



# Assessing Threats of Self- Harm

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# Disclosures

We do not have any financial relationships with ineligible companies to disclose.

# Learning Objectives

1. Enhance participants ability to identify and assess self-harm risk in patients.
2. Practice effective communication strategies for discussing sensitive issues related to self-harm.
3. Develop a structured approach for documenting and managing self-harm risk.

# Definitions

**Self-Harm:** Self-harm, also known as self-injury, refers to the deliberate, self-inflicted damage of one's own body tissue without suicidal intent. This behavior is typically a coping mechanism to manage emotional pain, stress, or frustration. Common methods of self-harm include cutting, burning, or hitting oneself. (Klonsky, E. D. 2007)

**Suicidal Thoughts:** Suicidal thoughts, or suicidal ideation, involve thinking about, considering, or planning taking one's life. These thoughts can range from fleeting considerations to detailed planning. Suicidal ideation is a serious symptom that requires prompt mental health intervention, as it indicates a risk for potential suicide attempts. (Nock et al 2008).

A man in a light blue suit and glasses is sitting at a desk, looking down at a laptop screen. The background is a solid blue color. The word "Case" is written in large, bold, black letters to the right of the man.

# Case

- **Patient Information:**

- **Name:** John Doe
- **Age:** 35
- **Gender:** Male
- **Occupation:** Software Engineer
- **Marital Status:** Married
- **Children:** Two

- **Presenting Problem:**

- **Primary Complaint:** Low motivation and overall sense of fatigue.

# John Doe

## Patient's Statements During Visit:

- "I've been feeling really tired and unmotivated for about six months now."
- "Work is going well, and I'm performing at a high level, but I just feel drained all the time."
- "I love my family, but sometimes I feel like I'm just going through the motions."
- "It's hard to find joy in anything these days; everything feels kind of pointless."
- "I don't think I'm a burden, but I do wonder if everyone would be better off without me sometimes."
- "I'm scared to tell my wife how I'm really feeling because I don't want to worry her."



## **Mental Status Examination:**

- **Appearance:** Well-groomed, appropriately dressed.
- **Behavior:** Cooperative, maintains eye contact.
- **Mood:** Describes mood as "numb" and "hopeless."
- **Affect:** Restricted, tearful at times.
- **Thought Process:** Logical, goal-directed.

- **Thought Content:** Passive suicidal ideation without a concrete plan or intent.

- **Insight:** Good; understands the severity of his feelings.

- **Judgment:** Intact; seeks help voluntarily.



**Are you worried  
about John Doe?**



# Warning signs for identifying self-harm and suicidal behavior

# Common fears of primary care providers

1. **Missing Warning Signs:** worry about not recognizing the subtle signs of suicidal ideation or self-harm, which can sometimes be masked by other medical or psychological issues.
2. **Inadequate Training:** Many PCPs feel they lack sufficient training in mental health, particularly in assessing and managing suicidal patients, which can lead to feelings of inadequacy and fear of not providing appropriate care.
3. **Liability and Legal Concerns:** There is an ongoing fear of legal repercussions if a patient were to harm themselves after a visit, even if the physician followed all standard protocols.
4. **Time Constraints:** Primary care appointments are often brief, and PCPs may fear not having enough time to thoroughly assess a patient's mental health, especially if the patient is presenting with multiple issues.
5. **Referral Challenges:** PCPs often worry about the availability and accessibility of mental health specialists for referral. Long wait times or lack of mental health services can delay necessary care.
6. **Patient Non-Disclosure:** There is a fear that patients might not disclose their true feelings or intentions, either due to stigma, lack of trust, or fear of being hospitalized, making it difficult for the physician to assess the risk accurately.
7. **Emotional Impact:** Dealing with patients who are at risk of self-harm or suicide can be emotionally taxing for PCPs. They may fear the emotional toll it takes on them, including feelings of guilt or helplessness if an adverse event occurs.
8. **Follow-Up and Continuity of Care:** Ensuring that patients at risk receive continuous and consistent care can be challenging. PCPs may fear that patients will not follow through with recommended treatments or follow-up appointments.
9. **Communication Barriers:** Effective communication is crucial, and PCPs may fear that language barriers, cultural differences, or lack of rapport can hinder the ability to accurately assess and address suicidal risk.
10. **Resource Limitations:** In some settings, there may be limited resources for mental health support, such as crisis intervention teams or inpatient psychiatric beds, which can hinder the ability to provide immediate and effective care.

# Warning signs for self-harm

## Self Harm

- **Physical Signs**
  - Wearing long sleeves or pants in hot weather
  - Refusing to get changed in front of other people, for example, for PE or in changing rooms
  - Cuts, bruises, scratches or burn marks, sudden bald spots
  - Keeping sharp objects on hand
  - Exercising excessively
  - Frequent accidents
- **Emotional and Behavioral Signs:**
  - **Isolation:** Withdrawal from friends, family, and social activities.
  - **Mood Swings:** Noticeable changes in mood, such as increased irritability, sadness, or anger.
  - **Depression Symptoms:** Persistent feelings of hopelessness, worthlessness, or sadness.
  - **Low Self-Esteem:** Expressing feelings of failure, guilt, or self-hatred.
  - **Impulsivity:** Engaging in risky behaviors without considering the consequences.
  - **Substance Abuse:** Increased use of alcohol or drugs.
  - **Eating Disorders:** Changes in eating habits, such as binge eating, purging, or extreme dieting.

# Warning signs for self-harm

## Self Harm

- **Verbal and Cognitive Signs:**
  - **Talking about Self-Harm:** Openly discussing self-harm or making indirect statements about wanting to hurt oneself.
  - **Negative Self-Talk:** Frequent self-criticism or expressions of worthlessness.
  - **Preoccupation with Death:** Talking or writing about death, dying, or suicide.
  - **Difficulty in Relationships:** Struggles with maintaining personal relationships or feeling misunderstood by others.
- **Academic and Occupational Signs:**
  - **Decline in Performance:** Sudden drop in academic or work performance.
  - **Absenteeism:** Frequent absences from school or work without a clear reason.
  - **Lack of Concentration:** Difficulty focusing on tasks or making decisions.
- **Social Media and Online Activity:**
  - **Search History:** Looking up information on self-harm methods or suicide.
  - **Online Posts:** Sharing distressing or alarming content on social media platforms.

# Warning signs for suicide

## Suicide

### Direct and Indirect Verbal Cues:

- Talking about wanting to die or kill oneself.
- Statements of hopelessness: "I can't see any way out."
- Expressions of feeling trapped or in unbearable pain.
- Talking about being a burden to others.

### Behavioral Signs:

- Increased use of alcohol or drugs.
- **Searching for methods to end one's life:** Looking up information online or acquiring means such as firearms or medications.
- **Withdrawal from social connections:** Isolating from friends, family, and social activities.
- **Changes in sleep patterns:** Insomnia or excessive sleeping.
- Giving away prized possessions or making arrangements for dependents or pets.
- **Sudden calmness:** A sudden sense of peace after a period of depression or moodiness, which might indicate a decision to commit suicide.
- **Engaging in risky or self-destructive behavior:** Reckless driving, unsafe sex, or other dangerous activities.

# Warning signs for suicide

## Suicide

### Emotional Signs:

- Intense mood swings: Exhibiting dramatic changes in mood.
- Expressions of severe anxiety or agitation.
- Feelings of worthlessness, shame, or guilt.
- Persistent sadness or depression.

### Cognitive Signs:

- Preoccupation with death: Frequently talking or writing about death, dying, or suicide.
- Lack of interest in future planning: Expressing a sense of having no future or purpose.

# Warning signs for suicide

## Suicide

### Physical Signs:

- Neglect of personal appearance and hygiene.
- Unexplained physical complaints: Chronic pain or fatigue without a clear medical cause.

### Situational Signs:

- Recent trauma or life crisis: Experiencing significant losses such as the death of a loved one, divorce, or financial problems.
- History of previous suicide attempts or family history of suicide.
- Access to lethal means: Having access to firearms, medications, or other means of self-harm.

# Risk Factors for Self-Harm

1. **Psychiatric Disorders:** Presence of mental health conditions such as depression, anxiety, borderline personality disorder, and eating disorders (Klonsky, 2007).
2. **History of Trauma or Abuse:** Experiences of physical, emotional, or sexual abuse, particularly during childhood (Yates, 2004).
3. **Substance Abuse:** Misuse of alcohol or drugs, which can exacerbate emotional distress and impulsivity (Hawton et al., 2003).
4. **Family History of Self-Harm:** Genetic or environmental influences from family members who have engaged in self-harm (Brent et al., 1996).
5. **Social Isolation:** Lack of social support and feelings of loneliness or alienation (Joiner, 2005).
6. **Impulsivity and Poor Emotional Regulation:** Inability to manage emotional responses and impulsive behavior (Klonsky, 2007).
7. **Chronic Medical Conditions:** Physical illnesses that cause significant pain or disability (Sansone & Sansone, 2010).
8. **Bullying or Peer Victimization:** Experiences of being bullied or harassed by peers (Hinduja & Patchin, 2010).

# Risk Factors for Suicide

1. **Previous Suicide Attempts:** The most significant predictor of future suicide attempts (Harris & Barraclough, 1997).
2. **Mental Health Disorders:** Conditions such as major depressive disorder, bipolar disorder, schizophrenia, and PTSD (Nock et al., 2008).
3. **Substance Use Disorders:** Alcohol and drug abuse are strongly linked to increased suicide risk (Wilcox et al., 2004).
4. **Family History of Suicide:** Genetic predisposition and environmental factors from family members who have died by suicide (Brent & Mann, 2005).
5. **Chronic Illness and Pain:** Long-term medical conditions that cause pain and disability (Tang & Crane, 2006).
6. **Lack of Social Support:** Feelings of isolation and lack of a support network (Joiner, 2005).
7. **Access to Lethal Means:** Availability of methods to carry out suicide, such as firearms or medications (Miller & Hemenway, 2008).
8. **Significant Life Events:** Stressful life events such as the loss of a loved one, relationship breakdowns, or financial problems (Gould et al., 1996).

# Risk Factors

## Non modifiable

- Age, race, gender.
- Separation, divorced, widowed
- Prior attempt, exposure to suicide by another, self harm, recent psychiatric hospitalization
- History of violence/ reckless behavior/ impulsivity.

## Modifiable

- Current psychiatric illness
- Chronic medical conditions
- Low self esteem and tolerating attitude towards suicide/death/self harm

## Proximate

- **Mood and behaviors-** suicide/self harm ideation/intent/plan, hopelessness, withdrawn, aggression, impulsivity
- **Social situation-**access to lethal means, housing difficulties, relationship strain, separation/divorce, substance use
- **Psychological factors-**poor problem-solving skills, identifying none/few reasons of living

# Assessing self-harm risk

# Screening Tools

SAD Persons (SPS)

Beck Suicide Intent Scale (SIS)

Beck Scale for Suicide ideation (SSI)

C-SSRS

C-CASA

CHRT

HCR-20

# Screening Tools

## Box 1. SAD PERSONS scale for assessment of suicide risk:

- S** Sex (male)
- A** Age (< 20 or > 44 years)
- D** Depression
- P** Previous suicide attempt
- E** Ethanol abuse
- R** Rational thinking loss (psychosis)
- S** Social support lacking
- O** Organised suicide plan
- N** No spouse (divorced or separated, widowed or single)
- S** Sickness (presence of a chronic or debilitating illness)

Each risk factor that is present is accorded a score of 1 point, for a maximum of 10 points.

Patterson et al<sup>(13)</sup> recommended:

- Close monitoring for patients with scores of 3 to 4
- To strongly consider hospitalisation for those with scores of 5 and 6
- Hospitalisation for further assessment for patients with scores of 7–10

*Note: Regardless of the score obtained, overall clinical assessment is still paramount and the primary care physician should err on the side of caution.*

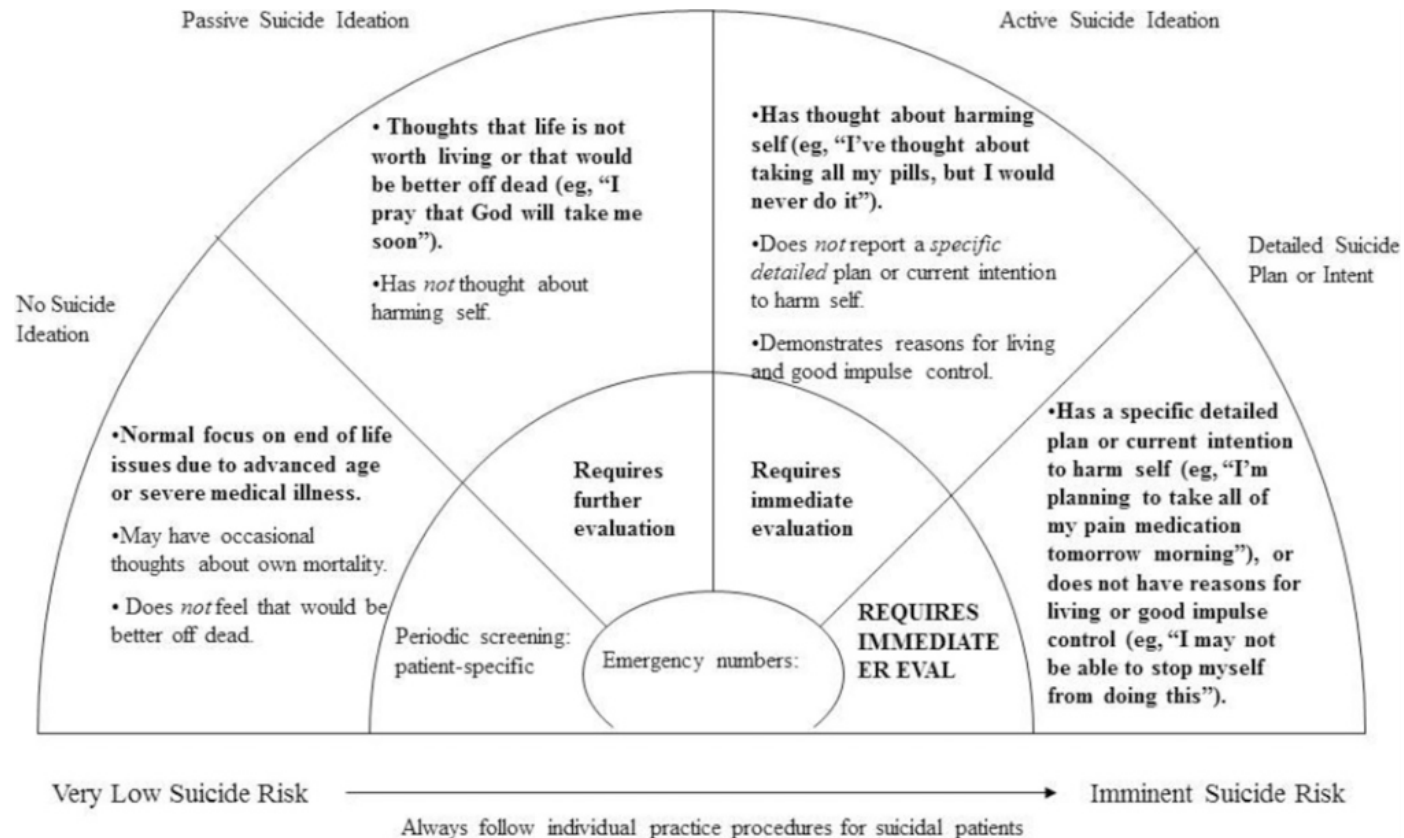
Image from: <http://www.smj.org.sg/article/depression-primary-care-assessing-suicide-risk>

# Scales for assessing adult suicide risk in primary care settings

Scale	Advantages	Disadvantages
<b>1. SAD PERSONS scale</b> [11][13][14][18][19][23]	Brief Does not require training Free Easy to remember Includes recommended interventions based on score.	Does not predict suicide attempt or suicide. Considers environmental/contextual risk factors that are not necessarily associated with suicidal intent. Overestimates suicide risk and the need for hospitalization.
<b>2. Beck's Hopelessness Scale</b> [11][12][13][14][16][19]	Multiple websites provide tools for rapid calculation of the score and estimation of suicide risk. Quick to administer.	Must be administered by trained personnel. Variable sensitivity and specificity. Poor predictive power. Hopelessness is a risk factor only (not an indicator of suicide ideation or attempt).
<b>3. Beck's Scale for Suicide Ideation</b> [11][12][15][17][19][34]	Comes close to measuring suicide ideation. Quick to administer.	Must be administered by trained personnel. Measurement is more characterological than categorical. Poor predictive power. No cutoff points to allow for classification of risk and/or recommendations of specific interventions). Tends to overestimate risk.
<b>4. Columbia–Suicide Severity Rating Scale (C-SSRS)</b> [11][12][17][25][22][35][37][38]	Considered by some as the “gold standard” for evaluating suicide risk. Predictive in both adolescents and adults. Has short (screening) version designed for use in primary care. Validated for the Latin American population. Easy to access. Can be administered by non-specialist staff. Includes suggested interventions based on score. Validated in Spanish-speaking adolescent and young adult population (Argentina).	Controversial because it does not measure the full spectrum of suicide (e.g., ideation and behavior). Still being validated in Chile.

Table 3: Columbia-suicide severity rating scale Screen with Triage Points for Primary Care (C-SSRS)		Past month	
Ask questions that are in bold and <u>underlined</u> .		YES	NO
Ask questions 1 and 2			
Wish to be dead: Subject endorses thoughts about a wish to be dead or not alive anymore or wish to fall asleep and not wake up. <b><u>Have you wished you were dead or wished you could go to sleep and not wake up?</u></b>			
Non-specific active suicidal thoughts: General non-specific thoughts of wanting to end one's life/die by suicide (e.g., "I've thought about killing myself") without thoughts of ways to kill oneself/associated methods, intent, or plan during the assessment period <b><u>Have you had any actual thoughts of killing yourself?</u></b>			
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6			
Active suicidal ideation with any methods (Not Plan) without intent to act: Subject endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out (e.g., thought of method to kill self but not a specific plan). Includes person who would say, "I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it... and I would never go through with it." <b><u>Have you been thinking about how you might do this?</u></b>			
Active suicidal ideation with some intent to act, without specific plan: Active suicidal thoughts of killing oneself and subject reports having <u>some intent to act on such thoughts</u> , as opposed to "I have the thoughts but I definitely will not do anything about them." <b><u>Have you had these thoughts and had some intention of acting on them?</u></b>			
Active suicidal ideation with specific plan and intent: Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out. <b><u>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</u></b>			
<b>Past 3 months</b>			
Suicidal behavior: <b><u>Have you ever done anything, started to do anything, or prepared to do anything to end your life?</u></b> Examples: 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; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.			
<div style="display: flex; align-items: center;"> <div style="width: 15px; height: 15px; background-color: yellow; margin-right: 5px;"></div> Mild suicide risk  <div style="width: 15px; height: 15px; background-color: orange; margin-right: 5px; margin-top: 5px;"></div> Moderate suicide risk  <div style="width: 15px; height: 15px; background-color: red; margin-right: 5px; margin-top: 5px;"></div> Severe suicide risk </div>			
Source: Posner K., Brent D., Lucas C., Gould M., Stanley B., Brown G., et al. Columbia-suicide severity rating scale (C-SSRS). Screener with triage for primary health settings. The Research Foundation for Mental Hygiene, Inc. 2008. Available from: <a href="http://cssrs.columbia.edu/the-columbia-scale-c-srs/cssrs-for-communities-and-healthcare/#filter=general-use.english">http://cssrs.columbia.edu/the-columbia-scale-c-srs/cssrs-for-communities-and-healthcare/#filter=general-use.english</a> Free PDF download.			

# Visual for suicide risk in older adults



From the educational videotape by Brown EL, Bruce ML, Raue PJ et al. (2004): Depression Recognition and Assessment in Older Homecare Patients  
 Used with permission from Raue PJ, Brown EL, Meyers BS, Schulberg HC, Bruce ML: Does every allusion to possible suicide require the same response? *The Journal of Family Practice*. 55:7 2006 July, pg 605-12

# Liability and Legal

Suicide screening/self harm risk assessments is the first step in identifying the need for further risk assessment.

Special attention to risk reduction related to firearms has received increased attention in recent years given that access to means has increased.

Reducing the risk of liability entails:

- understanding the suicide and self harm.
- approaching suicide risk assessment from a clinical perspective.
- conceptualizing how malpractice cases unfold.
- proper risk assessment
- proper documentation
- developing a risk management approach to mitigate against the potential for a bad outcome.

# Liability and Legal

## Risk Mitigation

Screening and assessment of suicide/self harm risk.

1. Identifying the level of care and placement
  - determination regarding hospitalization, partial hospitalization and sometimes involuntary admissions.
2. Treat symptoms with the proper pharmacological strategy and psychotherapeutic approaches.
3. Counseling and guidance on substance use, whether the patient engages in binge use or has a pattern of more chronic use, must be considered.
4. Safety planning and intervention
  - Identifying acute vs chronic risk looking out for warning signs
  - Basic safety planning also typically including what to do if suicidal ideation/intent or self harm re-emerges and how to access emergency services as well as restriction measures.

**Where there can be a delay in accessing lethal suicide means, the potential for suicidal acts can be reduced!!!!**

Let's work through some  
examples

# The Reluctant Discloser

**Description:** This patient may have suicidal thoughts but is reluctant to disclose them due to fear of stigma, hospitalization, or judgment. They might present with vague symptoms like chronic pain or fatigue.

**Challenge:** Extracting accurate information and assessing the true risk can be difficult.

**Support:** Build trust and create a safe, non-judgmental environment. Use open-ended questions and active listening techniques. Follow up regularly to monitor their mental health status.

**Patient Quote:** "I don't think anyone would understand what I'm going through. I just feel tired all the time."

**Concerning Quote:** "Sometimes, I think it would be easier if I just didn't wake up at all."

# The Non-compliant patient

**Description:** This patient has a history of mental health issues and suicidal ideation but often refuses to follow treatment plans or take prescribed medications. They may frequently miss appointments.

**Challenge:** Ensuring adherence to treatment and consistent follow-up is challenging.

**Support:** Use motivational interviewing to understand their barriers to compliance. Involve family members or support systems if appropriate, and set up reminders for appointments and medications.

**Patient Quote:** "I don't see the point in taking these pills. They don't change anything for me."

**Concerning Quote:** "I stopped taking my meds because I don't care what happens to me anymore."

# Struggling with Substance Use/Abuse

**Description:** This patient uses drugs or alcohol excessively, which exacerbates their mental health issues. They may present with acute intoxication or withdrawal symptoms.

**Challenge:** Substance abuse can mask or worsen suicidal ideation.

**Support:** Coordinate care between mental health services and addiction treatment programs. Provide resources for substance abuse counseling and consider integrated treatment plans.

**Patient Quote:** "Sometimes, drinking is the only way I can get through the day. It feels like nothing else helps."

**Concerning Quote:** "I've been drinking a lot more lately because I just don't care if I live or die."

# The High Functioning Professional

**Description:** This patient appears to be highly functional and successful in their professional life but is experiencing severe depression and suicidal thoughts. They may fear the impact of disclosure on their career.

**Challenge:** Their outward appearance of success can be misleading, making it harder to recognize the severity of their condition.

**Support:** Ensure confidentiality and handle their concerns sensitively. Offer flexible appointment times to accommodate their schedule and consider telehealth options if appropriate.

**Patient Quote:** "I can't let anyone at work know about this. They expect me to have everything together."

**Concerning Quote:** "Sometimes, I think about ending it all because the pressure is just too much."

# The Chronic Mental Health Patient

**Description:** This patient has a long history of mental health issues, multiple hospitalizations, and chronic suicidal ideation. They may have borderline personality disorder or other complex psychiatric conditions.

**Challenge:** Managing chronic suicidality requires a multidisciplinary approach and often involves navigating complex treatment plans.

**Support:** Ensure consistency and coordination among care providers. Develop a comprehensive care plan that includes regular therapy sessions, medication management, and crisis intervention strategies.

**Patient Quote:** "I've been in and out of hospitals for years. It feels like nothing ever really changes."

**Concerning Quote:** "I'm tired of this cycle. One of these days, I'm just going to end it for good."

# The Adolescent

**Description:** This young patient presents with signs of depression, anxiety, or self-harm behaviors. They may be dealing with bullying, family issues, or identity struggles.

**Challenge:** Adolescents may be less likely to communicate openly about their feelings.

**Support:** Involve parents or guardians while respecting the patient's autonomy and confidentiality. Use age-appropriate communication and consider involving school counselors or youth support groups.

**Patient Quote:** "Nobody at school gets me. I just feel so alone and misunderstood."

**Concerning Quote:** "Sometimes, I think everyone would be better off without me."

# The Elderly Patient

**Description:** This older adult may be dealing with loneliness, chronic illness, or loss of loved ones, leading to depression and suicidal thoughts.

**Challenge:** Suicidal ideation in the elderly can be overlooked or attributed to aging.

**Support:** Conduct a comprehensive assessment that includes social and physical health issues. Connect them with community resources, senior centers, and support groups to reduce isolation.

**Patient Quote:** "Since my spouse passed away, I don't see the point in going on. I'm just so lonely."

**Concerning Quote:** "I don't have much time left anyway, so why not end it now?"

# The Patient with Severe Medical Illness

**Description:** This patient is coping with a severe or terminal medical condition, such as cancer or chronic pain, and expresses a desire to end their suffering.

**Challenge:** Balancing empathy for their physical suffering with the need to address their mental health is complex.

**Support:** Integrate palliative care and psychiatric support. Provide counseling that addresses both their physical and emotional pain, and involve family members in care discussions.

**Patient Quote:** "The pain is unbearable. Sometimes, I just wish it would all end."

**Concerning Quote:** "I've thought about taking all my pain meds at once to make it stop."

# The Impulsive Patient

**Description:** This patient may have impulsive tendencies, possibly related to a personality disorder, and may suddenly express suicidal thoughts or engage in self-harm without prior warning.

**Challenge:** Ensuring immediate safety and creating a crisis plan is critical.

**Support:** Develop a safety plan that includes emergency contact numbers and crisis intervention strategies. Regularly monitor their mental state and consider involving a case manager for consistent follow-up.

**Patient Quote:** "Sometimes, I get these urges out of nowhere, and I don't know how to stop them."

**Concerning Quote:** "I nearly jumped off a bridge yesterday. I don't know what came over me."

# The Patient with Limited Social Support

**Description:** This patient lacks a strong support system, which exacerbates feelings of isolation and hopelessness. They may be estranged from family or living alone.

**Challenge:** Connecting them with community resources and support groups can be beneficial.

**Support:** Provide information on community resources, support groups, and social services. Regular follow-up and check-ins are important to monitor their well-being and ensure they feel supported.

**Patient Quote:** "I don't have anyone I can turn to. It feels like I'm all alone in this."

**Concerning Quote:** "I don't see a point in living if no one cares about me. Maybe it's time to end it."

# Structured approach to document and manage self-harm risk

# Which screening tool do I pick?

Insufficient evidence to support the use of any one tool, inclusive of clinician assessment of risk, for self-harm and suicidality. (Saab et al 2022)

Is there a “fallacy” of risk assessment? Are assessment tools more likely to be serving the organization instead of the patient? Kapur and Goldney (2019) argue that there is a fallacy

Structured interview, using tools if they are helpful, stratifying risks, document plan and what you did

# Documentation

## Current Mental Status Examination

### Risk Factors

- Non-modifiable risk factors
- Modifiable risk factors
- Proximate risk factors

### Protective Factors

- Support systems
- Coping Skills
- Engagement in treatment

### Risk Formulation

- Risk to self (acute vs chronic)
  - Someone who has attempted suicide numerous times is chronic high risk but acutely may be moderate
- Risk to others
- Risk of neglect if applicable

### Risk Management Plan:

- Immediate actions
- Follow-up plan
- Patient instructions
- Collateral

# Returning to John Doe

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- **Assessment:**
  - **Diagnosis:** Major Depressive Disorder, recurrent, Severe, without psychotic features.
  - **Risk Level:** Moderate due to the presence of suicidal ideation, male gender, hopeless thoughts. No active plan or intent



# Suicide risk assessment for John Doe

## Current Risk Factors:

- **Presence of Suicidal Ideation:** Yes, passive thoughts of being better off not alive.
- **Duration of Suicidal Thoughts:** Approximately six months.
- **Frequency of Thoughts:** Increasing over the past few months.
- **Specific Plan:** No specific plan identified.
- **Access to Means:** No access to means.
- **History of Previous Attempts:** None reported.
- **Mental Health History:** Major Depressive Disorder, Severe, without psychotic features.
- **Substance Use:** No substance abuse reported.
- **Social Support:** Married with two children, supportive family environment.
- **Occupational Functioning:** High functioning at work despite internal struggles.



# Suicide risk assessment for John Doe

## Protective Factors:

- **Family:** Strong connection to wife and children.
- **Insight:** Good insight into his mental health condition.
- **Help-Seeking Behavior:** Voluntarily seeking help and open to intervention.
- **Engagement in Treatment:** Willing to engage in medication and therapy.
- **Clinical Judgment:** Moderate risk due to passive suicidal ideation and increasing frequency of thoughts. Will increase visits, recommend psychotherapy and start SSRI

Provide patient with emergency contact numbers and ensure they understand the importance of reaching out if the situation worsens.

Collateral: Can also reach out to John's spouse if he is willing to discuss concerns with her.



# Questions/Discussion

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