Risk Factors – Warning Signs of Suicide

The most common risk factors associated with youth suicide include depression, previous suicide attempts, frequent thought about death, and the use of drugs or alcohol. The following information was accessed from the American Academy of Child and Adolescent Psychiatry (AACAP) Website to provide you with additional information about identifying and managing potentially suicidal patients.

Many of the signs and symptoms of suicide are similar to those of depression:

- Change in eating and sleeping habits
- Withdrawal from friends, family, and regular activities
- Violent actions, rebellious behavior, or running away
- Drug and alcohol use
- Unusual neglect of personal appearance
- Marked personality change
- Persistent boredom, difficulty concentrating, or a decline in the quality of schoolwork
- Frequent complaints about physical symptoms, often related to emotions, such as stomachaches, headaches, fatigue, etc.
- Loss of interest in pleasurable activities
- Not tolerating praise or rewards

A youth who is planning to commit suicide may also:

- Complain of being a bad person or feeling rotten inside
- Give verbal hints with statements such as: I won't be a problem much longer; Nothing matters; It's no use; and I won't see you again
- Put his or her affairs in order, for example, give away favorite possessions, clean his or her room, throw away important belongings, etc.
- Become suddenly cheerful after a period of depression
- Have signs of psychosis (hallucinations or bizarre thoughts)

Suicide Risk Assessment[1]

If your patient endorses either of the suicide questions on the questionnaire, or the patient displays common risk factors associated with depression and/or suicide (see above), we suggest conducting a comprehensive suicide risk assessment to determine the patient's level of risk and the most appropriate next steps. We also recommend that all patients that score positive on the questionnaire be assessed for depression and suicide.

You may want to begin by asking your patient about their feelings about being alive and generally about suicide ideation, using questions such as:

[1] Adapted from Petit J, Cohen G, Lednyak, L. Detecting and treating depression in adults. *City Health Information.* 207;26(9):59-66 [revised May 2008]. Available at: http://www.nye.gov/html/doh/downloads/pdf/chi/chi267-9.pdf

1. Have you ever felt that life is not worth living?

2. Did you ever wish you could go to sleep and just not wake up? How often? Since when?

3. Do you think about dying? Or wish you were dead?

Based on the patient's response, you may then want to proceed to more specific questions, such as:

1. Do you ever imagine that others would be better off without you?

2. Do you think about how it would be if you were dead? How often? Since when?

3. Do you think about people who have died? How often? Since when? Do you know someone who ended his or her own life? Do you know someone who tried to kill himself or herself?

4. Have you thought seriously about killing yourself? When was the first time you had those thoughts? When was the most recent time? What was going on with you or in your life that made you think about killing yourself? How often did you think about it?

5. How close have you come to acting on those thoughts, doing something to end your life? What did you do? When was that?

If a patient exhibits suicidal ideation, you may then want to ask if he or she has a suicide plan or if they have previously attempted suicide, such as:

1. Have you thought about how you would end your life? What would you do? When did you think you would do it? Where did you think you would do it? Are (guns/pills/other methods) (at home/easy to get)?

2. Have you ever started to do something to end your life but changed your mind? Have you ever started to do something to end your life but someone stopped your or interrupted you? What happened? When was that? How often did that happen?

3. On the questionnaire you mentioned that there was a time when you tried to end your life. How often did you do that? When was the first time? When was the most recent time? What did you do? What happened after you did that? At the time you did that, how much did you want to die? At the time you did that, how certain were you that you would die? Afterward, did you feel glad or sorry that you were alive?

4. Around the times you (tried to end your life/thought seriously about ending your life), were you drinking or using drugs? How was your mood? Did you tell anyone about what you did or about how you were feeling? Has anything changed since you (tried to end your life/thought seriously about ending your life)?

5. What things would make you feel more/less hopeful about the future? What things would make you more/less likely to want to kill yourself? What things

would make you more/less likely to try to kill yourself? What things would make you want to go on living?

Potential Crisis Situations

Before screening begins, it may be helpful to review standard crisis protocols and guidelines that are in place to manage situations and abuse situations that may arise as a result of screening. Crisis situations may involve any or all of the following:

Imminent Danger:

- Currently at high risk for suicidal behavior
- Currently at high risk for homicidal behavior
- Exhibits violent behavior
- Exhibits psychotic symptoms

Current Suicidal Ideation:

- Includes thinking about killing self within the last three months
- Includes transient thoughts of killing self that occurred within the last three months
- Does not include thoughts about suicide as an abstract concept

Past Suicide Attempts:

- Any self-injurious behavior accompanied by evidence (either explicit or implicit) that the person intended to die regardless of lethality of method
- Includes aborted or interrupted attempts: any potentially self-injurious behavior accompanied by evidence (either explicit or implicit) that the person intended to die but stopped or was interrupted before physical damage occurred

Risk Levels[2]

Low Risk	No current thoughts of hurting or harming self and no other major risk factors (thoughts of suicide as an abstract concept) **Action:** Follow-up visits or non-urgent referral to mental health specialist; continue to monitor the patient.
Intermediate Risk	Current thoughts of harming or killing self, but neither plans, previous attempts or other major risk factors. **Action:** Assess suicide risk at subsequent visits, involve family, and refer to a mental health specialist for an urgent mental health assessment.
High Risk	Current thoughts of harming or killing self, with plans, and/or access to method(s) and/or other major risk factors or warming signs. **Action:** Emergency management by a mental health specialist. Arrange a safe means for transport to the nearest emergency room.

If a patient is actively thinking of suicide and/or has made a suicide attempt in the past (and if he or she reports having a plan for committing suicide), arrange an immediately consultation with a psychiatrist or other qualified mental health professional. Actively thinking about suicide constitutes a medical emergency that may necessitate calling 911.

[2] Adapted from Intermountain Health Care. Depression 2006 Update. P.11. Available at: https://kr.ihc.com/ext/Dcmnt?ncid=51061767