three behaviors may indicate a person is at **immediate risk** for suicide:

- Talking about wanting to die or to kill oneself
- Looking for a way to kill oneself, such as seeking available pills
- Talking about feeling hopeless or having no reason to live

If a patient exhibits any of these three warning signs, you should take immediate action to protect the person and follow your office protocol for patients in crisis or at immediate risk of suicide. For guidance on developing an office protocol, see the Suicide Prevention Toolkit (pp. 8–10) at http://www.sprc.org/sites/sprc.org/files/pctoolkit.pdf.

Other behaviors may indicate a person is at **serious risk**—especially if the behavior is new, has increased, and/or seems related to a painful experience or major change.

- Talking about feeling trapped or in unbearable pain
- Talking about being a burden to others
- Increasing the use of alcohol or drugs
- Acting anxious or agitated; behaving recklessly
- Sleeping too little or too much
- Withdrawing or feeling isolated
- Showing rage or talking about seeking revenge
- Displaying extreme mood swings

Staff may observe warning signs of suicide in patients while talking with them on the phone or in the office. When they detect a warning sign, they need to immediately alert office clinicians who are trained and prepared to ask the patient about suicidal ideation.

It is essential to screen for suicidality if there is any suspicion that a patient might be suicidal. Using screening tools such as the Patient Health Questionnaire (PHQ-9) can be an effective and time-efficient way to screen patients. The PHQ-9 is a nine-item depression scale, and the final item screens specifically for the presence of suicidal ideation. For more information on the PHQ-9, go to http://www.phqscreeners.com. If screening tools such as the PHQ-9 are used, providers must be diligent about reviewing patient responses and specifically monitoring whether patients endorse items related to suicidality.

1 Ahmedani, B. K., Stewart, C., Simon, G. E., Lynch, F., Lu, C .Y., Waitzfelder, B. E., . . . Williams, K. (2015). Racial/Ethnic differences in health care visits made before suicide attempt across the United States. Medical Care, 53(5). 430–435.

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Risk Factors

There are many factors that increase risk for suicide. Whereas warning signs are current and observable behaviors, risk factors are underlying circumstances or conditions in an individual, in his or her environment, or within society. A person with more risk factors may indicate greater risk.

Individual Risk Factors

- Previous suicide attempt
- Impulsive and/or aggressive tendencies
- Major physical illnesses, especially with chronic pain
- Central nervous system disorders, including traumatic brain injury (TBI)
- Mental disorders, particularly:
  - » Mood disorders, schizophrenia, anxiety disorders (e.g., posttraumatic stress disorder [PTSD]), and certain alcohol and other substance use disorders
  - » Personality disorders (PD); (e.g., borderline PD, antisocial PD, and obsessive-compulsive PD)
  - » In youths: attention deficit hyperactivity disorder (ADHD) and conduct disorders (e.g., antisocial behavior, aggression, impulsivity)
- Psychiatric symptoms and states of mind: severe anxiety or panic, insomnia, command hallucinations, intoxication, self-hate, and anhedonia
- History of trauma or abuse
- Family history of suicide
- Triggering events that lead to humiliation, shame, or despair (e.g., loss of relationship, health or financial status—real or anticipated)

Social/Environmental Risk Factors

- Lack of social support and increasing isolation
- Easy access to/familiarity with lethal means (e.g., guns, illicit drugs, medications)
- Chaotic family history (e.g., separation or divorce, change in caretaker, change in living situation, incarcerations)
- Local clusters of suicide that have a contagious influence
- Legal difficulties, contact with law enforcement, and/or incarceration
- Barriers to accessing health care, especially mental health and substance abuse treatment

When significant risk factors are present in patients, an initial suicide inquiry is warranted. For guidance on asking about suicidal thoughts and screening patients who may be at risk of suicide, see the Suicide Prevention Toolkit (Module 4) at http://www.sprc.org/sites/sprc.org/files/pctoolkit.pdf.

For any patient you are concerned about, consider a referral to a mental health provider and be sure to give them the National Suicide Prevention Lifeline number: 1-800-273-TALK (8255).

Source: Adapted with permission from Western Interstate Commission for Higher Education (WICHE) and Suicide Prevention Resource Center (SPRC). (2009). *Suicide prevention toolkit for rural primary care. A primer for primary care providers.* Boulder, CO: Western Interstate Commission for Higher Education.