# Suicide Risk Assessment and Management with Role Play

**Joshna Singh, M.D**
Assistant Professor of Clinical Psychiatry, Jacobs School of Medicine and Biomedical Sciences, University at Buffalo

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# Disclosures

"Neither I nor my spouse/partner has a relevant financial relationship with a commercial interest to disclose."

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# Learning Objectives

- Conduct systematic suicide risk assessment in perinatal patients who screen positive for suicidal ideation using direct questioning to evaluate frequency, timing, intent, plan, preparatory behaviors, prior attempts, current thoughts, and protective factors in a clinically empathic manner.
- Stratify suicide risk level to distinguish low-risk patients from moderate-risk patients.
- Implement safety planning and treatment linkage for perinatal patients with suicidal ideation.

# Risk

- Perinatal suicide rates ≈1.6 to 4.5 per 100,000 live births

  (5.3 - 5.5 in non perinatal women)
- Completed suicide account for ≈ 20% of post partum deaths
- Prevalence of suicidal ideation ≈ 16.4% from early pregnancy to 6 weeks postpartum (12.1 percent in pregnancy, 7.8 % postpartum)
- Rates of attempted or completed suicide  are lower in peripartum
- Subgroups at elevated risk: severe psychiatric illness, young age
- More likely to use more lethal or violent means
- Maternal suicide often occur later in post partum period (6 months)

*Ref: Chin et al 2022, Lindhal et al 2005,Grigoriadias et al 2017,Thortonet al 2013, Xiao et al 2023*

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# Suicide and Psychiatric Illness

Suicide risk ≈ 300 times higher with postpartum psychiatric illness
Incident rate of suicidal behavior  5.62 /1000 person /year in PND
Suicidal behavior risk is 3 times higher in women with PND
Risk remains doubled 5 or more years later
No data for risk of suicide in bipolar d/o and  postpartum psychosis
Most women who die by suicide have affective or anxiety d/o
Less likely in any pharmacological or nonpharmacological treatment

***ref: Hang Yu et al 2024,Johannsen et al 2016,khalief 2016***

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# Risk Factors

| Individual | Pregnancy related | Socioeconomic |
|---|---|---|
| H/O of self harm or prior suicide attempts | Obstetrical or neonatal complications | Younger age |
| Prior or current psychiatric illness/substance use | Unwanted or unintended pregnancy | Intimate partner violence |
| H/O of trauma | Avoidance of health services from fear of losing custody | Lack of social support, |
| F/H of psychiatric illness, suicide ideations, suicide attempt | | Social, racial gender discrimination, inequalities |

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# Protective Factors

| Social Support; Belongingness | Strong Therapeutic Relationship with a Trusted Provider |
|---|---|
| Life Satisfaction | Problem-Solving Skills, Cognitive Flexibility |
| Sense of responsibility to family | Reality Testing Ability |
| Coping Skills | Religious Faith |

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# Don’t Ask, Don’t Tell, Don't Know

- Fear of increasing suicidal ideation
- Make patient uncomfortable
- Practitioner’s confidence/ comfort
- Inadequate expertise/ training
- Insufficient time
- Bias
- More likely to enquire if patient was depressed

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# Differential Diagnosis

- Postpartum Psychosis
- Ego-dystonic intrusive thoughts
- Nonsuicidal self injury
- Passive suicidal ideation

# ACOG Guidelines for Screening

- Screen for perinatal depression and anxiety at the initial prenatal visit, later in pregnancy, and postpartum.
- Assess suicidal thoughts using EPDS item 10 or PHQ-9 item 9
- Any positive response requires immediate suicide risk assessment.
- Evaluate suicidal intent, plan, access to means, and severity of risk.
- Implement risk-tailored management and appropriate follow-up.

*Ref: ACOG Clinical Practice Guidelines No. 4 2023*

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# Suicide Risk Assessment

- There are a lot of tools available to help guide the conversation
- Both the PHQ-9 and the EPDS include questions which can identify the presence of suicidal ideations, but need follow up
- P4 screener
- Ask Suicide Screening Questions (ASQ)
- Columbia Suicide Severity Rating Scale (CSSRS)

# P4 Suicidality Screener

**P4 Suicidality Screener ***

**Have you had thoughts of actually hurting yourself?**

NO YES

**Four Screening Questions** ←

1. **Have you ever attempted to harm yourself in the past?**

   **NO** **YES**

2. **Have you thought about how you might actually hurt yourself?**

   **NO** **YES** → [How? _____]

3. **There's a big difference between having a thought and acting on a thought. How likely do you think it is that you will act on these thoughts about hurting yourself or ending your life some time over the next month?"**

   a. **Not at all likely** _____
   b. **Somewhat likely** _____
   c. **Very likely** _____

4. **Is there anything that would prevent or keep you from harming yourself?**

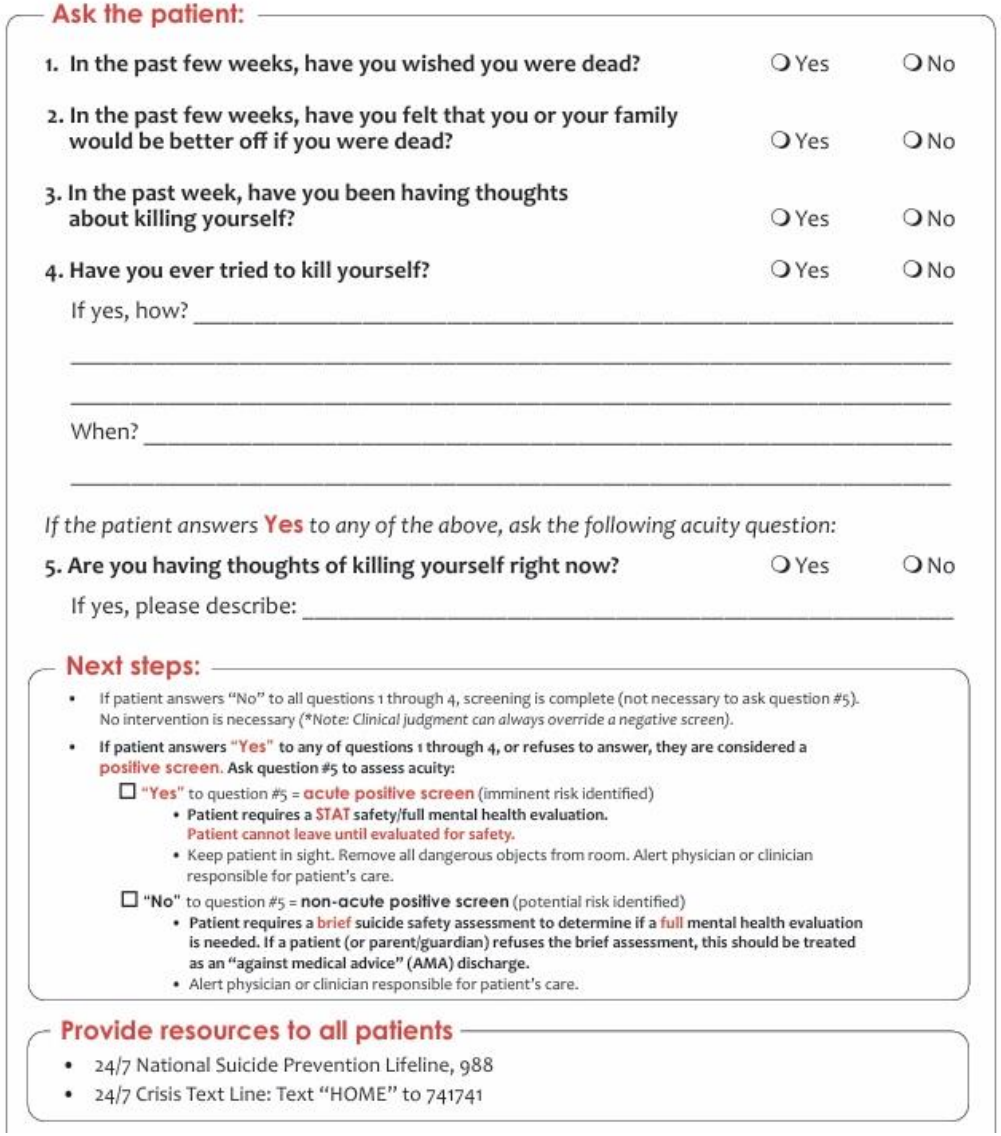
   **NO** **YES** → [What? _____]

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| Risk Category | Shaded ("Risk") Response | |
|---|---|---|
| | **Items 1 and 2** | **Items 3 and 4** |
| Minimal | Neither is shaded | Neither is shaded |
| Lower | At least one item is shaded | Neither is shaded |
| Higher | | At least one item is shaded |

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# ASQ Screening Tool



**Ask the patient:**

1. **In the past few weeks, have you wished you were dead?** ❍ Yes ❍ No
2. **In the past few weeks, have you felt that you or your family would be better off if you were dead?** ❍ Yes ❍ No
3. **In the past week, have you been having thoughts about killing yourself?** ❍ Yes ❍ No
4. **Have you ever tried to kill yourself?** ❍ Yes ❍ No

   If yes, how? _____

   _____

   _____

   When? _____

   _____

*If the patient answers **Yes** to any of the above, ask the following acuity question:*

5. **Are you having thoughts of killing yourself right now?** ❍ Yes ❍ No

   If yes, please describe: _____

**Next steps:**

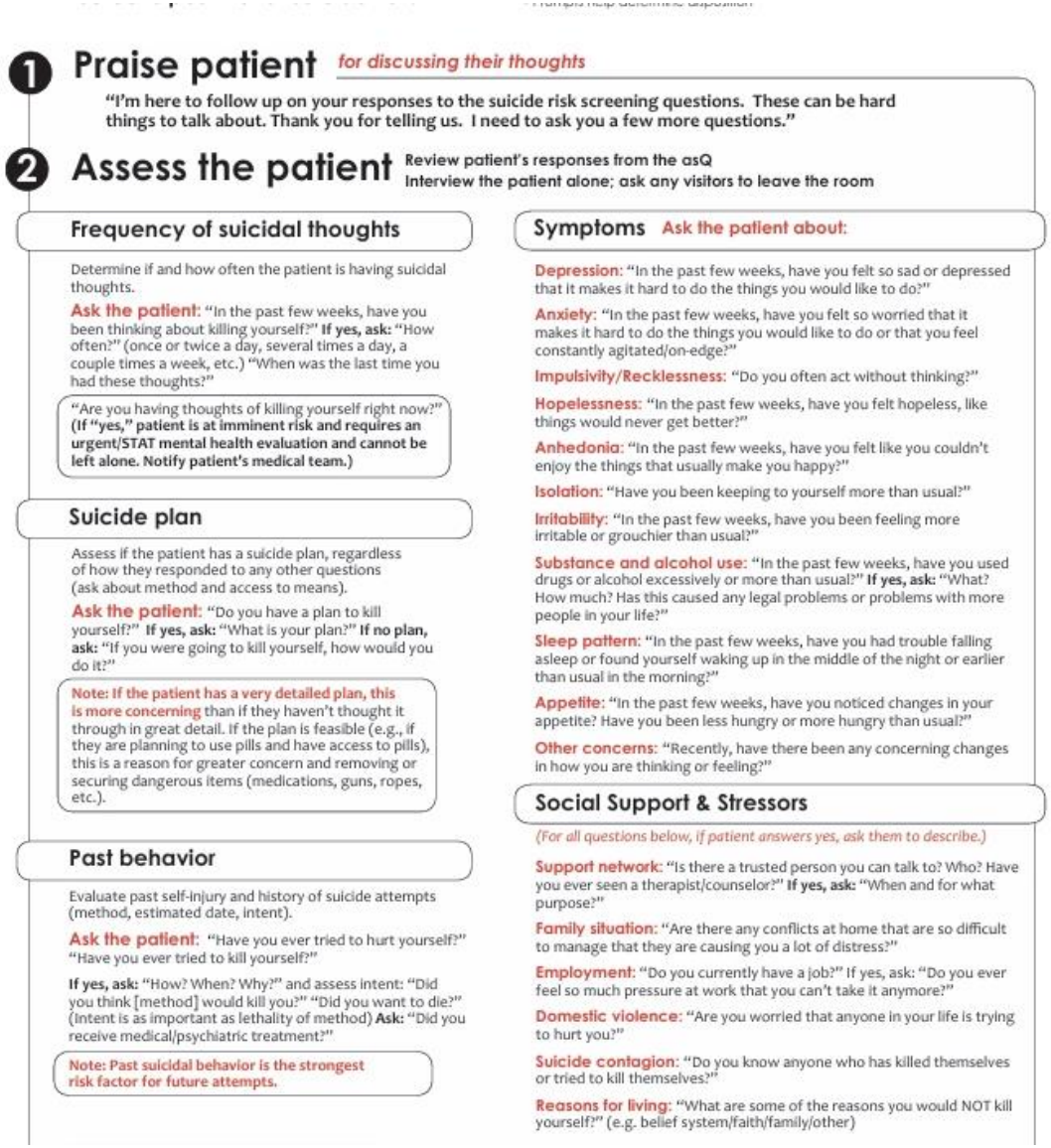
- If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary *(*Note: Clinical judgment can always override a negative screen).*
- **If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity:**
  - ☐ "Yes" to question #5 = **acute positive screen** (imminent risk identified)
    - **Patient requires a STAT safety/full mental health evaluation. Patient cannot leave until evaluated for safety.**
    - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.
  - ☐ "No" to question #5 = **non-acute positive screen** (potential risk identified)
    - **Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. If a patient (or parent/guardian) refuses the brief assessment, this should be treated as an "against medical advice" (AMA) discharge.**
    - Alert physician or clinician responsible for patient's care.

**Provide resources to all patients**

- 24/7 National Suicide Prevention Lifeline, 988
- 24/7 Crisis Text Line: Text "HOME" to 741741

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# ASQ Brief Suicide Assessment



## 1 Praise patient *for discussing their thoughts*

**"I'm here to follow up on your responses to the suicide risk screening questions. These can be hard things to talk about. Thank you for telling us. I need to ask you a few more questions."**

## 2 Assess the patient

**Review patient's responses from the asQ**
**Interview the patient alone; ask any visitors to leave the room**

### Frequency of suicidal thoughts

Determine if and how often the patient is having suicidal thoughts.

**Ask the patient:** "In the past few weeks, have you been thinking about killing yourself?" **If yes, ask:** "How often?" (once or twice a day, several times a day, a couple times a week, etc.) "When was the last time you had these thoughts?"

"Are you having thoughts of killing yourself right now?" **(If "yes," patient is at imminent risk and requires an urgent/STAT mental health evaluation and cannot be left alone. Notify patient's medical team.)**

### Suicide plan

Assess if the patient has a suicide plan, regardless of how they responded to any other questions (ask about method and access to means).

**Ask the patient:** "Do you have a plan to kill yourself?" **If yes, ask:** "What is your plan?" **If no plan, ask:** "If you were going to kill yourself, how would you do it?"

**Note: If the patient has a very detailed plan, this is more concerning** than if they haven't thought it through in great detail. If the plan is feasible (e.g., if they are planning to use pills and have access to pills), this is a reason for greater concern and removing or securing dangerous items (medications, guns, ropes, etc.).

### Past behavior

Evaluate past self-injury and history of suicide attempts (method, estimated date, intent).

**Ask the patient:** "Have you ever tried to hurt yourself?" "Have you ever tried to kill yourself?"

**If yes, ask:** "How? When? Why?" and assess intent: "Did you think [method] would kill you?" "Did you want to die?" (Intent is as important as lethality of method) **Ask:** "Did you receive medical/psychiatric treatment?"

**Note: Past suicidal behavior is the strongest risk factor for future attempts.**

### Symptoms *Ask the patient about:*

**Depression:** "In the past few weeks, have you felt so sad or depressed that it makes it hard to do the things you would like to do?"

**Anxiety:** "In the past few weeks, have you felt so worried that it makes it hard to do the things you would like to do or that you feel constantly agitated/on-edge?"

**Impulsivity/Recklessness:** "Do you often act without thinking?"

**Hopelessness:** "In the past few weeks, have you felt hopeless, like things would never get better?"

**Anhedonia:** "In the past few weeks, have you felt like you couldn't enjoy the things that usually make you happy?"

**Isolation:** "Have you been keeping to yourself more than usual?"

**Irritability:** "In the past few weeks, have you been feeling more irritable or grouchier than usual?"

**Substance and alcohol use:** "In the past few weeks, have you used drugs or alcohol excessively or more than usual?" **If yes, ask:** "What? How much? Has this caused any legal problems or problems with more people in your life?"

**Sleep pattern:** "In the past few weeks, have you had trouble falling asleep or found yourself waking up in the middle of the night or earlier than usual in the morning?"

**Appetite:** "In the past few weeks, have you noticed changes in your appetite? Have you been less hungry or more hungry than usual?"

**Other concerns:** "Recently, have there been any concerning changes in how you are thinking or feeling?"

### Social Support & Stressors

*(For all questions below, if patient answers yes, ask them to describe.)*

**Support network:** "Is there a trusted person you can talk to? Who? Have you ever seen a therapist/counselor?" **If yes, ask:** "When and for what purpose?"

**Family situation:** "Are there any conflicts at home that are so difficult to manage that they are causing you a lot of distress?"

**Employment:** "Do you currently have a job?" If yes, ask: "Do you ever feel so much pressure at work that you can't take it anymore?"

**Domestic violence:** "Are you worried that anyone in your life is trying to hurt you?"

**Suicide contagion:** "Do you know anyone who has killed themselves or tried to kill themselves?"

**Reasons for living:** "What are some of the reasons you would NOT kill yourself?" (e.g. belief system/faith/family/other)

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# ASQ Brief Suicide Assessment

## 3 Make a safety plan with the patient

Create a safety plan for managing potential future suicidal thoughts. A safety plan is different than making a "safety contract"; asking the patient to contract for safety is NOT effective and may be dangerous or give a false sense of security.

**Say to patient:** "Our first priority is keeping you safe. Let's work together to develop a safety plan for when you are having thoughts of suicide."

Examples: "I will tell my partner/friend/sibling." "I will call the hotline." "I will call _____."

Discuss coping strategies to manage stress (such as journal writing, distraction, exercise, self-soothing techniques).

**Discuss means restriction** (securing or removing lethal means): "Research has shown that limiting access to dangerous objects saves lives. How will you secure or remove these potentially dangerous items (guns, medications, ropes, etc.)?"

**Ask safety question:** "Do you think you need help to keep yourself safe?" (A "no" response does not indicate that the patient is safe; but a "yes" is a reason to act immediately to ensure safety.)

## 4 Determine disposition

After completing the assessment, choose the appropriate disposition plan. *If possible, nurse should follow-up with a check-in phone call (within 48 hours) with all patients who screened positive.*

- ❑ **Emergency psychiatric evaluation:** **Patient is at imminent risk for suicide (current suicidal thoughts).** Send to emergency department for extensive mental health evaluation (unless contact with a patient's current mental health provider is possible and alternative safety plan for imminent risk is established).
- ❑ **Further evaluation of risk is necessary:** Review the safety plan and send home with a mental health referral as soon as patient can get an appointment (preferably within 72 hours).
- ❑ **Patient might benefit from non-urgent mental health follow-up:** Review the safety plan and send home with a mental health referral.
- ❑ **No further intervention is necessary at this time.**

*For all positive screens, follow up with patient at next appointment.*

## 5 Provide resources to all patients

- **24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454**
- **24/7 Crisis Text Line: Text "HOME" to 741-741**

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# Columbia Suicide Severity Rating Scale

| 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.<br>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?<br>*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.<br>**If yes, was this within the past 3 months?** | | **High Risk** |

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# Assessing Risk to Infant

Intrusive thoughts about harm coming to baby are common

- Have you had any intrusive or unwanted thoughts?
- Have you had any thoughts of harm coming to your baby?
- Do you ever worry or think about harming the baby yourself?

If yes to any of the above questions, ask:

How often?

When did you last experience these thoughts?

How scary and/or worrisome are the thoughts?

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*Ref: MCPAP for Moms 2021*

# Management

**Imminent Risk: Seek a higher level of care**

This is appropriate whenever a patient is assessed to at imminent risk of harm, or is unable/unwilling to engage in safety planning

**Mild to Moderate Risk**

- Monitor and re-assess
- Safety Plan
- Treatment of underlying psychiatric illness
- Linkage to therapy
- Optimize social supports

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# What We Would Like To Know

- Current suicidal thoughts(nature, timing, intent)
- Current suicidal plan (access to means, details, preparation )
- Current treatment (accessibility to treatment, current
- Previous attempt (timing, intent, method, consequences)
- Current substance abuse
- Current psychiatric diagnosis and severity of symptoms
- Current medications
- Ongoing substance use
- Current stressors and social supports
- Impulsivity
- Protective factors
- Collateral information

# Safety Planning: Suicide Risk is Dynamic

- Steps to limit access to lethal means
- List of concrete warning signs of a developing crisis
- Available coping strategies the patient can utilize
- Social supports patient can reach out to
- Professional contacts and crisis resources

# Patient Safety Plan Template

**Step 1:** Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____
2. _____
3. _____

**Step 2:** Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. _____
2. _____
3. _____

**Step 3:** People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____ 4. Place_____

**Step 4:** People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

**Step 5:** Professionals or agencies I can contact during a crisis:

1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
3. Local Urgent Care Services_____
   Urgent Care Services Address_____
   Urgent Care Services Phone_____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

**Step 6:** Making the environment safe:

1. _____
2. _____

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The one thing that is most important to me and worth living for is:

_____

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# Suicide Risk Assessment

- Remember that asking about SI does not increase the risk of suicide attempts or “give people ideas”
- Normalize the process: the more uncomfortable you appear, the less forthcoming your patient is likely to be
- Don’t assume a negative response and don’t use vague language/euphemisms
- Follow up and be thorough – adequate risk assessment (and management) requires details

# Suicide Risk Resources

- 988 Suicide and Crisis Lifeline
- https://projectteachny.org/maternal-rating-scales/
- Home - Suicide Prévention Center NY (preventsuicideny.org)
- Alliance of Hope For Suicide Loss Survivors | Home

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