

Suicide Risk Assessment

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Agenda

Terminology

Epidemiology

Clinical assessment

Management

Documentation

Special situations

Terminology

Suicidal Ideation (SI)

- Passive
- Active
- Plan, Intent

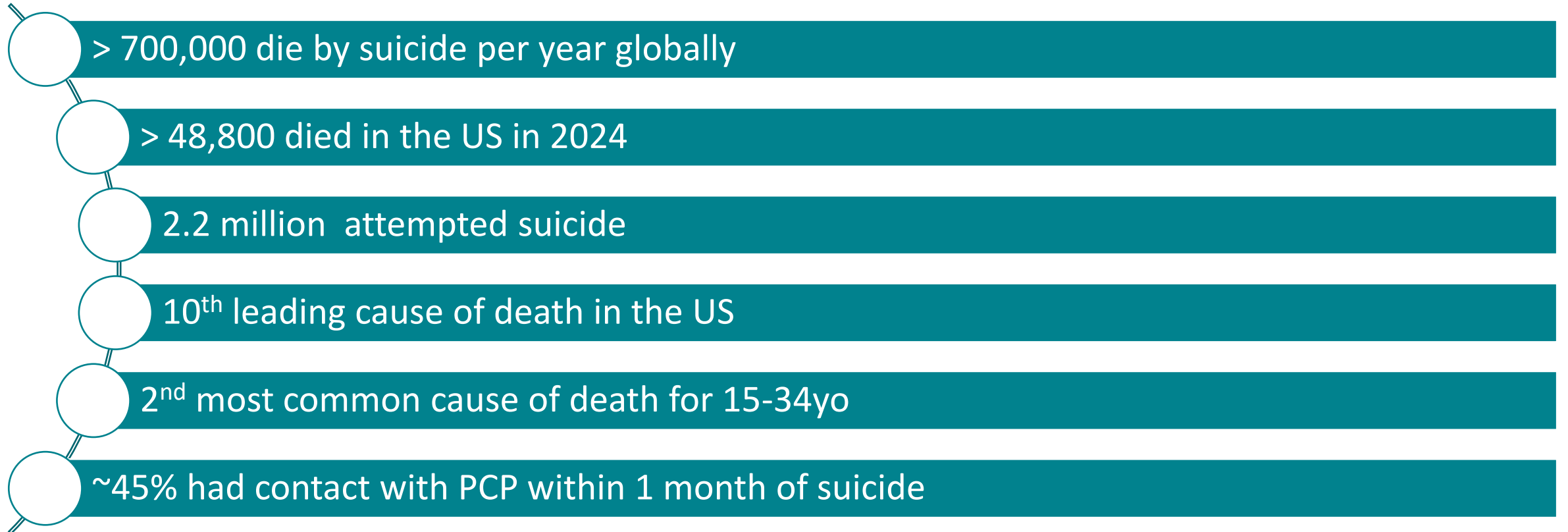
Suicidal Behavior

- Preparatory behavior
- Attempt: aborted/Interrupted, potential injury
- Death by Suicide

Assessing intent

Non-suicidal self-harm or self-injurious behavior (NSSIB)

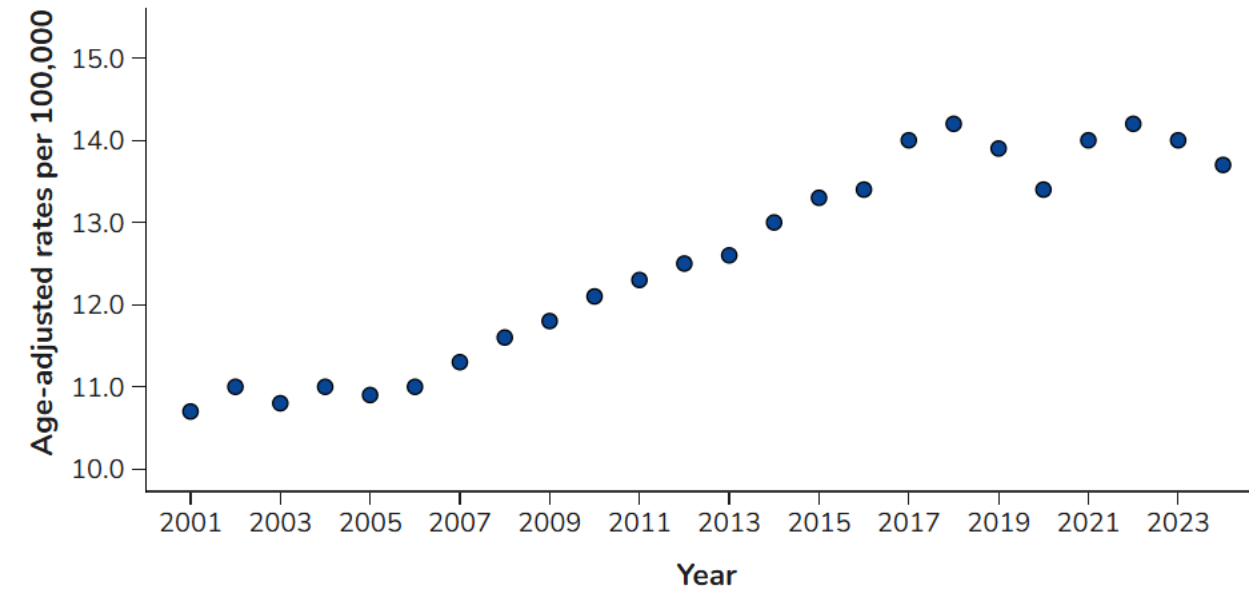
Epidemiology



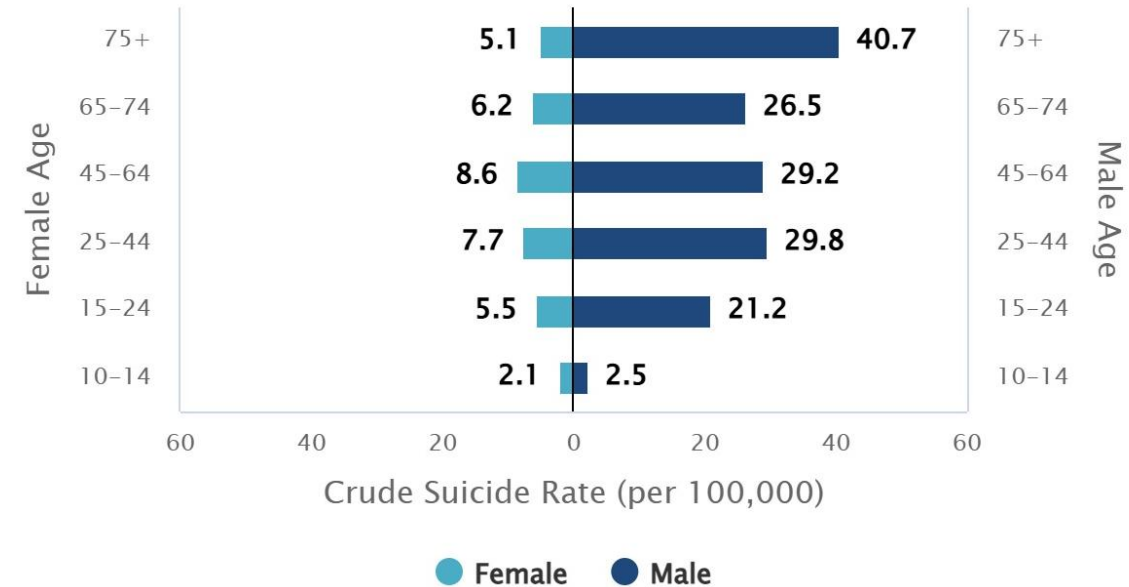
CDC [WISQARS], 2024); (WHO, 2025); SAMHSA; AFSP, 2026

Epidemiology: Trends and Disparities

Suicide trends 2001-2024



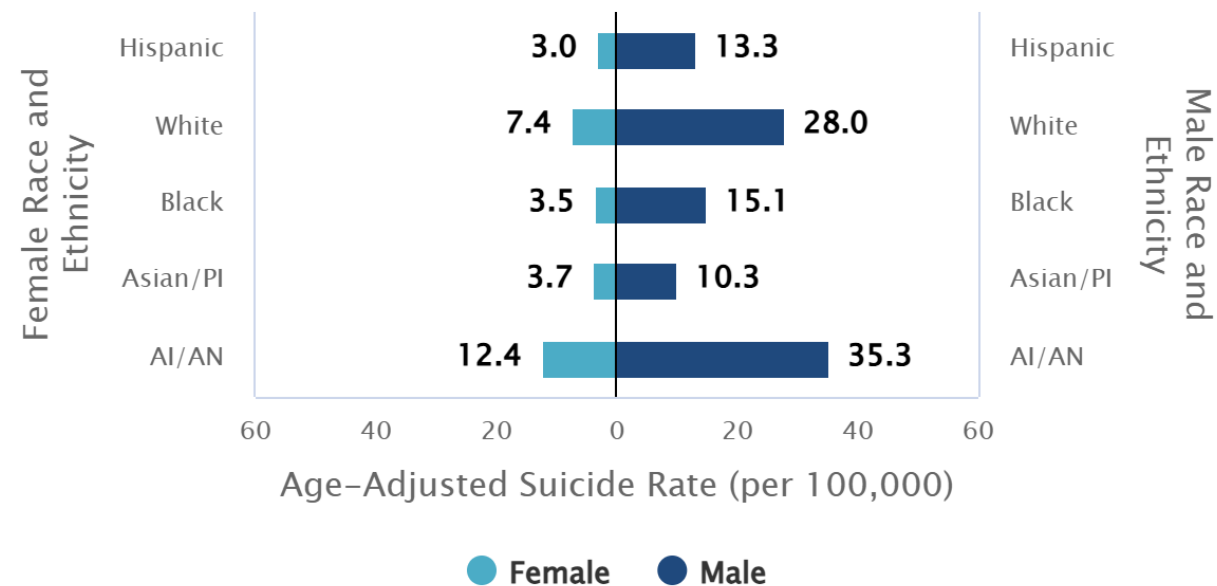
Suicide Rates by Age Group (2023)



Epidemiology: Trends and Disparities

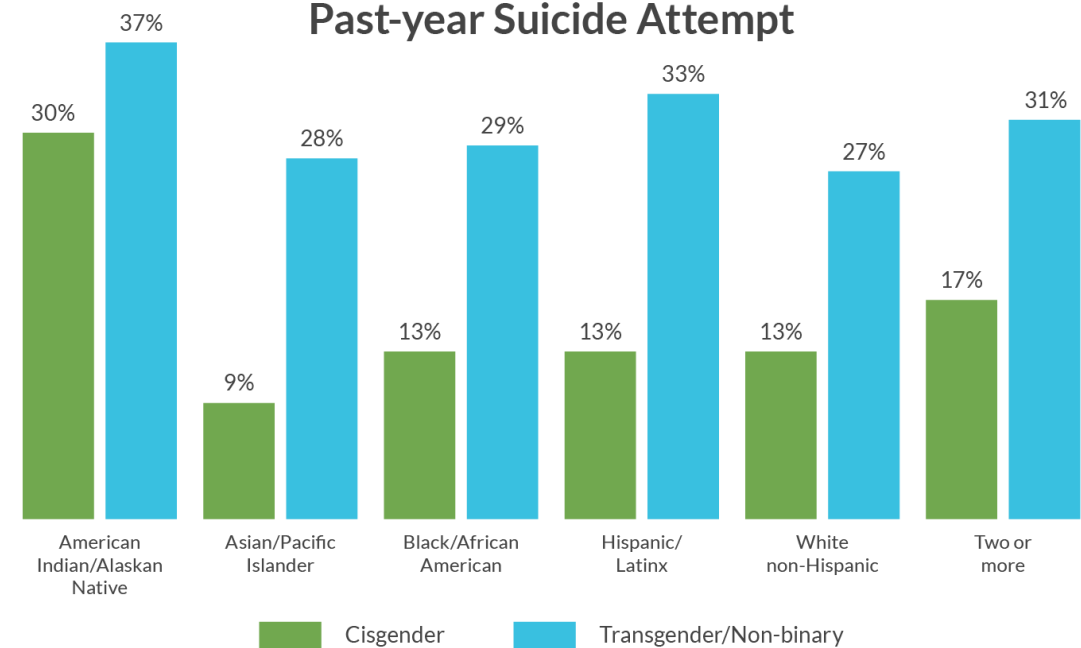
Suicide Rates by Race and Ethnicity (2023)

Data Courtesy of CDC



*Persons of Hispanic origin may be of any race; all other racial and ethnic groups are not
AI/AN = American Indian/Alaskan Native, PI = Pacific Islander

Portion of LGBTQ Youth Who Reported a Past-year Suicide Attempt



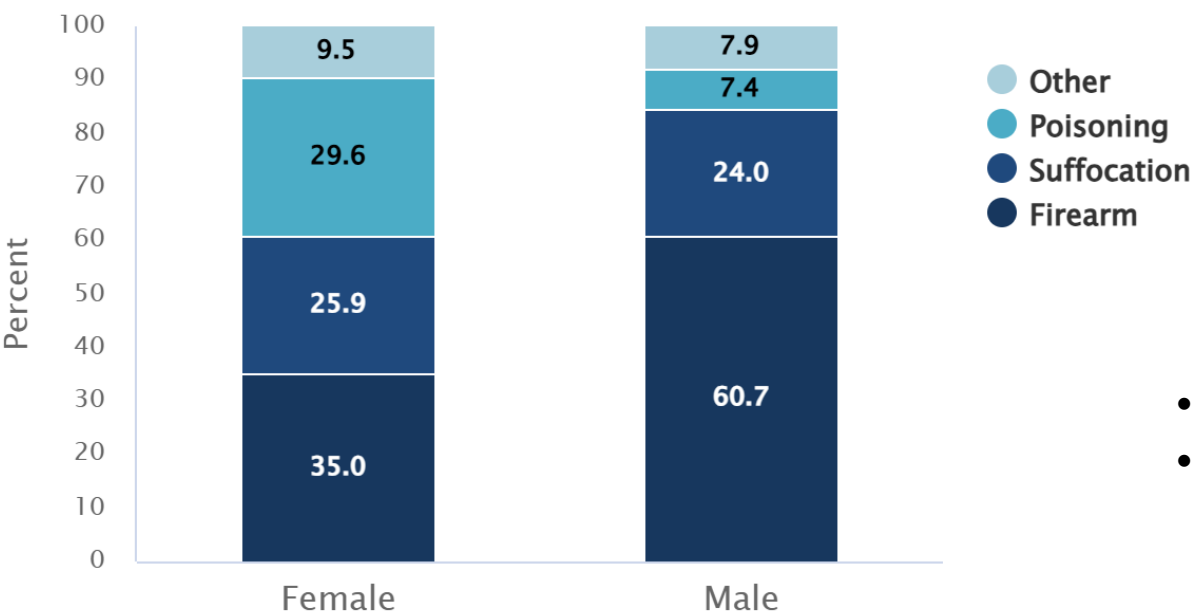
NIMH (CDC data); The Trevor Project (2019)



Suicide Deaths by Method

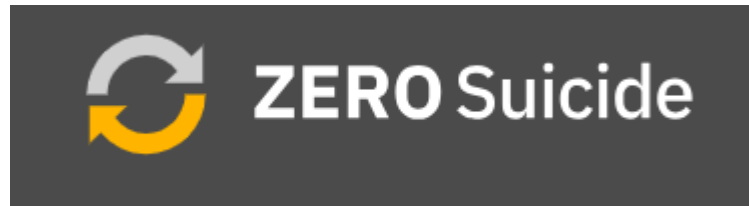
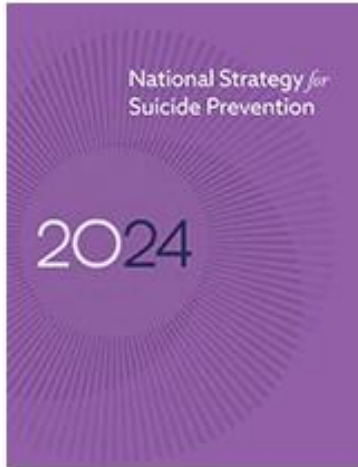
Percentage of Suicide Deaths by Method in the United States
(2023)

Data Courtesy of CDC

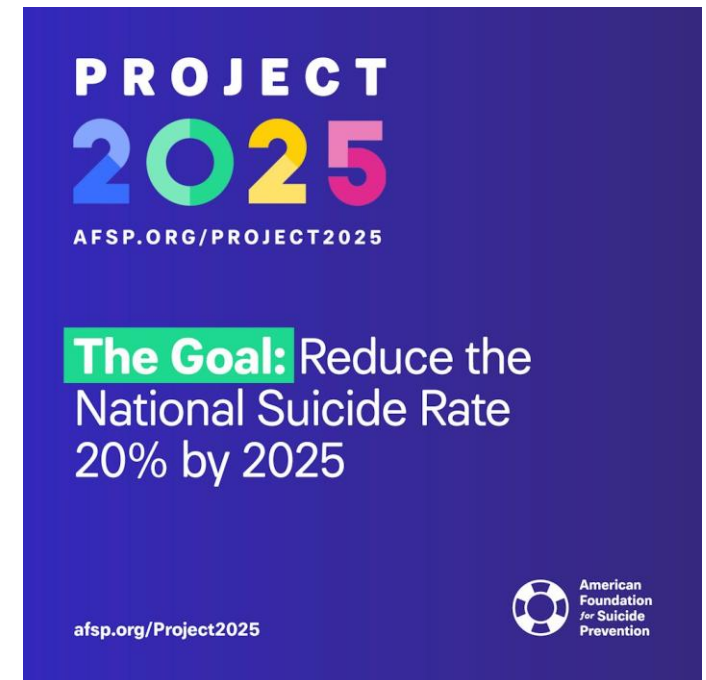


- Firearms are the most common method
- In general, men tend to choose more lethal means

Strategies, goals, and initiatives



- The Joint Commission National Patient Safety Goals



How did we get here?

- Traditional risk factor approaches do not predict suicide risk well
 - Low base-rate event
 - Evaluations consider only a handful of factors at a time (limited interactions)
 - Different groups may have different paths
 - Multiple reviews and meta-analyses – decades of research - risk factors, older prediction models, clinical instruments
 - Very poor positive predictive value
 - Most patients in high risk group will not die by suicide
 - Many deaths occur in low risk groups
 - Assessment is not improving over time
- From risk factors to algorithms: Machine learning
 - Combining self-report, EMR, and clinician evaluation
 - Identifying highest risk groups to focus resources
 - But still in development: navigating disagreement with clinical judgment, ethics, medicolegal concerns
 - **Evolving field!**



Franklin et al., 2017; Large et al., 2016; Carter et al., 2018

We cannot predict suicide: Now what?

Establish baseline

- Identify chronic, static risk factors (often demographics and prior suicide attempts)

Assess for changes from baseline: Where are we now and what happened?

- Identify acute, exacerbating factors; inadequate protective factors?

Look for opportunities to intervene

- Identify modifiable risk factors: create strategy to mitigate risk, which frames decisions regarding treatment and disposition

Be on guard for periods of “imminent risk”

- Know when to intervene promptly and aggressively

Clinical Assessment: The Conversation

- **Set the Stage**
- **Assessing Suicidal Thoughts and Behavior (STB)**
 - Onset: chronic vs. new onset
 - Frequency, duration, intensity: fleeting vs. lingering; stable vs. increasing frequency
 - Ego-syntonic vs. dystonic
 - Method/Plan
 - Intent
 - Lethality
 - Probability of rescue (e.g., rented hotel room)
 - Research
 - Access to means

Beyond Self-Report

Do not depend on explicitly stated suicidal ideation...

- Recall bias
- Fluctuation
- Failure to disclose

What else can we use?

- Concerning recent or current behavior
- Withdrawal from school/work/family/friends
- Incongruent affect, agitation
- Profound hopelessness+ , lack of future plans
- “Warning signs”, Suicidal Crisis Syndrome

Obegi, 2021; Berman et al., 2020; Berman, 2018; Schuck et al., 2019; VA/DoD Clinical Practice Guideline



Collateral: Other Sources of Information

- Information from multiple sources – **limits of confidentiality**
 - Patient
 - Primary team
 - Sleep, PO intake, affect (observation)
 - Current OP providers (especially mental health)
 - Family
 - Chart (including Rx)



Complete the evaluation!

- Psychiatric history, medical history, substance use history, social history, family history, **recent stressors, future-orientation, hopefulness, access to lethal means (firearms, medication stockpiles)**
- Mental status exam
 - Cognitive exam*

Pause...

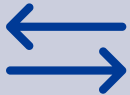


- **Differential**
 - Idiom of distress
 - Unmet needs
 - Delirium
 - Acute intoxication
 - Misunderstanding (language, culture)

Risk Factors



Chronic vs acute



Static vs (potentially) modifiable



“warning signs”

Risk Factors

- Demographics: older age, male
- Medical history: especially new diagnoses of chronic or terminal illness, loss of autonomy
- Family history of suicide, early parental separation
- Developmental/history of trauma
- Past psychiatric history: prior suicide attempts, recent psychiatric hospital discharge, mental health conditions (affective disorder, psychosis, substance use)
- Social factors: relationship/marital status, housing, financial challenges, lack of employment
- Recent significant losses
- Uncontrolled pain, insomnia, restlessness, hopelessness, substance use, access to lethal means

Favril et al., 2022; Fazel and Runeson, 2020; Brendel et al., 2018; VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide, 2024



Protective Factors

- Problem solving
- Effective coping
- Social support
- Marital/relationship status
- Responsibility for family, pets
- Sense of connectedness
- Engagement in school, work
- Sense of purpose
- Future-orientation
- Restricted access to lethal means
- Access to treatment and willingness to engage

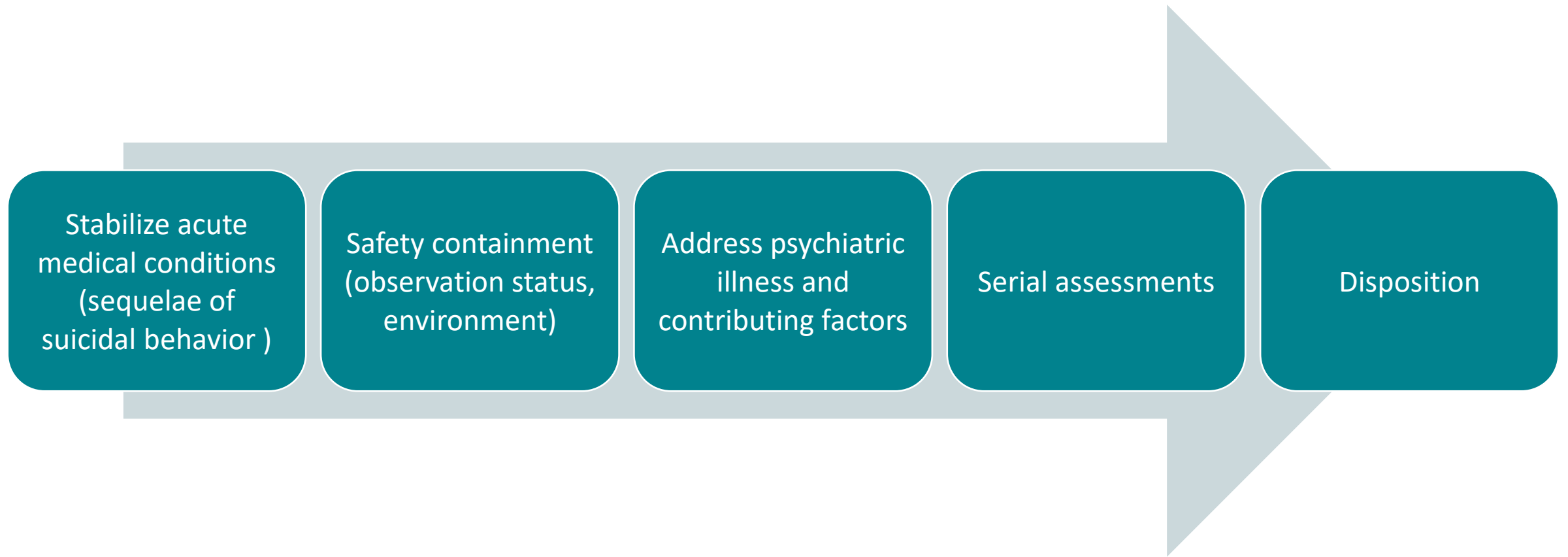


44yoF in the ED with SI, almost took a bottle of Tylenol. Please help!

Case 1: 44yo partnered, employed woman with a history of Borderline Personality Disorder and PTSD, currently seeing psychiatrist, long-standing therapist, and just started working with a new trauma therapist. Has had suicidal ideation x 10+ years, usually centered on overdosing on over-the-counter medications; sometimes takes them out and looks at them (maybe x1/month). Has had four prior suicidal attempts via overdose; two required medical admission of < 24 hours each. She came in for nausea/vomiting and disclosed an episode of staring at a Tylenol bottle two nights ago. Agrees to have partner dispose of the bottle; outpatient mental health providers not concerned and will follow up tomorrow.

Case 2: 44yo woman, with a history of Major Depressive Disorder, and no prior suicide attempts; recently started divorce proceedings and was asked to take a leave of absence from her job last week. Partner moved out; patient has not left the house for a week; unable to sleep and feels restless. Came to the ED today due to insomnia and nausea; then disclosed ordering a few bottles of vodka and a bottle of Tylenol, after “looking stuff up” online two nights ago; now says “for a headache”. No current mental health providers. No one to provide collateral; patient lives alone and has no close friends/family.

Risk Management



In-hospital safety and prevention

Aggressively manage distressing symptoms: insomnia, pain, anxiety, agitation, psychosis

Trauma-informed care

Clear and consistent communication with inpatient and outpatient teams; and -- per patient preference – family/friends

Enlist hospital supports: social work, spiritual care, OT, psychology

Ensure safety:

- Observation status
- Room environment: remove cords, IV poles, cleaning supplies, unnecessary furniture, plastic bags
- Caution with other items provided: safe meal trays only, no aluminum cans, no batteries/paper clips, no sharps
- Open windows, stairwells, ligature points
- Patient belongings

Risk Management: Focus on Modifiable Risk Factors

- Lethal means counseling
- Crisis resources
- Address substance use
- Treat pain, insomnia, co-morbid medical conditions
- Housing and food insecurity
- Access to primary care
- Safety planning
- Address psychiatric illness:
 - Level of care needed? Barriers to moving forward?
 - Is the patient medically admitted? In the ICU?
 - Can you start/adjust psychiatric treatment now?



Treatment

- Treat underlying mood disorder or acute distress
- Lithium
- Clozapine
- Ketamine/esketamine
- Antidepressants*
 - SSRI
- Neuromodulation

Disposition

Home with follow-up

PCP

Established mental health provider

Referral for walk-in care

Post-ED check-in

Partial Hospitalization Program (PHP)/PHP+

Intensive Outpatient Program

Community Crisis Stabilization (CCS)/Crisis
Stabilization Unit (CSU)

Inpatient Psychiatric Hospitalization

Voluntary

Involuntary

Impact of involuntary psychiatric hospitalization?

Admission for medical stabilization (e.g., post suicide
attempt)

Follow while admitted; serial assessments

Beyond “risk level → disposition”

What can we do as a health system for this patient

Documentation: timely and clear

- Formulation and risk profile: structured and narrative
 - What is the baseline: chronic/static risk factors
 - What is exacerbating risk: acute and potentially modifiable
 - Any protective factors?
 - What else can you do to mitigate risk?
 - Required to include a risk level
- Document patient interview and relevant observed/reported behavior
 - *Called work to request LOA paperwork from HR, made appointment with PCP vs episodic agitation*
- Explain reasoning and decision-making – including disposition
- Safety plan
- **Lethal means counseling and outcome**
 - *Brother will take ownership of firearm*
- Ensure follow-up
 - *PCP, post-ED SW phone call, family will check in*
- Involve family (with patient permission)
- **Crisis resources**

Special Situations

Survivors of serious suicide attempts

- Recollection of attempt
- Disposition

Intoxication

Altered Mental Status/Delirium

End of Life Care

Code Status

Take-home points



Suicide is a public health crisis



Risk assessment is crucial and expected



Assessment $\neq$ Prediction



Risk factors help us build an individual, multidimensional, dynamic profile



Consider a patient's baseline, acute changes, and potential to mitigate risk in creating a treatment and disposition plan



Assessment should be actionable



Document!

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