

# Suicide Risk Assessment

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**Brigham and Women's Hospital**  
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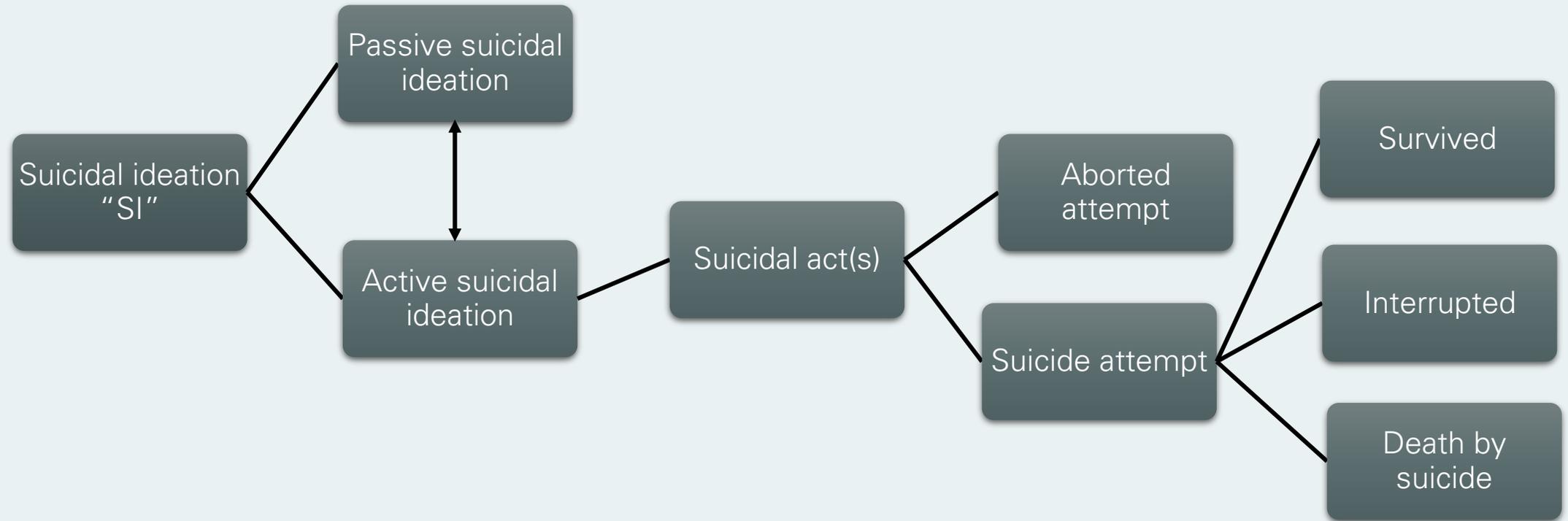
# Disclosures

I have no financial disclosures or conflicts of interest with the presented material in this presentation.

# Agenda

- Definitions
- Epidemiology
- Assessment
- Management
- Documentation
- Conclusion

# Definitions



# Definitions continued

- Instrumental behaviors
  - Parasuicidal or gestural
  - Manipulative
- Non-intentional suicidal or self-harm behaviors
  - Self injurious behaviors (SIB) or Non-suicidal self-injurious behaviors (NSSIB)
  - Reactive

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# Epidemiology: Caveats

- Accurate, reliable, and timely data is challenging to obtain
- Data is under-reported individually, nationally, and globally
- Data is often reported in binary sex/gender categories

# Global epidemiology

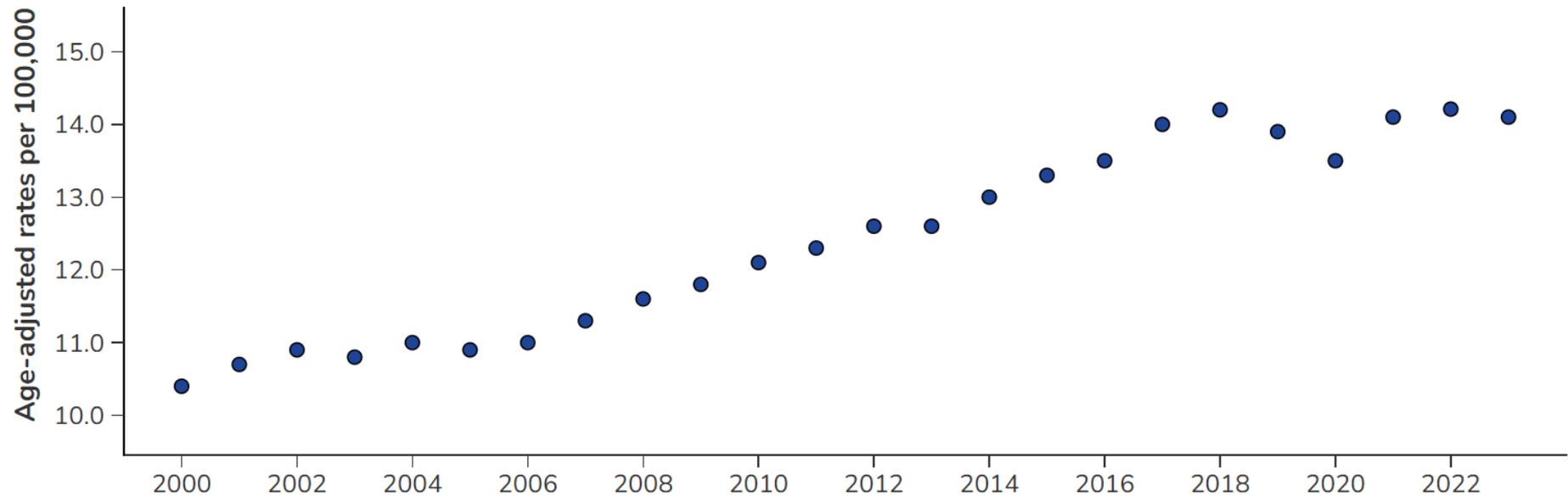
- >720,000 people die by suicide every year
- Suicide is the third leading cause of death amongst 15–29-year-olds
- 73% of global deaths by suicide occur in low- and middle-income countries



# National epidemiology

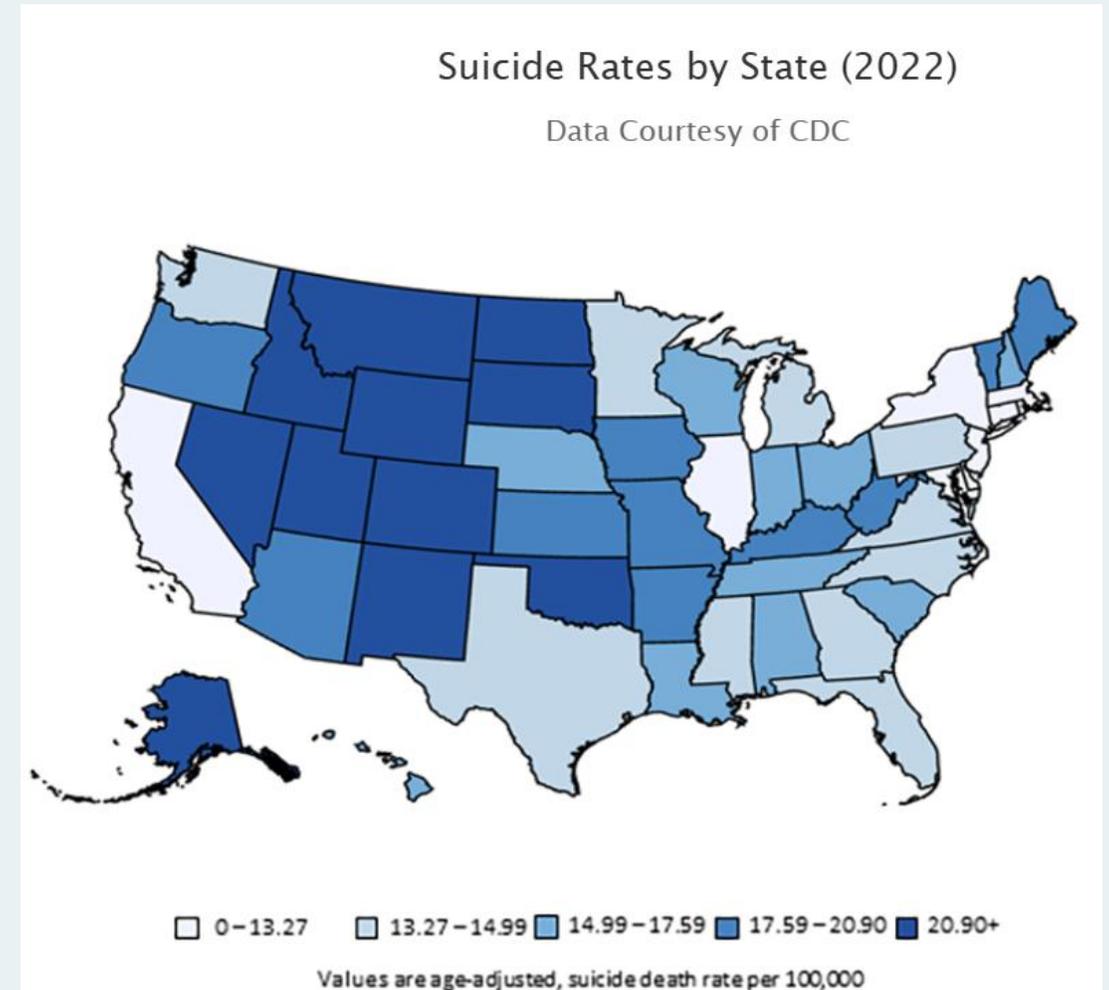
## Suicide rates

Suicide rates increased 37% between 2000-2018 and decreased 5% between 2018-2020. However, rates returned to their peak in 2022.



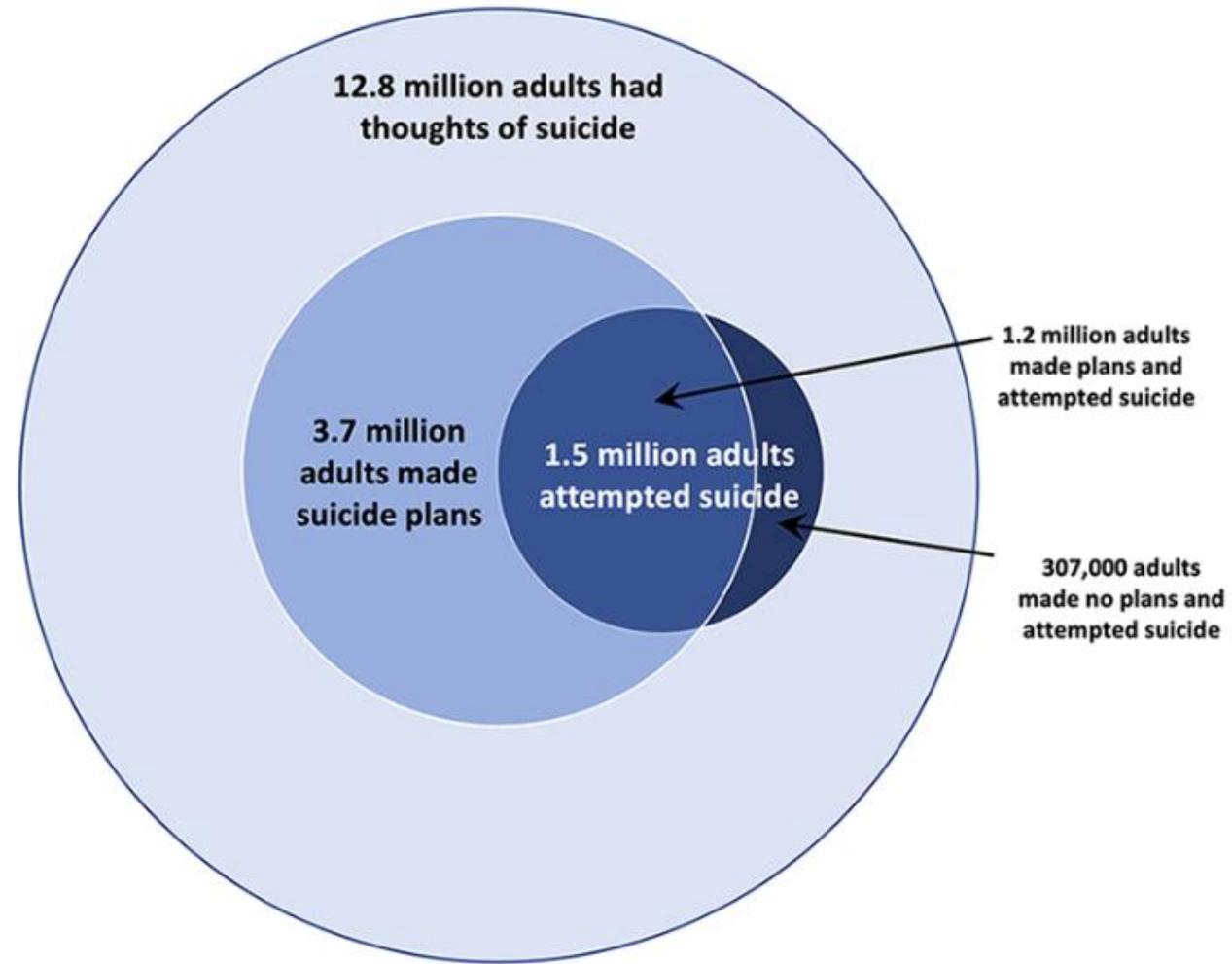
# National epidemiology continued

- Age
  - Females: highest rates for suicide in those aged 45-64 years old
  - Males: highest rates for suicide in those aged 75+ years old
  - Suicidal thoughts are most prevalent in 18–25-year-olds
- Race and ethnicity (males and females)
  - Highest rates for American Indian/Alaskan Native, Non-Hispanic
- Geography
  - Highest rates in the mid-west



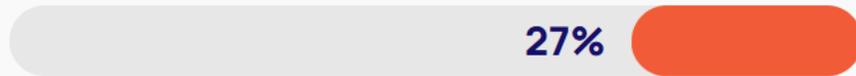
# Past Year Suicide Thoughts and Behaviors Among U.S. Adults (2023)

Data Courtesy of SAMHSA

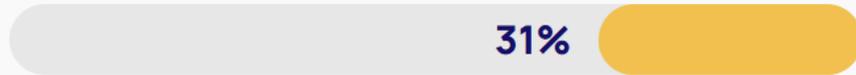


# Rates among LGBTQ+ young people

## Considered suicide in the past year



Cisgender Men



Cisgender Women



Transgender Women



Transgender Men

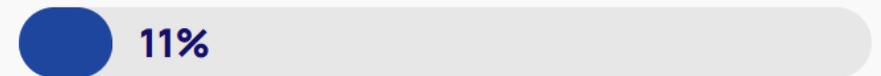
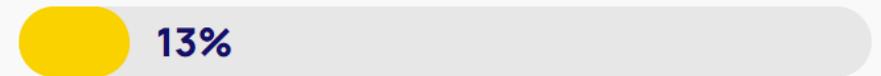


Nonbinary/  
Genderqueer



Questioning

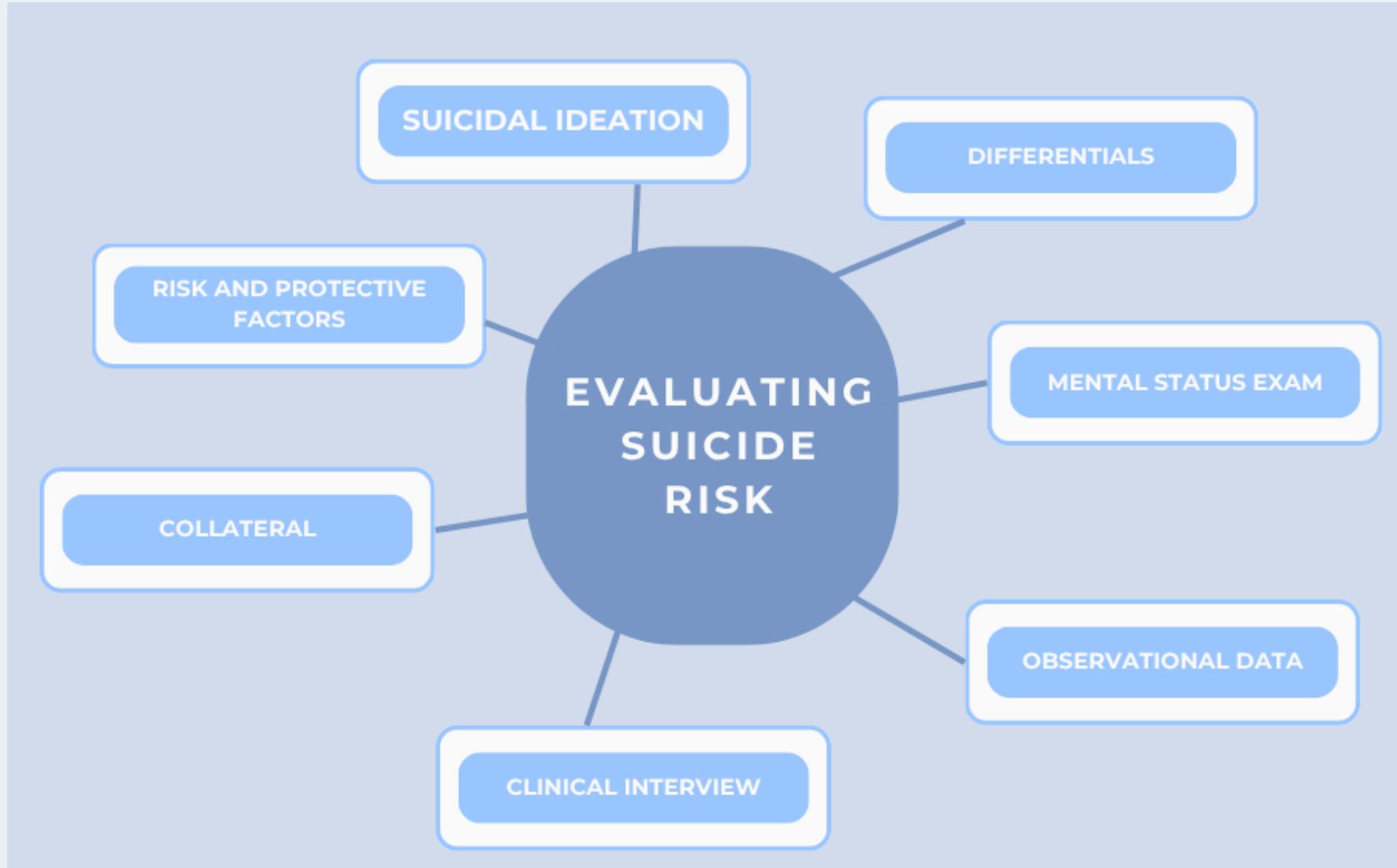
## Attempted suicide in the past year



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# Components of assessment



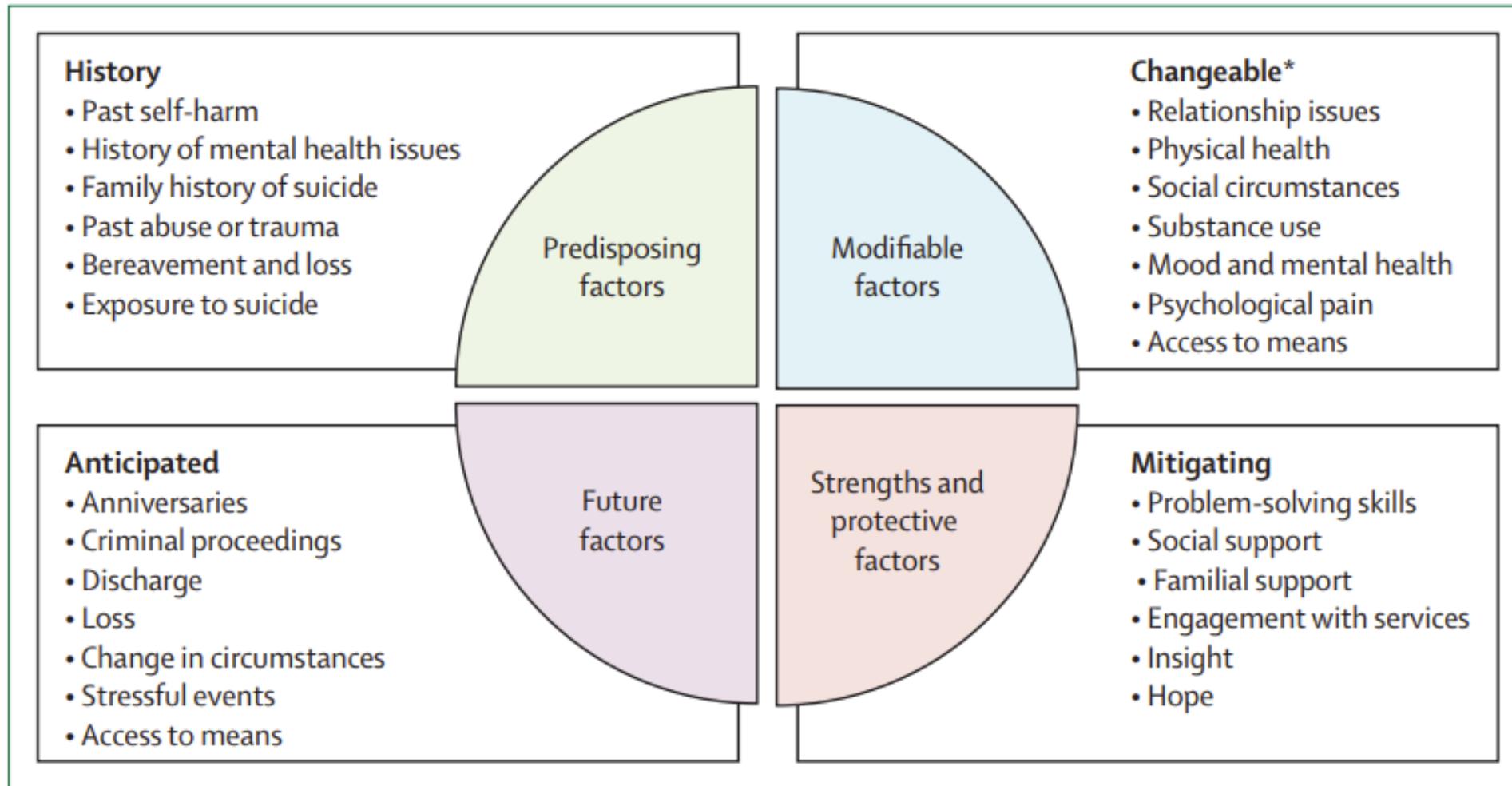
# Risk scales

- Adults
  - C-SSRS
  - SAFE-T
  - Combined CSSRS-SAFE-T
  - Suicide Risk Assessment (SRA)
- Special populations
  - Adolescents: TASR-A
  - Autism spectrum: Ask Suicide-Screening Questions (ASQ)

Always ask questions 1 and 2.		Past Month	
1) Have you wished you were dead or wished you could go to sleep and not wake up?			
2) Have you actually had any thoughts about killing yourself?			
If YES to 2, ask questions 3, 4, 5 and 6. If NO to 2, skip to question 6.			
3) Have you been thinking about how you might do this?			
4) Have you had these thoughts and had some intention of acting on them?		High Risk	
5) Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?		High Risk	
Always Ask Question 6		Life-time	Past 3 Months
6) Have you done anything, started to do anything, or prepared to do anything to end your life? <i>Examples: Took pills, tried to shoot yourself, cut yourself, tried to hang yourself, or collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump, etc.</i> If yes, was this within the past 3 months?			High Risk

# Efficacy of assessments

- Validated/standardized risk scales
  - Low predictive values and sensitivity
  - Large datasets and machine learning approaches also with limited efficacy
  - Majority of suicides occur amongst patients who score low to moderate risk
  - Some organizations advise against the use of risk scales to predict risk or make aftercare decisions
  - Note: The Joint Commission requires screening for SI using a validated tool starting at 12 years old
- Clinical interview
  - Asking about suicide has not been shown to increase risk
  - Patients report genuine listening, validation, and empathy facilitates disclosures
  - Begin with “here and now” before asking about history
  - Acknowledging commonality of SI can reduce perceived stigma/shame



**Figure: Interactive components of risk assessment that can inform risk formulation and therapeutic management**

\*Acute exacerbation of any of these factors may constitute warning signs.

# Assessing suicidal ideation

Onset

Frequency:  
Chronic vs acute

Duration:  
Fleeting vs lingering

Intensity

Triggers

Associated factors

Passive vs Active

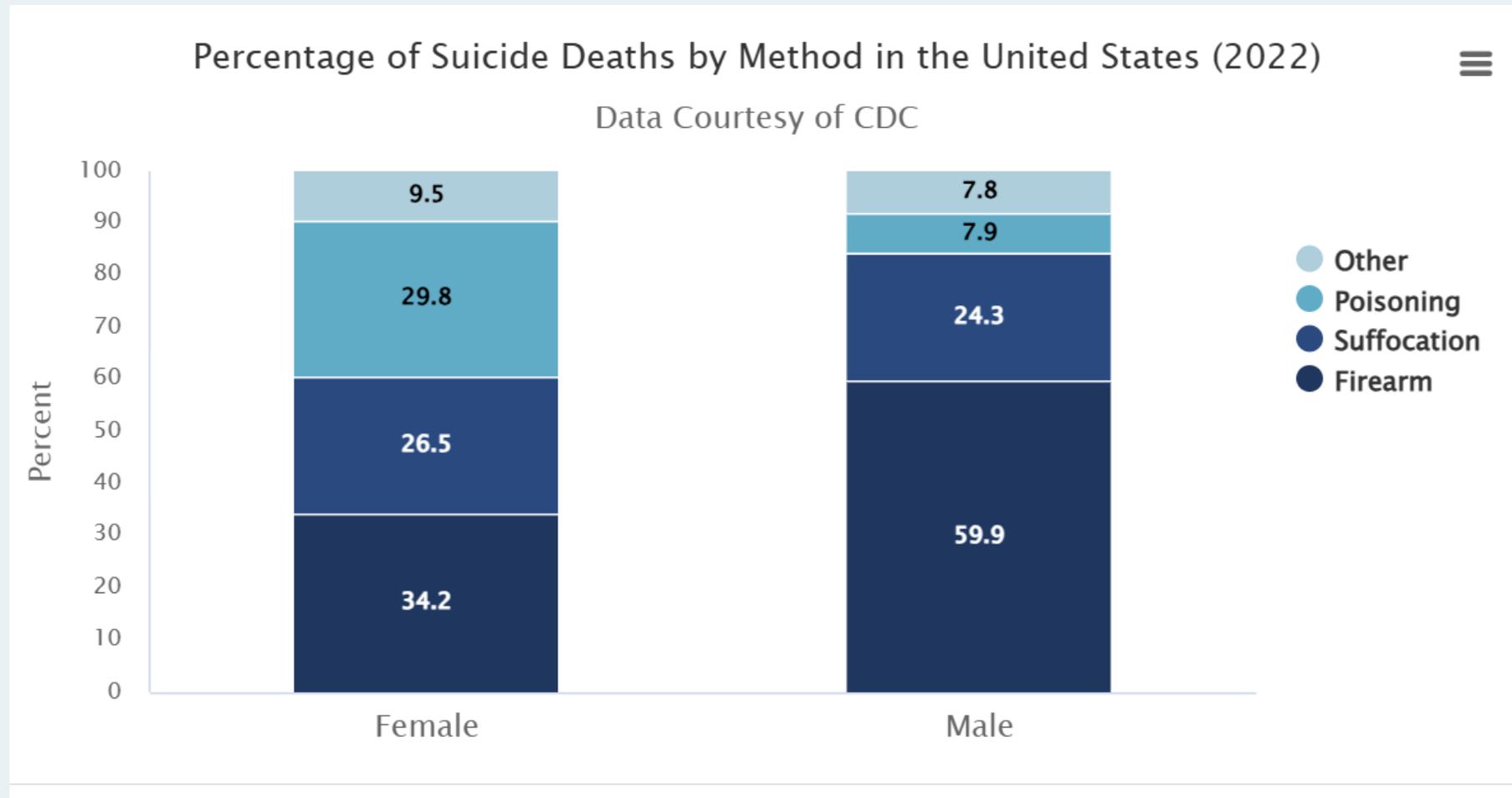
Plan and intent

- Seriousness
- Risk vs Rescue
- Means, access
- When, where

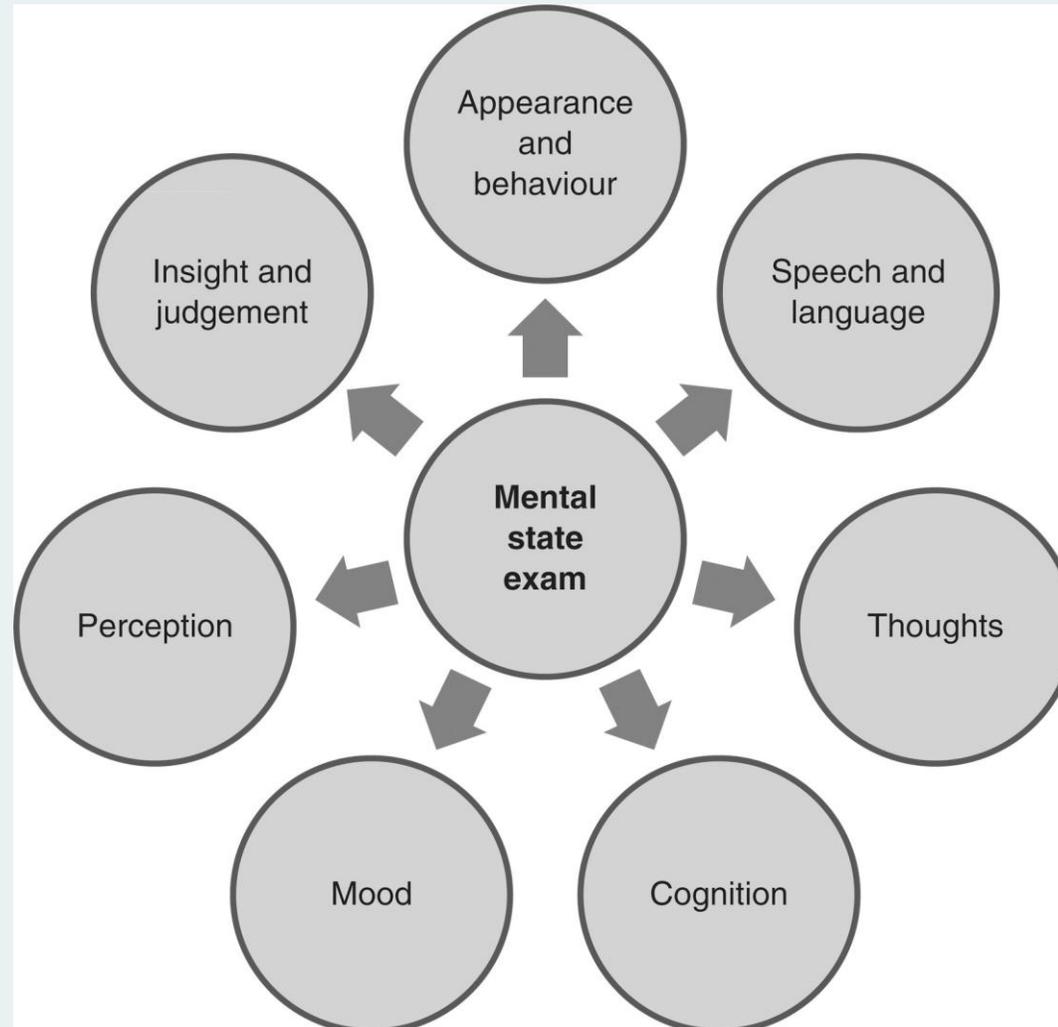
# Assessing suicidal intent

Lethality of method	Knowledge of lethality	Planning, organizing, persistence	Efforts to avoid detection
<ul style="list-style-type: none"><li>• Guns</li><li>• Hanging, suffocation</li><li>• Poisoning, OD</li></ul>	<ul style="list-style-type: none"><li>• Researching</li></ul>	<ul style="list-style-type: none"><li>• Acts of furtherance</li><li>• Suicide note</li><li>• Practicing</li><li>• Preparatory behaviors</li></ul>	<ul style="list-style-type: none"><li>• Booking hotel room</li></ul>

# Assessing lethality of method



# Mental status exam



# Observational data

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## Higher Risk

Impulsivity

Psychomotor agitation

Emotional lability

Aggression, violence

Low self-esteem

Polarized thinking

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## Lower risk

Somnolent, sleepy

Calm

Hungry, eating

Self-directed actions and statements

Future directed actions and statements

Manipulative behaviors and statements

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# Collateral

Outpatient  
team

Inpatient/ED  
team

Family

Friends

Roommates

EMS

# Assessing risk factors

AREA	NON-MODIFIABLE	MODIFIABLE
<b>Health</b>	History of mental illness <i>Mood or psychotic disorders</i> Substance use/abuse History of chronic medical illness <i>Epilepsy, concussion, COPD, cancer</i>	Pain Insomnia Anxiety, panic
<b>Environment</b>	Prolonged stress Discrimination Negative life events	Access to means <i>Firearms</i> Limited access to basic needs Social isolation, loneliness
<b>Psychiatric History</b>	<b>Prior suicide attempt or self-harm</b> <b><i>Strongest predictor</i></b> Prior psychiatric hospitalization <i>100 fold increase for 3 months after</i> Family history of suicide Exposure to trauma, ACEs	Low resiliency Help rejecting Minimal treatment engagement
<b>Demographics</b>	?Gender <i>Data varies</i> Caucasian race Younger and older ages LGBTQIA+ Contact with criminal justice system	Single relationship status Financial instability Unemployment Lower level of education

# Assessing protective factors

## TREATMENT

Access  
Awareness  
Stable health  
Positive coping skills

## INDIVIDUAL

Strong resiliency  
Problem solving abilities  
Hopefulness  
Fear of death  
Stable impulse control

## RELATIONSHIPS

Responsible for children  
Parental support  
Close friends  
Partnerships  
Responsible for pets

## COMMUNITY

Negative cultural, moral, or spiritual attitudes towards suicide  
Community support  
Cultural or spiritual norms  
Strong sense of cultural identity

## OTHER

Lack of access to means  
Limited media exposure to suicide

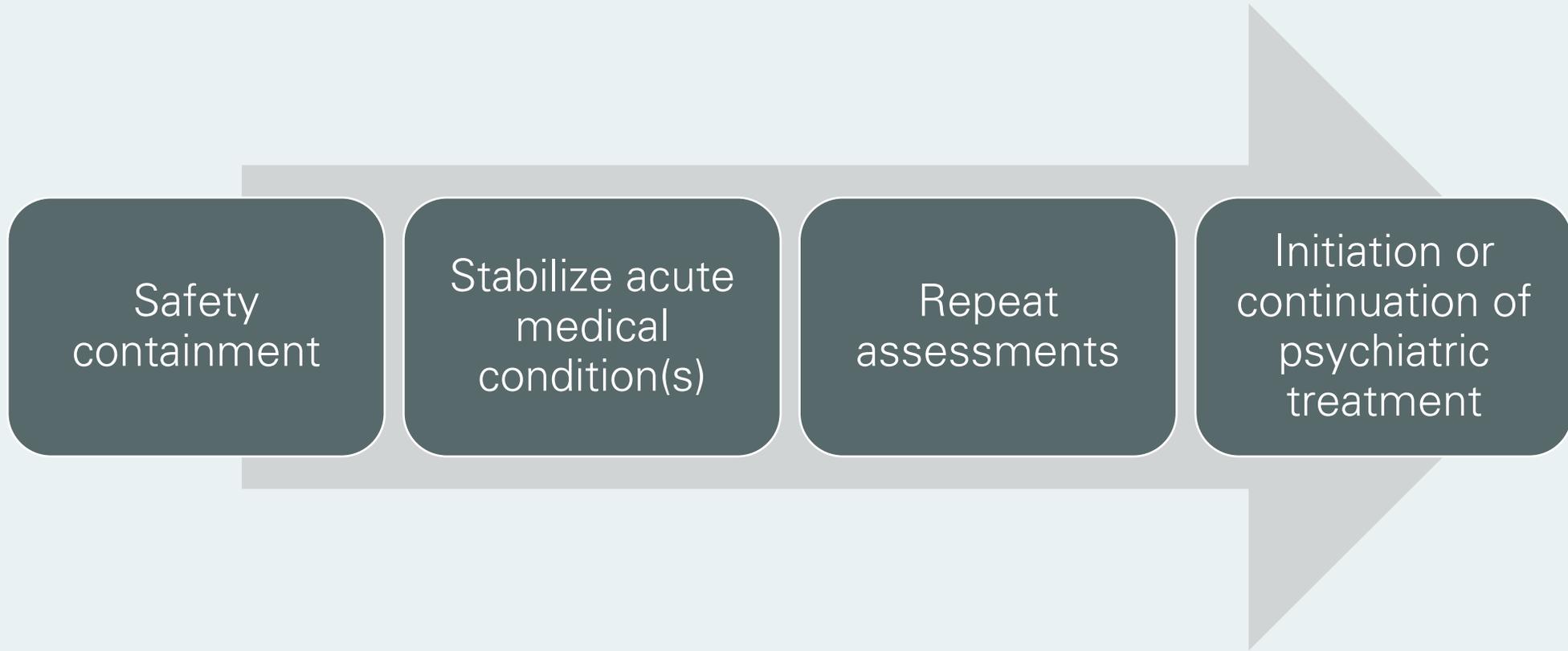
# Differentials

- Provocative statements
- Secondary gain
- Idiom of distress
- Delirium
- Acute pain, suffering
- Acute intoxication
- Miscommunication, language barrier

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# Initial management



# In-hospital prevention

- Managing symptoms that may increase distress
  - Physical: pain, insomnia
  - Psychiatric: hallucinations, delusions, agitation, panic
- Consistent communication with patient, family/friends, and inpatient/outpatient teams
- Utilization of hospital resources
  - Distractions
  - Bedside therapeutic interventions
- Observation status
  - Direct (1:1, 2:1): for patients that post acute risk to self/others (e.g. agitation, history of self harm in health care environments), typically includes bathroom visits
  - Indirect (video monitoring): for patients that have demonstrated behavioral regulation
- Room safety

# Room safety

- Lock spare linens or remove from room
- Remove unnecessary IV poles, electric cords, cleaning supplies
- Do not provide metal cutlery with meals (“safe meal trays”)
- Limit access to foreign objects (paper clips, staples, batteries in remote controls)
- Remove unnecessary furniture
- Remove plastic bags
- Pour liquids out of aluminum cans or plastic bottles into cups

# Patient belongings

- Paper scrubs
- Body check
- Belongings check
- Visitor checks
- Remove shoelaces, hoodie strings, belts, elastics, necklaces, bracelets, rings
- Consider removing phone per organization policy and risk assessment

# Suicide in the general hospital

## Safety classifications

- Sentinel event: event that reaches the patient, results in death or permanent/severe but temporary harm
- Never event: event that is identifiable, measurable, serious, and usually preventable

## Rates

- >65% are in psychiatric hospitals not general hospitals ( $\approx$  15-20 annually)
- Numbers lower than what is often reported (uses old and extrapolated data)
- Reporting mostly voluntary

## Methods

- Hanging ( $\approx$ 72%)
- Drug overdose ( $\approx$ 11%)
- Jumping from height (6.5%)

## Locations

- Bathroom ( $\approx$ 34%)
- Closet and showers (both  $\approx$ 4%)
- Other ( $\approx$ 8%)

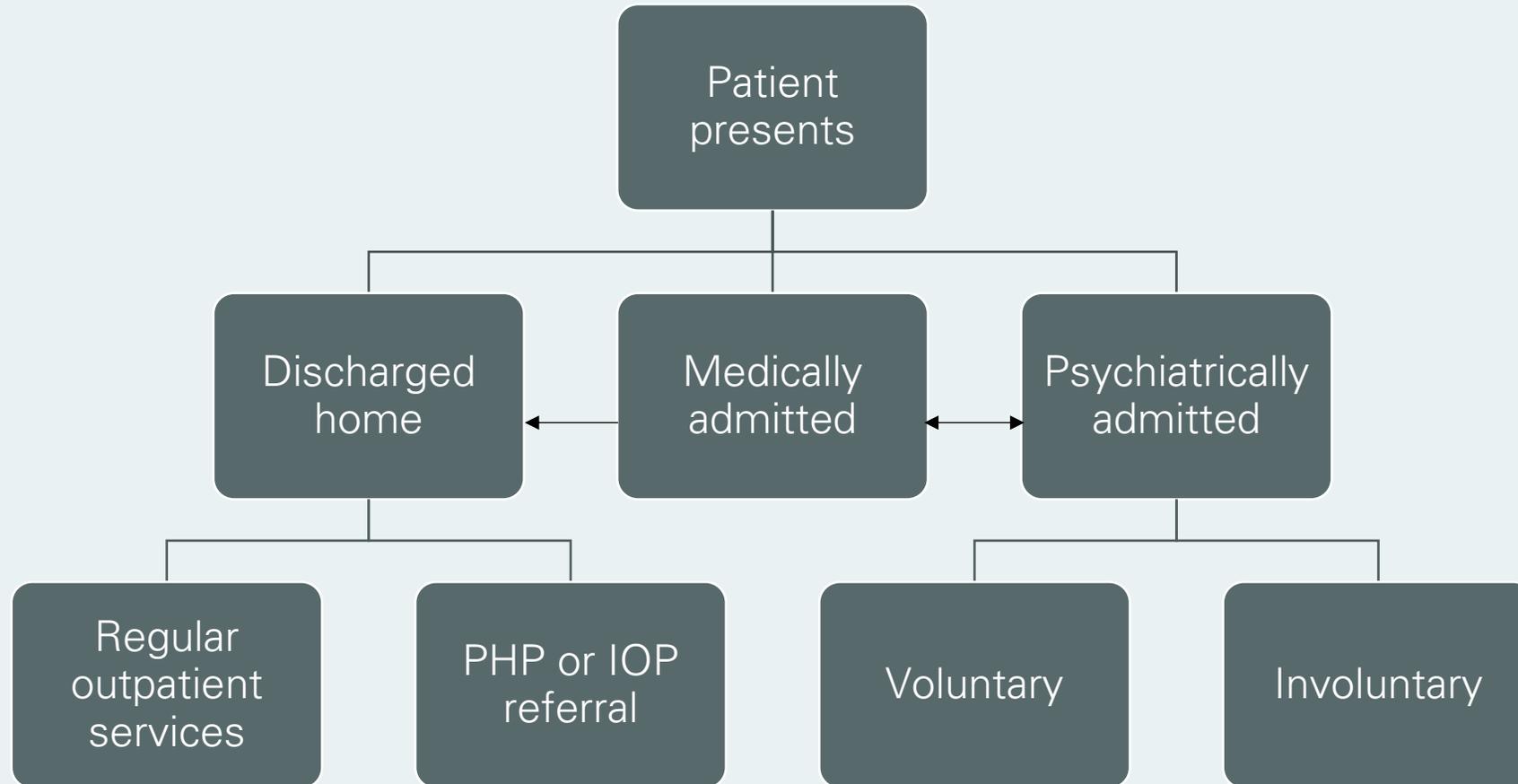
## JCO Recommendation

- Make private spaces ligature resistant

# Addressing modifiable risk factors

- Treat psychiatric disorder/symptoms
- Manage co-morbid symptoms
- Address access to social and community supports
- Address environmental and demographic concerns
- Communicate with relevant team and community members
- Utilization of other relevant consult services
- Referrals for non-psychiatric needs
- Document

# Disposition options



# Deciding on disposition

- Acute, imminent risk = High risk
  - Safety containment, psychiatric admission
- If concerned but unsure
  - Consider containing for further observation, collateral, and safety planning
  - Consider voluntary psychiatric admission
- Resolved crisis/precipitant/acute symptoms, strengthened supports/treatment, no plan/intent = Lower risk
  - Consider discharging with varying levels of increased support
  - “Routine outpatient” likely not enough

# Legal considerations

- Containment
- Special circumstances (e.g. anti-psychotics)
- Malpractice

# Treatment

## Psychopharmacology

- Antidepressants
- Ketamine/esketamine
- Clozapine
- Lithium

## Neuromodulation

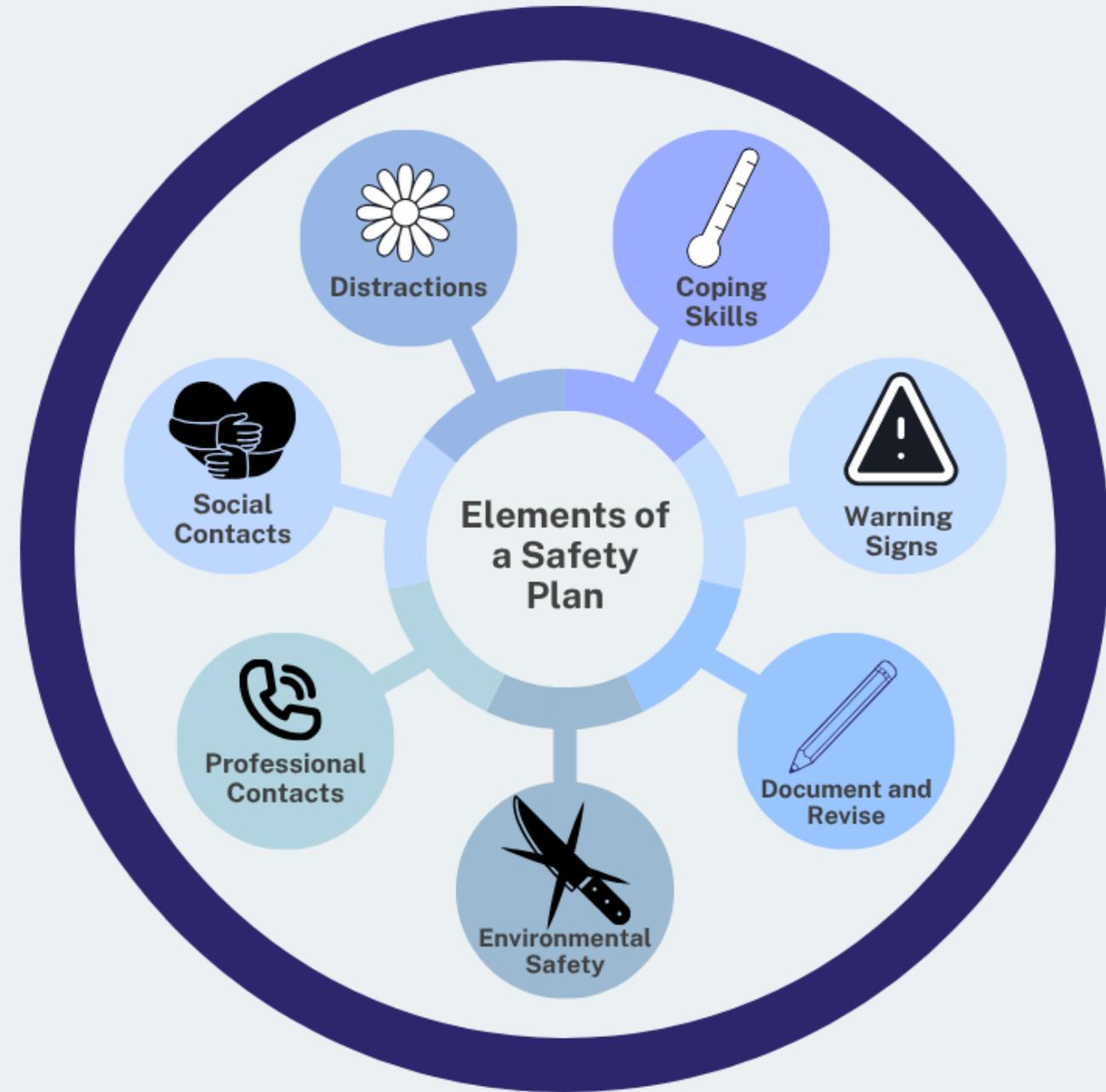
- ECT

## Psychotherapy

- CBT for suicide prevention (CBT-SP)
- Dialectical behavior therapy (DBT)
- Attachment-based family therapy (ABFT)
- Prolonged grief disorder therapy (PGT)

*Note: if discharging from ED with script consider providing small amounts to reduce risk of OD*

# Safety planning



# Resources for safety planning

- Currently available
- Relevant/specific
- Culturally sensitive
- Accessible
- Document
- Share with colleagues

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# Essential elements

- Current SI/SIB/NSSIB, indicating with or without plan/intent
- Past suicide attempts with methods and most recent date
- Prior psychiatric hospitalizations with most recent date
- Risk and protective factors
- Collateral/data
- Determination of level of risk (high, medium, low)
- Disposition plan

# Documentation: Example

Patient is a 66-year-old widowed Caucasian male with a past medical history of diabetes, hypertension, and a past psychiatric history of complicated grief, generalized anxiety disorder, one prior suicide attempt (in 2020 via hanging), and no prior psychiatric hospitalizations who presents reporting passive suicidal ideation with plan to hang self without current intent in the setting of ongoing grief. Patient reports he had intent a week ago, stopped taking his insulin, and thought about buying a rope but stopped when he thought about how his family would react. Reports he has since re-started insulin. Endorses symptoms of helplessness, insomnia, panic attacks, and reduced motivation. Chronic risk factors include chronic medical illnesses, history of mental health, widowed status, male gender, Caucasian race, older age, and prior suicide attempt. Acute risk factors include exacerbation of mental illness, preparatory behaviors, and current passive suicidal ideation with plan. Current protective factors include denial of current intent, supportive family/friends, no history of violence, connection to psychiatrist and therapist (with appointments in two days), grandchildren, help seeking behavior, and spontaneous report of upcoming plans (vacation with friend, work meeting tomorrow). Collateral from patient's brother denies concern for patient harming self or others and indicates he is able to stay with him tonight. Patient is felt to be at elevated risk compared to his baseline given worsening mental health symptoms and passive suicidal thoughts with recent plan/intent, however, is not deemed to be at acute or imminent risk of harm to self or others. Patient is amenable to trialing medication for insomnia and panic attacks as well as to referral to a partial hospitalization program. He reports he feels able to inform family, friends, or his outpatient team, and/or re-present to the emergency room should his suicidal thoughts worsen.

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# An important reminder

"We must be vigilant for signs of burnout and depression within ourselves and among our colleagues, and we must not hesitate to seek help when we recognize something is amiss. Physicians have resilience and self-reliance in abundance, but when we rely on those traits above all others, we put our own well-being and that of our patients and colleagues at risk."

Susan R. Bailey, MD, president (2020-2021), AMA

# Conclusion

- Suicide is a lethal outcome of mental illness
- Risk varies and can be modifiable or non-modifiable
- Outcomes are difficult to predict
- Systematic, but individualized, assessments are critical
- Documentation is key

# Resources and Tools

- [https://www.nimh.nih.gov/sites/default/files/documents/research/research-conducted-at-nimh/asq-toolkit-materials/adult-outpatient/bssa\\_outpatient\\_adult\\_asq\\_nimh\\_toolkit.pdf](https://www.nimh.nih.gov/sites/default/files/documents/research/research-conducted-at-nimh/asq-toolkit-materials/adult-outpatient/bssa_outpatient_adult_asq_nimh_toolkit.pdf)
- [https://www.aap.org/en/patient-care/blueprint-for-youth-suicide-prevention/strategies-for-clinical-settings-for-youth-suicide-prevention/conducting-a-brief-suicide-safety-assessment/?srsltid=AfmBOookD2\\_J5Ws4dpLESLg0owF0qBZlqGNgpjc4B6ek1rhwKovombE0](https://www.aap.org/en/patient-care/blueprint-for-youth-suicide-prevention/strategies-for-clinical-settings-for-youth-suicide-prevention/conducting-a-brief-suicide-safety-assessment/?srsltid=AfmBOookD2_J5Ws4dpLESLg0owF0qBZlqGNgpjc4B6ek1rhwKovombE0)
- <https://ictp.uw.edu/wp-content/uploads/2024/03/Suicide-risk-assessment-and-documentation-8-3-23.pdf>
- <https://swsphn.com.au/wp-content/uploads/2022/02/SWSPHN-Clinical-Suicide-Risk-Assessment-Word-pdf.pdf>
- <https://pmc.ncbi.nlm.nih.gov/articles/PMC3146379/>
- <https://www.mentalhealth.va.gov/docs/va029assessmentguide.pdf>
- [who.int/health-topics/suicide](https://www.who.int/health-topics/suicide)

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