



Suicide screening: How to recognize and treat at-risk adults

Choose a screening tool that focuses on current and past suicidal ideation, intent, and plan, and interview the patient. Plus: Avoid this common action step.

> THE CASE

Emily T,* a 30-year-old woman, visited her primary care physician as follow-up to reassess her grief over the loss of her father a year earlier. Emily was her father's primary caretaker and still lived alone in his home. Emily had a history of chronic pain and major depressive disorder and had expressed feelings of worthlessness and hopelessness about her future since her father's passing. In addition to her continuing grief response, she reported feeling worse on most days. She completed the Patient Health Questionnaire-9, and results indicated anhedonia, depressed mood, psychomotor retardation, hypersomnia, decreased appetite, decreased concentration, and thoughts that she would be better off dead.

○ HOW WOULD YOU PROCEED WITH THIS PATIENT?

**The patient's name has been changed to protect her identity.*

In the United States, 1 suicide occurs on average every 12 minutes; lifetime prevalence of suicide attempts ranges from 1.9% to 8.7%.¹ Suicide is the 10th overall cause of death in the United States, and it is the second leading cause of death for adults 18 to 34 years of age.² In one study, nearly half of suicide victims had contact with primary care providers within 1 month of their suicide.³ Unfortunately, additional research suggests that primary care physicians appropriately screen for suicide in fewer than 40% of patient encounters.^{4,5}

Suicide is defined as "death caused by self-directed injurious behavior with any intent to die as a result of the behavior."⁶ When screening for suicide, be aware of the many terms related to suicide evaluation (TABLE 1⁶). Be mindful, too, of the differences between suicidal and nonsuicidal ideation (death wish);

the continuum of such thoughts ranges from those that lead to suicide to those that do not.

SUICIDE SCREENING RECOMMENDATIONS VARY

Although most health care providers would agree that intervening with a suicidal patient first requires competence in assessing suicide risk, regulating bodies differ on the use of routine screening and on appropriate screening tools for primary care. The Joint Commission recommends assessing suicide risk with all primary care patients,⁷ while the US Preventive Services Tasks Force (USPSTF) advises against universal suicide screening in primary care⁸ due to insufficient evidence that its benefit outweighs potential harm (TABLE 2⁷⁻¹²). Instead, the USPSTF recommends screen-

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TABLE 1

Terms commonly used in suicide assessment⁶

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|--|--|
| Means reduction | Strategies to reduce the availability or ease of access to lethal means for suicidal self-directed injurious behavior (eg, gun removal/locks, reduced access to high volumes of prescription medication) |
| Nonsuicidal ideation or death wish | Thoughts about termination of life or being better off dead that do not include contemplation of suicidal self-directed injurious behavior |
| Safety plan | Written list of coping strategies, warning signs, and means reduction to reduce the likelihood of engagement in suicidal self-directed injurious behavior |
| Suicidal ideation | Thoughts about engaging in suicidal self-directed injurious behavior |
| Suicidal intent | The intent of an individual engaging in suicidal self-directed injurious behavior (or contemplating suicidal self-directed injurious behavior) to complete suicide, and an awareness that this act will be completed imminently or in the future |
| Suicidal means | What is used to carry out the suicidal self-directed injurious behavior |
| Suicidal plans | How the suicidal self-directed injurious behavior will be completed |
| Suicidal self-directed injurious behavior | Deliberate behavior that results in injury or death by suicide or the potential for death by suicide (eg, preparatory acts, recent and past suicide attempts, or death) |

TABLE 2

Suicide screening recommendations for primary care practice

| Recommendation | SORT | Source |
|---|----------------|----------------------------------|
| Conduct universal screening ⁷ | C ^a | Joint Commission |
| Screen patients with known mental disorders, recent inpatient psychiatric hospitalization, prior attempts at suicide or self-harm, or increased emotional distress ⁸ | C | USPSTF ^b |
| Perform a comprehensive suicide risk assessment after a positive screen for suicide ⁷⁻¹¹ | C | APA, SPRC, USPSTF, VA/DoD, WICHE |
| Complete a safety plan after a positive screen for suicide ¹⁰⁻¹² | C | SPRC, VA/DoD, WICHE |

APA, American Psychiatric Association; DoD, Department of Defense; SORT, strength of recommendation taxonomy; SPRC, Suicide Prevention Resource Center; USPSTF, US Preventive Services Task Force; VA, Veterans Affairs; WICHE, Western Interstate Commission for Higher Education.

^aA “C” recommendation is based on consensus, disease-oriented evidence, usual practice, expert opinion, or case series.

^bThe American Academy of Family Physicians supports this recommendation.

ing primary care patients with known mental health disorders, recent inpatient psychiatric hospitalization, prior suicide or self-harm attempts, or increased emotional distress.⁸ USPSTF does support screening for depression with routine mental health measures that include items assessing suicidality.^{8,13,14} The American Academy of Family Physicians supports the recommendations by USPSTF.¹³

When screening for suicide, a comprehensive suicide risk assessment is recommended by both the Joint Commission and USPSTF.^{7,8} A comprehensive suicide risk assessment has 4 components: (1) identification of current suicide risk factors, (2) identifica-

tion of protective factors, (3) inquiry about suicidal ideation, intent, and plan, and (4) primary care practitioner judgment of risk level and plan for clinical intervention.⁹⁻¹¹

Take into account both risks and protective factors

Unfortunately, there is no “typical” description of a patient at risk for suicide and no validated models to predict suicide risk.^{8,10} A multitude of factors, both individual and societal, can increase or reduce risk of suicide.^{11,15} Each patient’s unique history includes risk factors for suicide including precipitating events (eg, job loss, termination of a relationship, death of

TABLE 3

Risks and protective factors for suicide^{8,10,11,15}

| Risk factors | Protective factors |
|--|--|
| <ul style="list-style-type: none"> • Loss of relationship(s) or isolation • Psychosocial stress • Financial hardship • Chronic mental or physical health conditions • History of trauma • Substance abuse • Recent psychiatric hospitalization • Past suicide attempt and suicidal ideation • Constant/recurring guilt or shame • Male gender • American Indian/Alaskan native; non-Hispanic white race • Veteran or active duty military • Physician • Rural residence • Access to lethal means • Exposure to others' suicidal self-injurious behavior • Domestic violence | <ul style="list-style-type: none"> • Supportive relationships • Life satisfaction • Problem-solving or coping skills • Religious/cultural beliefs against suicide • Participation in treatment for chronic mental or physical health conditions, or substance use • Reduced access to lethal means |

a loved one) and protective factors that may be evaluated to determine overall risk for suicide (TABLE 3^{8,10,11,15}). According to the Centers for Disease Control and Prevention (CDC), there are several warning signs for patients who may be at greater risk for suicide: isolation, increased anxiety or anger, obtaining lethal means (eg, guns, knives, ropes), frequent mood swings, sleep changes, feeling trapped or in pain, increased substance use, discussing plans for death or wishes of death, and feeling like a burden.¹⁶

CHOOSING FROM AMONG SUICIDE SCREENING TOOLS

Brief mental health screening tools such as the Patient Health Questionnaire-9 (PHQ-9) are commonly used as primary screening tools for suicidal ideation.¹⁷ However, to attain a fuller understanding of a patient's suicidality, select a screening tool that specifically focuses on suicidal ideation, intent, or plan, and then interview the patient (TABLE 4^{10,11,15}).

Several screening tools are available for exploring a patient's suicidality. Unfortu-

nately, most of them are supported by limited evidence of effectiveness in identifying suicide risk.⁸⁻¹⁰ An exception is the well-researched and commonly used Columbia-Suicide Severity Rating Scale (C-SSRS).^{18,19} In a comparative study conducted at 2 primary care clinics, researchers found that the suicide item included in the PHQ-9 provided poor sensitivity but moderate specificity (60% and 84%, respectively),²⁰ while the C-SSRS showed high sensitivity (100%) and specificity (96%-100%) in accurately identifying various suicidal self-injurious behaviors above and beyond what was identified through a structured clinical interview.²⁰ Free copies of the C-SSRS, training materials, and follow-up assessments in multiple languages can be obtained on The Columbia Lighthouse Project Web site (<http://cssrs.columbia.edu/>).¹⁹

RECOMMENDATIONS FOR INTERVENTION

While there is debate regarding whom to screen for suicide, the importance of interven-

TABLE 4

Clinical interview guide for assessing suicide risk^{10,11,15}

Pursue 3 lines of inquiry in any risk assessment by asking about

- current and past suicidal ideation, intent, and plans, using 1 or more questions
- previous suicide attempts including completed attempts and aborted attempts due to a change of mind, someone intervening, or failure of the method employed
- risks and protective factors that increase or decrease likelihood of current or future suicidal behavior.

Consider how you might use the suggested questions below.

Suicidal ideation

- With increased stress, have you had any thoughts of hurting or killing yourself or thinking that you are better off dead?
- Can you describe the recent thoughts you have been having?
- When did these thoughts begin and how often have you had them?
- When have these thoughts been at their worst?
- Is there anything that causes these thoughts to ease off or to worsen?

Suicidal intent

- How likely are you to try to kill yourself today or in the near future?
- How confident are you that you could carry out your plan today or in the near future?
- Have you considered how soon you would implement your plan?
- Is there anything or anyone that currently stops you from attempting suicide or anything you think would possibly stop you in the future?

Suicidal plans

- Do you have a plan of how you would kill yourself or end your life?
- Can you describe your plan?
- Do you have a timeframe for implementing the plan?
- Have you gathered the items you need to successfully complete your plan?
- Have you told anyone about your plan?
- Is there anything or anyone that has caused you to develop your plan now or anyone or anything that would cause you to not go through with your plan?

Prior suicide history

- Have you tried to harm or kill yourself before?
- What have you done in the past to try to kill yourself?
- Have you ever been hospitalized in a medical or psychiatric hospital after attempting to end your life?
- What stopped you before from killing yourself? Did someone or something intervene or did you stop yourself?

> The Columbia-Suicide Severity Rating Scale has higher sensitivity and specificity for suicide risk than the PHQ-9.

tion when a patient is revealed to be at risk is clear. After completing a comprehensive suicide risk assessment, designate the patient's level of risk as high, moderate, or low, and follow a stepped approach to clinical care (see the Assessment and Interventions with Potentially Suicidal Patients table (page 31) at [https://](https://www.sprc.org/sites/default/files/Final%20National%20Suicide%20Prevention%20Toolkit%202.15.18%20FINAL.pdf)

www.sprc.org/sites/default/files/Final%20National%20Suicide%20Prevention%20Toolkit%202.15.18%20FINAL.pdf).¹¹ Provide any patient at risk, regardless of level, with contact information for local crisis and peer support as well as national resources (National Suicide Prevention Lifeline, (800) 273-TALK (8255),

TABLE 5

Safety planning should include these elements¹²

| |
|---|
| Work with the patient to identify the following: |
| Warning signs —thoughts, images, moods, situations, or behaviors that indicate a crisis may be developing |
| Coping and distraction strategies —actions or activities that can help reduce thoughts or urges to engage in suicide behaviors. These may include individual strategies or strategies involving social support from others |
| Reasons to live —important reasons for life to have meaning and purpose |
| Supportive people to contact in crisis —family members, friends, providers, and national/local resources in the event of a crisis |
| Additional strategies for safety —ideas for reducing lethal or harmful means and instructions and contacts for psychiatric hospitalization |

<https://suicidepreventionlifeline.org/>; Crisis Text Line, Text HOME to 741741, <https://www.crisistextline.org/>).

When a patient is at high risk for suicide and reports an imminent plan or intent, ensure their safety through inpatient psychiatric hospitalization and then close follow-up upon hospital discharge. First encourage voluntary hospitalization in a collaborative discussion with the patient; resort to involuntary hospitalization only if the patient resists.

■ **What not to do.** When the patient does not require immediate hospitalization, evidence recommends against contracting for patient safety via a written contract or requiring patients to verbally guarantee that they will not commit suicide upon leaving a provider's office.²¹ Concerns about such contracts include a lack of evidence supporting their use, decreased vigilance by health care workers when such contracts are in place, and questions regarding informed consent and competence.²¹ Instead, engage a patient who is at moderate or low risk in safety planning, and meet with the patient frequently to discuss continued safety planning through close follow-up (or with a behavioral health provider if available).^{10-12,22} With patients previously identified as at high risk for suicide who return from inpatient psychiatric hospitalization, continue to screen them for suicide at subsequent visits and engage them in collaborative safety planning.

Safety planning (TABLE 5¹²), also known as crisis response planning, is considered a best practice and effective suicide prevention in-

tervention by the Suicide Prevention Resource Center and the American Foundation for Suicide Prevention Best Practices Registry for Suicide Prevention.²³ Safety planning involves a collaboration between patient and physician to identify risk factors and protective factors along with crisis resources and strategies to reduce engagement in suicide behaviors.^{12,22}

► THE CASE

Based on the concerning results from the PHQ-9 suicide item, Emily's physician conducted a comprehensive suicide risk assessment using both clinical interview and the C-SSRS. Emily reported that she was experiencing daily suicidal ideations due to a lack of social support and longing to be with her deceased father. She had not previously attempted suicide and had no imminent intent to commit suicide. Emily did, however, have a plan to overdose on opioid medications she had been collecting for many months. Her physician determined that Emily was at moderate risk for suicide and consulted with the clinic's behavioral health consultant, a psychologist, to confirm a treatment plan.

Emily and her physician collaboratively developed a safety plan including means reduction. Emily agreed to have her physician contact a friend to assist with safety planning, and she brought her opioid medications to the primary care clinic for disposal. Follow-up appointments were scheduled with the physician for every other week. The psychologist was available at the time of the first biweekly

►
After a comprehensive suicide risk assessment, determine the patient's level of risk and follow a stepped approach to clinical care.

appointment to consult with the physician if needed. This initial appointment was focused on Emily's suicide risk and her ability to engage in safety planning. In addition, the physician recommended that Emily schedule time with the psychologist so that she could work on her grief and depressive symptoms.

After several weeks of the biweekly appointments with both the primary care provider and the psychologist, Emily was no longer reporting suicidal ideation and she was ready to engage in coping strategies to deal with her grief and depressive symptoms. **JFP**

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