Risk Factors and Warning Signs

For 2025 Zero Suicide Training

Suicides in Wisconsin: Why it is important to screen

From an Action Alliance press release:

Washington, D.C. (June 30th, 2016)— data from a CDC article reviews suicide rates by occupation and found that the highest suicide rates were among persons:

- working in farming, fishing, and forestry (84.5 per 100,000);
- construction and extraction (53.5); and
- installation, maintenance, and repair (47.9)

The report also describes disparities by sex:

- Among **females** the highest suicide rates were among persons working in the protective services occupations (e.g. law enforcement offices and firefighters) (14.1 per 100,000).
- Among **males** the highest suicide rates were among persons in the occupations of farming, fishing and forestry (90.5 per 100,000).

http://www.cdc.gov/mmwr/volumes/65/wr/mm6525a1.htm

Attempts

No complete count is kept of suicide attempts in the U.S.; however, each year the CDC gathers data from hospitals on non-fatal injuries from self-harm.

494,169 people visited a hospital for injuries due to self-harm in 2015. This number suggests that approximately 12 people harm themselves for every reported death by suicide. However, because of the way these data are collected, we are not able to distinguish intentional suicide attempts from non-intentional self-harm behaviors

The ratio of suicide attempts to suicide death in youth is estimated to be about 25:1, compared to about 4:1 in the elderly

Many suicide attempts, however, go unreported or untreated. Surveys suggest that at least one million people in the U.S. each year engage in intentionally inflicted self-harm

Females attempt suicide three times more often than males

Males are 4 times more likely than females to die by suicide

Risk Factors

Risk Factors: are habits, characteristics or histories that put someone at greater likelihood they will consider, attempt, or die by suicide

Risk factors are those characteristics associated with suicide - they might not be direct causes

Some risk factors have been shown to significantly increase risk, whereas other risk factors do not have as strong or well-demonstrated relationships to risk

Long lists mask the fact that some risk factors are much more powerful than others. High risk for suicide, whether for individuals or communities, is usually found in a combination or “constellation” of multiple risk factors

Risk factors (continued)

The number one risk factor is:

Previous suicide attempt

The risk of suicide is twice as high than the general suicide rate for one-year follow-up of suicide attempts with the risk more significant within the first few weeks after an attempt.

It's okay to ask, "have you ever had these thoughts before?" and if so, "have you ever done anything about them?"

This is especially important when conditions are similar to prior attempts and if they are attention needs to be directed at identifying/monitoring the presence of warning signs

Risk factors (continued)

Serious/major illness or physical or chronic pain or impairment with the risk increasing the more chronic and serious the condition is across time.

Central nervous system disorders, including Traumatic Brain Injury

Mental disorders, particularly mood disorders, schizophrenia, anxiety disorders (e.g., PTSD), and

- certain alcohol and other substance use disorders
- personality disorders (such as Borderline PD, Antisocial PD, and Obsessive-Compulsive PD)
- In youths: ADHD and conduct disorders (antisocial behavior, aggression, impulsivity) f Psychiatric symptoms/states of mind: anhedonia, severe anxiety/panic, insomnia, command hallucinations, intoxication, self-hate Impulsive and/or aggressive tendencies

History of trauma or abuse (Importance of employing the ACE assessment tool)

Precipitants/triggering events leading to humiliation, shame, or despair (e.g., loss of relationship, health or financial status – real or anticipated

Family history of suicide

Risk factors (continued)

Social isolation - lack of social support and increasing isolation

A pattern/history of aggressive or antisocial behavior

Discharge from inpatient psychiatric care *especially within the first year after treatment services and particularly within the first weeks and months after discharge*

Access to/familiarity with lethal means (e.g., guns, illicit drugs, medications) – especially firearm ownership or easy accessibility coupled with suicidal thoughts

Acute or enduring unemployment

Stress (job, marriage, school, relationships, etc.)

Risk Factors

Why Ideation and Behavior?

"Studies of risk factors predicting suicide consistently suggest that suicidal ideation and a history of suicide attempts are among the most salient risk factors for suicide" (Posner et al, 2011)

The first three warning signs are:

1. Threatening to hurt or kill self
2. Looking for ways to kill self
3. Talking or writing about death, dying, or suicide

(Brown GK, Beck AT, Steer RA, Grisham JR, 2000) – The history of a prior suicide attempt is the best known predictor for future suicidal behaviors, including completed suicide (American Psychiatric Association, 2004; Sentinel Event Alert-TJC, 2010)

Middle-aged Men and Suicide

Middle-aged years: 35 – 64 accounts for 19% of US population but slightly greater than 40% of suicide deaths

Much of the increase in completed suicides in the US since 1999 can be attributed to males 35 – 64 years of age. This group comprises more than ½ the US male population. It appears based upon data that this group will not “age out” of risk

In 2012, more than 55 percent of the suicides in the U.S. took place among adults between ages 35 and 64, and more than 87 percent of suicides were among people older than 24

According to the CDC males in the 45 – 60 age group had a 43% increase in suicide deaths from 1997–2014 with an even sharper increase since 2005 (there was a 1% increase beginning in 1999 – 2006 that rose to 2% annually from 2007 on)

Risk Factors – Middle-aged Men

- an increase in untreated mental disorders including bipolar disorder, depression, anxiety
- substance abuse especially opioids
- the Great Recession which resulted in a loss of hope in the future
- work related issues involving downsizing and outsourcing resulting in an inability to provide especially if it involves multiple job losses, with a higher incidents in farming, fishing, forestry, construction and extraction jobs
- decrease in self-esteem and self-worth
- a reluctance to reach out for help/services

Risk Factors – Middle-aged Men (continued)

access to and use of firearms

“grey divorces” - the demographic trend of an increasing divorce rate for older ["grey-haired“] couples in long-lasting marriages

increased social isolation

the rise of social media/internet and cyberbullying

the perception that “things just aren’t panning out”

lower educational achievement, lower SES and more rural in nature

Social/Environmental Risk Factors

Chaotic family history (e.g., separation or divorce, change in caretaker, change in living situation or residence, incarcerations)

Local clusters of suicide that have a contagious influence - Exposure to, including through the media, and influence of others who have died by suicide

Legal difficulties/contact with law enforcement/incarceration including domestic violence

Barriers to accessing health care, especially mental health and substance abuse treatment

Certain **cultural and religious beliefs** (for instance, the belief that suicide is a noble resolution of a personal dilemma)

Other Risk Factors

Triggering events or contributory risk factors add to the possibility that someone may attempt or complete suicide including:

- losses, such as the breakup of a relationship or a death
- academic failures
- trouble with authorities, such as school suspensions or legal difficulties
- bullying
- health problems and grief, especially when prolonged, associated with theses losses. This is especially true for youth already vulnerable because of low self-esteem or a mental disorder, such as depression

Warning Signs

Signs that indicate someone may be thinking about/planning to attempt suicide **now:**

- Say they are always thinking about death or they are talking about wanting to die or kill themselves
- Say they are looking for ways to kill themselves
- Clinical depression -- deep sadness, loss of interest
- Tempting fate by taking risks that could lead to death, such as driving fast or running red lights
- Losing interest in things one used to care about
- Putting affairs in order, tying up loose ends, changing a will
- Saying things like "it would be better if I wasn't here" or "I want out"
- Sudden, unexpected switch from being very sad to being very calm or appearing to be happy
- Visiting or calling people to say goodbye
- Increased complaints of being in intense, unbearable pain

Warning Signs

- Talking about feeling hopeless or having no purpose
- Talking about feeling trapped or being in unbearable pain
- Talking about being a burden to others
- Increasing the use of alcohol or drugs
- Acting anxious, agitated, or reckless
- Trouble sleeping or sleeping too little or too much
- Withdrawing or feeling isolated
- Showing rage or talking about seeking revenge
- Displaying extreme mood swings

IS PATH WARM?

- **I**ncreased **S**ubstance (alcohol or drug) use
- No reason for living; no sense of **P**urpose in life
- **A**nxiety, **A**gitation, unable to sleep or sleeping all of the time
- Feeling **T**rapped - like there's no way out
- **H**opelessness
- **W**ithdrawal from friends, family and society
- Rage, uncontrolled **A**nger, seeking revenge
- Acting **R**eckless or engaging in risky activities, seemingly without thinking
- Dramatic **M**ood changes

If observed, seek help as soon as possible by contacting a mental health professional or calling 1-800-273-TALK (8255) for a referral.

Suicide assessments should be conducted at first contact, with any subsequent suicidal behavior, increased ideation, or pertinent clinical change; for inpatients, prior to increasing privileges and at discharge.

1. RISK FACTORS

- ✓ **Current/past psychiatric diagnoses:** especially mood disorders, psychotic disorders, alcohol/substance abuse, Cluster B personality disorders. Co-morbidity and recent onset of illness increase risk
- ✓ **Key symptoms:** anhedonia, impulsivity, hopelessness, anxiety/panic, global insomnia, command hallucinations
- ✓ **Suicidal behavior:** history of prior suicide attempts, aborted suicide attempts or self-injurious behavior
- ✓ **Family history:** of suicide, attempts or Axis 1 psychiatric diagnoses requiring hospitalization
- ✓ **Precipitants/stressors:** triggering events leading to humiliation, shame or despair (i.e., loss of relationship, financial or health status—real or anticipated). Ongoing medical illness (esp. CNS disorders, pain). History of abuse or neglect. Intoxication
- ✓ **Access to firearms**

2. PROTECTIVE FACTORS *Protective factors, even if present, may not counteract significant acute risk*

- ✓ **Internal:** ability to cope with stress, religious beliefs, frustration tolerance, absence of psychosis
- ✓ **External:** responsibility to children or beloved pets, positive therapeutic relationships, social supports

3. SUICIDE INQUIRY *Specific questioning about thoughts, plans, behaviors, intent*

- ✓ **Ideation:** frequency, intensity, duration--in last 48 hours, past month and worst ever
- ✓ **Plan:** timing, location, lethality, availability, preparatory acts
- ✓ **Behaviors:** past attempts, aborted attempts, rehearsals (tying noose, loading gun), vs. non-suicidal self injurious actions
- ✓ **Intent:** extent to which the patient (1) expects to carry out the plan and (2) believes the plan/act to be lethal vs. self-injurious; Explore ambivalence: reasons to die vs. reasons to live

* ***Homicide Inquiry:*** *when indicated, esp. postpartum, and in character disordered or paranoid males dealing with loss or humiliation. Inquire in four areas listed above.*

4. RISK LEVEL/INTERVENTION

- ✓ **Assessment of risk** level is based on clinical judgment, after completing steps 1-3
- ✓ **Reassess** as patient or environmental circumstances change

RISK LEVEL	RISK / PROTECTIVE FACTOR	SUICIDALITY	POSSIBLE INTERVENTIONS
High	Psychiatric diagnoses with severe symptoms, or acute precipitating event; protective factors not relevant	Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal	Admission generally indicated unless a significant change reduces risk. Suicide precautions
Moderate	Multiple risk factors, few protective factors	Suicidal ideation with plan, but no intent or behavior	Admission may be necessary depending on risk factors. Develop crisis plan. Give emergency/crisis numbers
Low	Modifiable risk factors, strong protective factors	Thoughts of death, no plan, intent or behavior	Outpatient referral, symptom reduction. Give emergency/crisis numbers

(This chart is intended to represent a range of risk levels and interventions, not actual determinations.)

5. DOCUMENT: Risk level and rationale; treatment plan to address/reduce current risk (i.e., medication, setting, E.C.T., contact with significant others, consultation); firearm instructions, if relevant; follow up plan

Warning Signs – Older Adults

The most significant indicator is an expression of suicidal intent

Loss of interest in things or activities that are usually found enjoyable

Cutting back social interaction, self-care, and grooming

Breaking medical regimens (such as going off diets, prescriptions)

Experiencing or expecting a significant personal loss (spouse or other)

Feeling hopeless and/or worthless

Putting affairs in order, giving things away, or making changes in wills

Stock-piling medication or obtaining other lethal means

Other clues are a preoccupation with death or a lack of concern about personal safety. Remarks such as "This is the last time that you'll see me" or "I won't be needing anymore appointments" should raise concern

Warning Signs – Youth

Feelings of **hopelessness**

Anxiety, agitation, sleep disturbance (trouble sleeping or sleeping all of the time)

Expressions of having **no reason for living**; **no sense of purpose** in life

Feelings of **being trapped** - like there's no way out

Increase **alcohol and/or drug use**

Withdrawal from friends, family, and community

Talks or writes about death, dying or suicide, when these actions are out of the ordinary.

If an individual **is indicating or communicates suicidal thoughts**

Warning Signs - Youth (continued)

Rage, uncontrolled anger, expressions of wanting or seeking revenge

Reckless behavior or **more risky activities**, seemingly without thinking

Dramatic **mood changes**

Giving away prized possessions

Threatens to hurt or kill him or herself; or talks of wanting to hurt or kill him or herself; and/or

Looks for ways to kill him or herself by seeking access to firearms, pills, or other means

Screening Follow-Up

If any suicide warning signs are evident or if significant risk factors are present, an initial suicide inquiry is warranted

Ask patients directly about suicide and seek collateral information from other clinicians, family members, friends, EMS personnel, police, and others

How you ask the question affects the likelihood of getting a truthful response. Use a non-judgmental, non-condescending, matter-of-fact approach

NEVER ask leading questions like:

“You’re not thinking of suicide, are you”?

Practice questions several times prior to a clinical encounter; asking about suicide for the first time may be harder than you think

Thoughts of Suicide: Ask patients you suspect may be feeling suicidal about thoughts or feelings related to suicide

Screening Follow-Up

Providers especially (and anyone preferably) need to become comfortable asking questions about suicide intent.

The sample questions below will help ease into the subject in a non-threatening way.

Sometimes, people in your situation (describe the situation) lose hope; I'm wondering if you may have lost hope, too?

Have you ever thought things would be better if you were dead?

With this much stress (or hopelessness) in your life, have you thought of hurting yourself?

Have you ever thought about killing yourself?

ASKING DOES NOT CAUSE OR PUT THE IDEA IN SOMEONE'S HEAD!!

Screening Follow-Up

***A history of a prior attempt is the strongest predictor of future suicidal behavior*.**

Always ask if the patient has **attempted suicide in the past**, even if there is no evidence of recent suicidal thinking

Sample question to assess prior attempt:

Have you ever tried to kill yourself or attempt suicide?

If your questioning reveals no evidence of suicidal ideation, you may end the inquiry here and document the finding. **However,** (remember about 30% don't disclose)

If your patient initially denies suicidal thoughts but you have a high degree of suspicion or concern due to agitation, anger, impaired judgment, etc., ask as many times as necessary in several ways until you can reconcile the disagreement about what you see and what the patient says

Screening Follow-Up

It is recommended those working in Emergency Departments also ask the following questions:

Have you wished you were dead or wished you could go to sleep and not wake up?

Have you had thoughts of killing yourself?

In your lifetime -have you ever attempted to kill yourself? If YES, then ask

When did this happen?

- Today
- Within the last 30 days (but not today)
- Between 1 and 6 months ago
- More than a six months ago

Screening Follow-Up

If the individual is having suicidal thoughts, ask specifically about

- frequency
- duration
- intensity

Sample questions to assess suicidal ideation:

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 they?

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?

Screening Follow-Up

After discussing the character of suicidal thoughts, providers should inquire about planning. Ask whether the patient has a plan and, if so, get the specifics.

Sample questions to assess suicidal planning:

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

Screening Follow-Up

Providers should determine:

The extent to which the patient expects to carry out the plan and believes the plan or act to be lethal vs. self-injurious

Explore the patient's reasons to die vs. reasons to live

Inquire should also be made about aborted attempts, rehearsals (such as tying a noose or loading a gun), and non-suicidal self-injurious actions, as these are indicators of the patient's intent to act on the plan

The patient's judgment and level of impulse control should be taken into account and a mental status exam administered if in doubt about their current mental state.

Screening Follow-Up

Sample questions to assess 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 this plan would actually end your life?

What have you done to begin to carry out the plan? For instance, have you rehearsed what you would do (e.g., held the 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)?

How likely do you think you are to carry out your plan?

What stops you from killing yourself?

Screening Follow-Up

Look for disagreement between what you see (objective findings) and what the patient tells you about their suicidal state (subjective findings)

When possible, and always with adolescents, seek to confirm the patient's reports with information from a family member, spouse, or close friend

Patients are more likely to tell a family member than a PCP that they are suicidal. It may also be helpful to explore the patient's cultural and/or religious beliefs about suicide and death

For patients who screened positive for suicidal ideation and deny or minimize suicide risk or refuse treatment, the provider should seek to obtain collaborative information by requesting the patient's permission to contact family, friends or outpatient treatment provider. HIPAA permits a clinician to make these contacts without the patient's permission when the commission believes the patient may be a danger to self or others

Protective Factors

While protective factors provide a poor equalizer to individuals who are at high-risk for attempting suicide (i.e., someone with strong ideation, intent, a plan, preparatory behaviors, and impaired judgment), protective factors can lessen risk in a person with moderate to low suicide risk. Protective factors buffer individuals from suicidal thoughts and behavior. To date, protective factors have not been studied as extensively or rigorously as risk factors. Identifying and understanding protective factors are, however, equally as important as researching risk factors. Strengthening protective factors can be a part of safety planning

Some important protective factors are:

- Sense of responsibility to family
- Social support; belongingness
- Problem-solving skills
- Reality testing ability
- Life satisfaction
- Coping skills
- Strong therapeutic relationship
- Religious faith

Columbia Suicide Severity Rating Scale (CSSRS)

The Columbia-Suicide Severity Rating Scale (C-SSRS), the most evidence-supported tool of its kind.

A simple series of plain-language questions that **anyone can use** anywhere in the world to prevent suicide.

Users of the C-SSRS tool ask people:

- Whether and when they have thought about suicide (ideation)
- What actions they have taken — and when — to prepare for suicide
- Whether and when they attempted suicide or began a suicide attempt that was either interrupted by another person or stopped of their own volition

The answers help users identify:

- whether someone is at risk for suicide
- assess the severity and immediacy of that risk, and
- gauge the level of support that the person needs

http://cssrs.columbia.edu

Columbia Suicide Severity Rating Scale (CSSRS)

Key Points about the CSSRS:

Demonstrated ability to predict suicide attempts in suicidal and non-suicidal individuals (which is a national priority for prevention).

The CDC adopted Columbia definitions of suicidal ideation and behavior; link to C-SSRS in CDC document; these definitions required by military

Field-use ready; mental health training not required to administer; Chaplains to first responders

Targeted versions for military active personnel, family members, veterans, online

Gathers key data to help direct limited resources to persons most in need.

Track record of many millions of administrations.

Available in 103 languages.

Electronic self-report is available and widely used (e-CSSRS)

Training video available on the CSSRS website