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Assessing Risk for Suicide in the Primary Care Setting

Jonathan Betlinski, MD, OHSU School of Medicine

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DATE: 01 October 2025

PRESENTED BY: Jonathan Betlinski, MD

Disclosures

- Dr. Betlinski has no relevant financial relationships to disclose.

- Unless otherwise noted, all pictures are from Unsplash.com, and used in accordance with their policies.

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Jonathan Betlinski, MD

OHSU Department of Psychiatry

George Saslow Professor

Medical Director for OPAL-A

Clinical Advisor to the Oregon ECHO Network

PI for Heal Oregon (funded through HRSA TTELP grant)

Boards: Big Lake Youth Camp, CareOregon, Inc., Columbia Pacific CCO, NAMI Oregon

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Learning Objectives

- Know the five steps of Suicide Assessment
- Know at least three risk screening tools
- Know the three steps of addressing Non-suicdal Self Injury
- Know at least two numbers to call for help when patients are at risk for suicide or NSSI

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Agenda

- Review the Epidemiology of Suicide
- Review Assessment and Triage of Suicide
  - SAFE-T from SAMHSA
  - Review the Oregon Revised Statutes about Involuntary Holds
- Review steps of addressing Non-Suicidal Self-Injury
- Review Additional Resources

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Photo by Nick Fewings on Unsplash.com

Epidemiology of Suicide

12-Month Prevalence of SI, SA and Suicide		
	World	USA
Suicidal Ideation	2%	5%
Suicide Attempt	0.3%	0.6%
Suicide	0.012%	0.014%

Lifetime Risk of Suicide Attempt	
General population	3%
Those with Suicidal ideation	30%
- SI with plan	55%
- SI with no plan	15%

- Women attempt more than men
- Men die more than women
- Risk of attempt is highest in first year of SI

https://www.uptodate.com/contents/suicidal-ideation-and-behavior-in-adults#H3857054625
https://www.kff.org/mental-health/state-indicator/suicide-rate/
https://www.kff.org/mental-health/state-indicator/adults-reporting-having-serious-thoughts-of-suicide-in-the-past-year/

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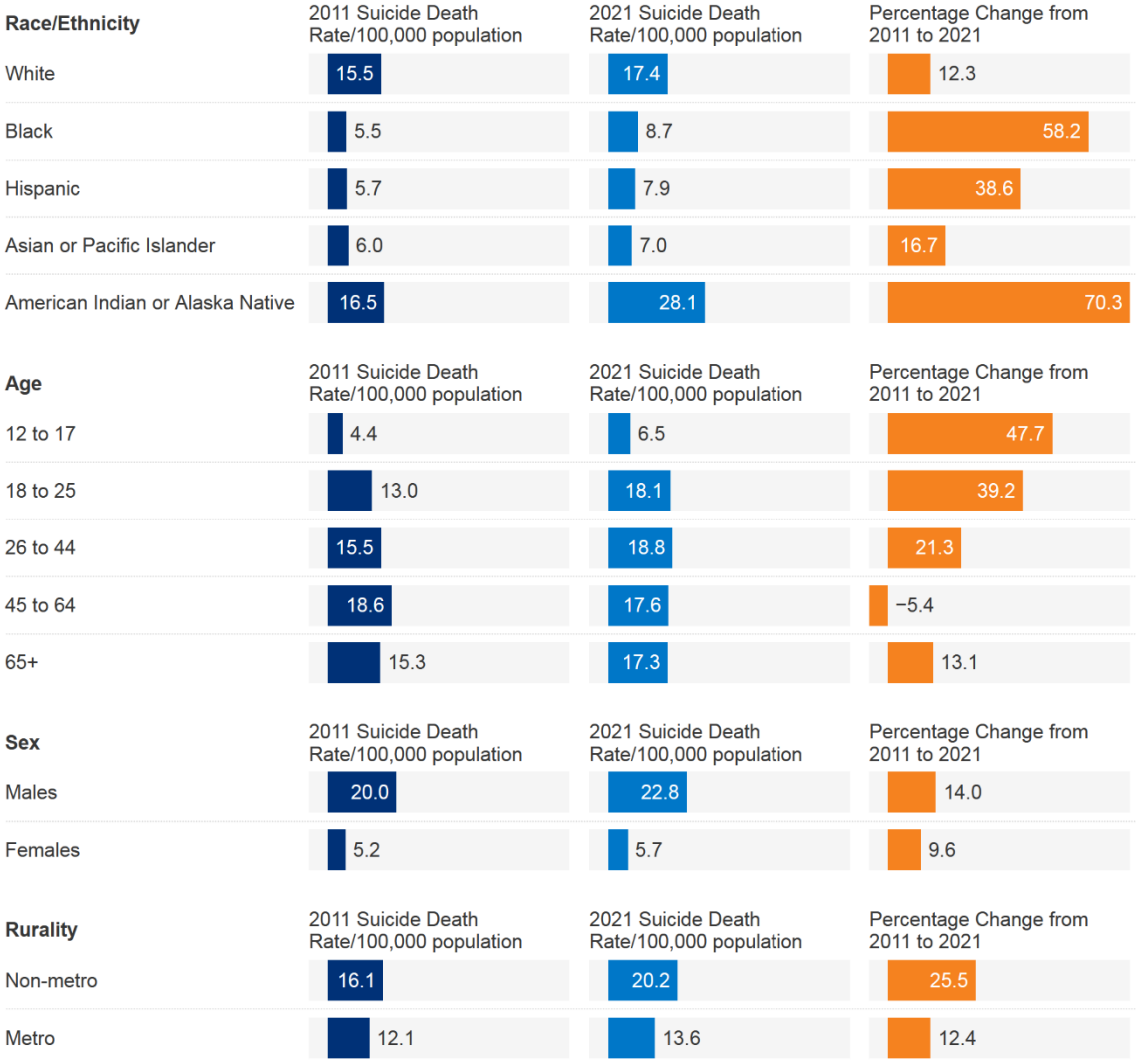
Suicide Death Rates by Demographics and Location, 2011 to 2021



NOTE: Analysis of CDC WONDER underlying cause of death data, 2011 to 2021. Suicide deaths were identified using ICD-10 113 Cause List, Intentional self-harm (U03, X60-X84, Y87.0). Rates are age-adjusted for all demographics except age groups. Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are non-Hispanic. Data were insufficient to allow for analysis of other racial groups.
SOURCE: KFF analysis of CDC WONDER, 2011 to 2021 • PNG

KFF

https://www.kff.org/mental-health/issue-brief/a-look-at-the-latest-suicide-data-and-change-over-the-last-decade/

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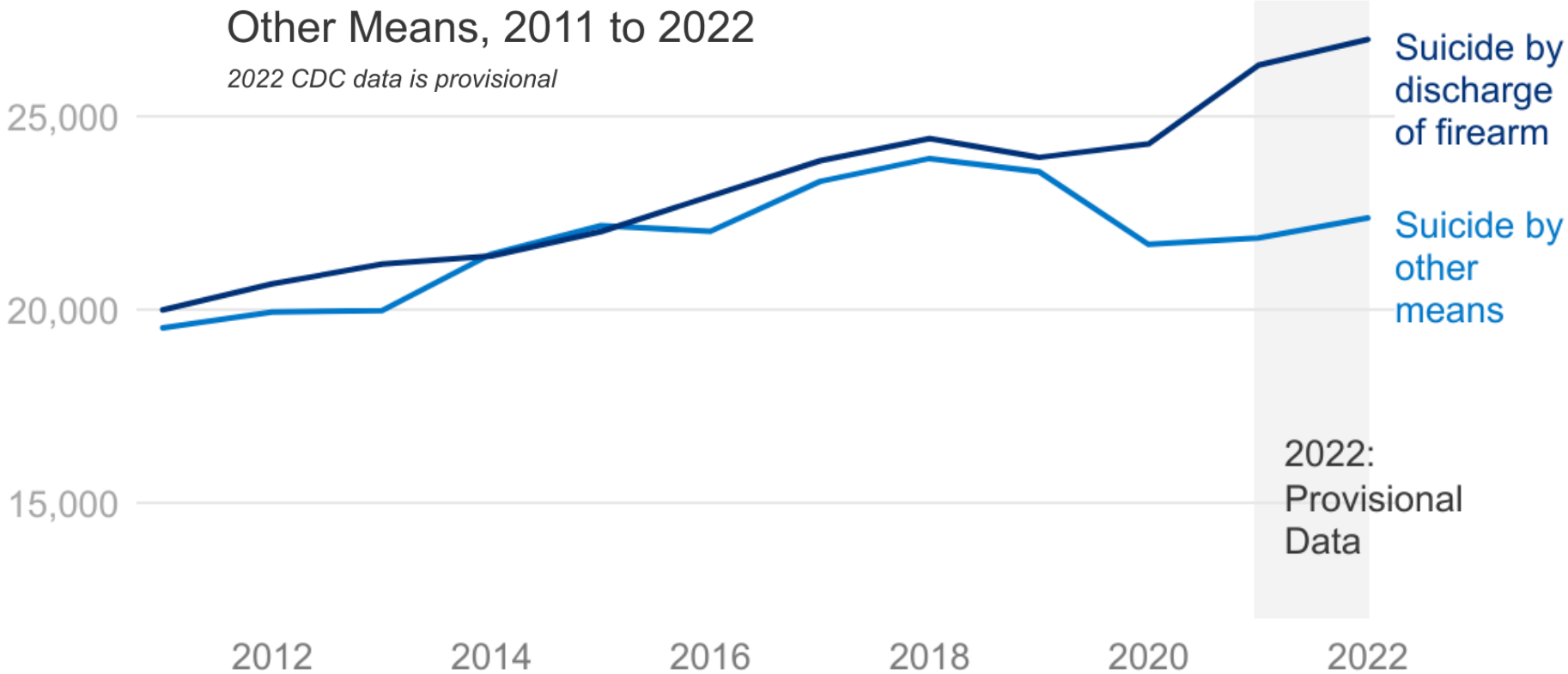
Number of Deaths Due to Suicide, by Firearm or Other Means, 2011 to 2022

2022 CDC data is provisional



NOTE: Analysis of CDC WONDER underlying cause of death data, 2011 to 2022. Suicide deaths by the discharge of a firearm were identified using codes X72-X74. Suicide deaths by other/unspecified means were identified using ICD-10 codes U03, X60-X71, X75-X84, and Y87.0) The rate of suicides by firearms and suicides by other means are statistically different in 2021 and 2022. It is possible that some suicides may be classified under other categories.

SOURCE: KFF analysis of CDC WONDER data, 2011 to 2021 https://www.kff.org/mental-health/issue-brief/a-look-at-the-latest-suicide-data-and-change-over-the-last-decade/

KFF

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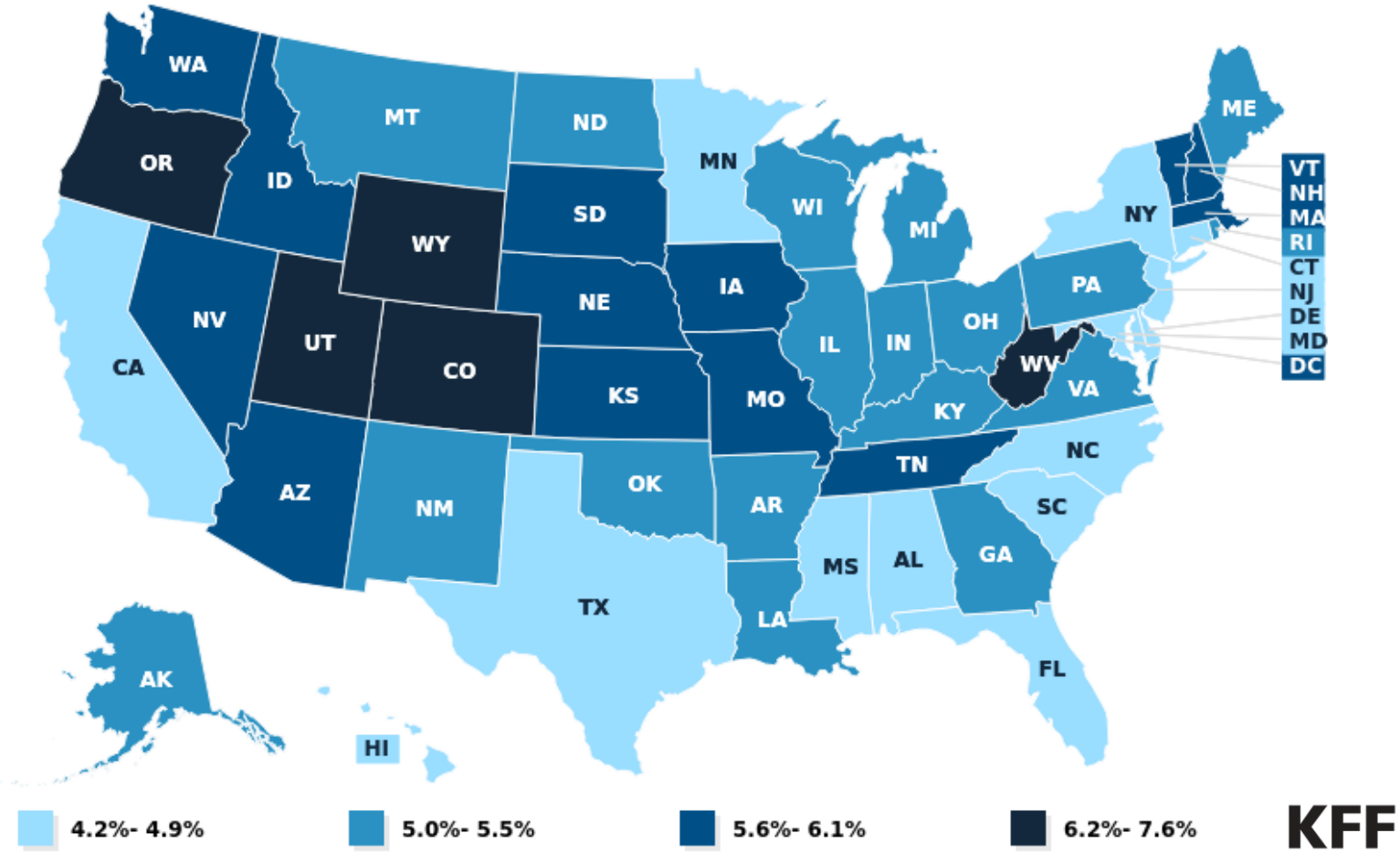
Adults Reporting Having Serious Thoughts of Suicide in the Past Year

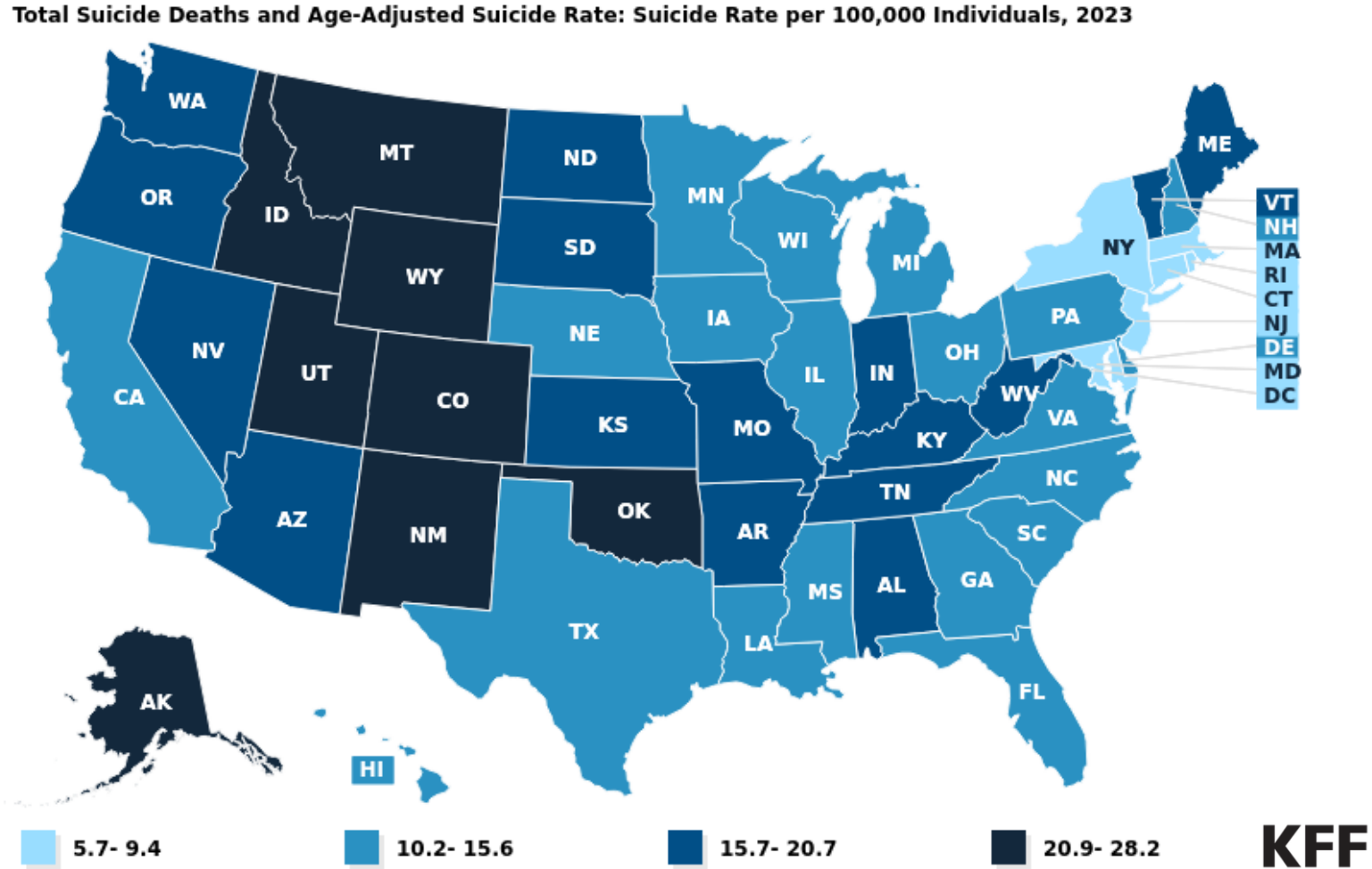
Timeframe: 2022-2023



SOURCE: KFF's State Health Facts. https://www.kff.org/other/state-indicator/adults-reporting-having-serious-thoughts-of-suicide-in-the-past-year/

Sources

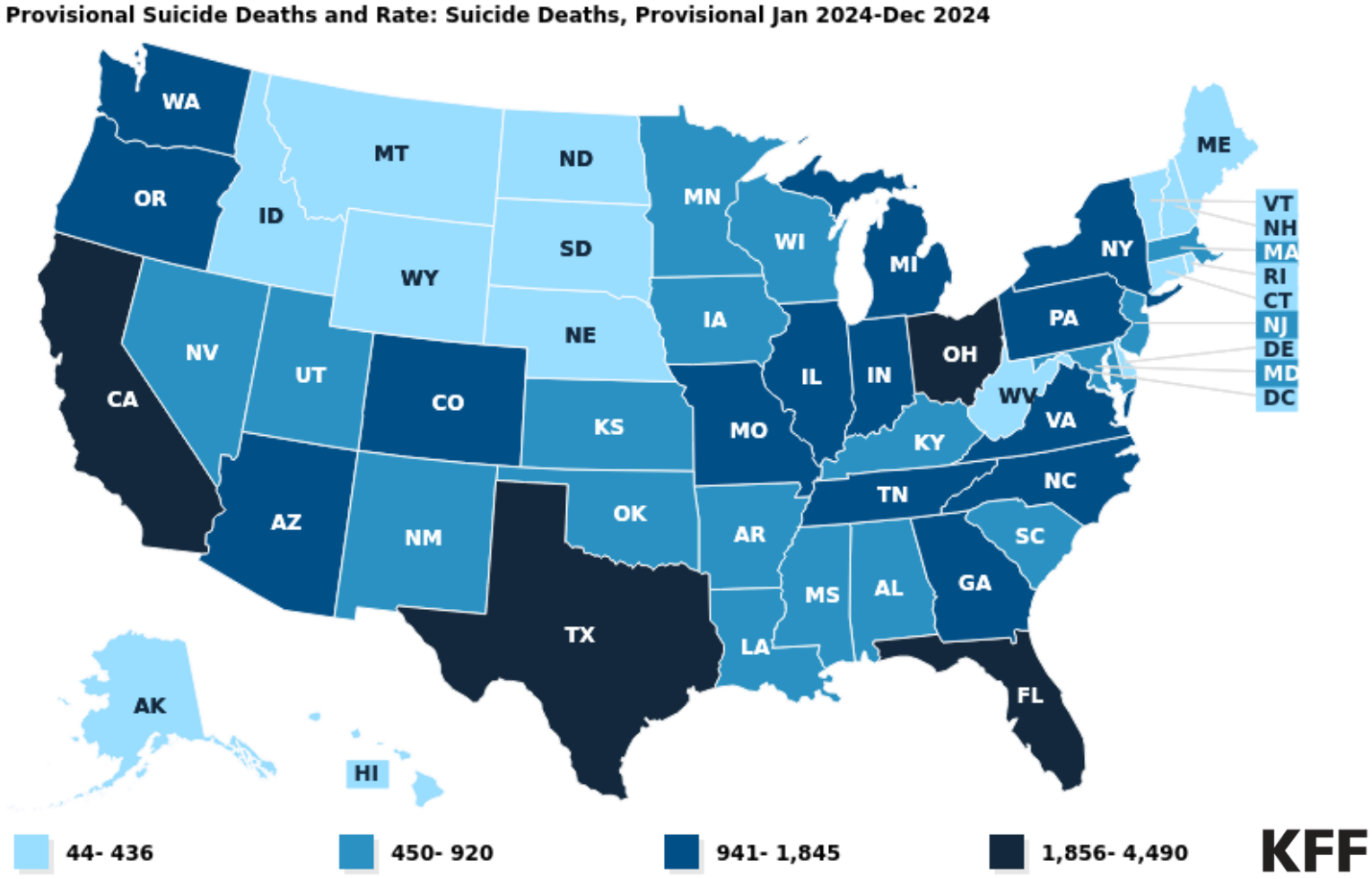
Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health (NSDUH), 2022 and 2023.



SOURCE: KFF's State Health Facts. https://www.kff.org/mental-health/state-indicator/suicide-rate/

Sources

Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2023 on CDC WONDER Online Database. Data are from the Multiple Cause of Death Files, 1999-2023, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at https://wonder.cdc.gov/mcd-icd10-expanded.html on January 30, 2025.



SOURCE: KFF's State Health Facts. https://www.kff.org/state-health-policy-data/state-indicator/provisional-suicide-deaths/

Sources

KFF analysis of Centers for Disease Control and Prevention (CDC), National Center for Health Statistics, Provisional Multiple Cause of Death Data on CDC WONDER Online Database. Accessed at https://wonder.cdc.gov/mcd-icd10-provisional.html on September 16, 2025.

Epidemiology, continued

- **60% of those who first attempt suicide die in that attempt**
- 20% of those who die from suicide have a prior attempt
  - 80% of those who die do so within 1 year of their first attempt
- 8.6% lifetime risk for psychiatric inpatients
  - Current/recent hospitalization is strongest single predictor
- 25-40% got MH services last year
  - 20% saw a MHP in the month prior
- **45% saw their PCP in the month prior**

https://pubmed.ncbi.nlm.nih.gov/21709131/
https://pubmed.ncbi.nlm.nih.gov/30581289/
https://pubmed.ncbi.nlm.nih.gov/27523496/

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Suicide and Firearms

- Guns are used in 55.4% of deaths due to suicides in the US
- People with access to a firearm are 3x more likely to die from suicide
- Men with home access to a firearm are 4x more likely than women to die from suicide with a firearm
- Men with home access to a firearm are 10x times more likely to die from suicide with a firearm then men with no home access
- Those who first attempt with a firearm have 140x the risk of dying
- 1.5% of first attempt survivors used a firearm for their attempt

https://pubmed.ncbi.nlm.nih.gov/24592495/
https://www.mentalhelp.net/blogs/guns-and-suicide/
https://pubmed.ncbi.nlm.nih.gov/27523496/
https://www.uptodate.com/contents/suicidal-ideation-and-behavior-in-adults#H3857054625
https://www.kff.org/mental-health/state-indicator/suicide-rate-by-method/

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Assessment and Triage

Photo by Joanna Kosinska on Unsplash.com

SAFE-T

Suicide Assessment Five-step Evaluation and Triage

"Predicting which patients with suicidal thoughts will go on to attempt suicide cannot be achieved with a high degree of sensitivity or specificity."

- Identify Risk Factors
  - Note those that can be modified
- Identify Protective Factors
  - Note those that can be enhanced
- Conduct Suicide Inquiry
- Determine Risk Level/Intervention
- Document

https://store.samhsa.gov/product/safe-t-pocket-card-suicide-assessment-five-step-evaluation-and-triage-clinicians/sma09-4432
https://www.uptodate.com/contents/suicidal-ideation-and-behavior-in-adults
https://pubmed.ncbi.nlm.nih.gov/30581289/

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Step 1 - Identify Risk Factors

Warning Signs of Acute Risk

- Threatening to hurt or kill him or herself, or talking of wanting to hurt or kill him/herself;
- Looking for ways to kill him/herself by seeking access to firearms, available pills, or other means;
- Talking or writing about death, dying or suicide, when these actions are out of the ordinary.

Statistical Risk Factors

- Male > Female
- Older > Younger
- Mental Illness

Additional Warning Signs

- Increased substance (alcohol or drug) use
- No reason for living; no sense of purpose in life
- Anxiety, agitation, unable to sleep or sleeping all the time
- Feeling trapped – like there's no way out
- Hopelessness
- Withdrawal from friends, family and society
- Rage, uncontrolled anger, seeking revenge
- Acting reckless or engaging in risky activities, seemingly without thinking
- Dramatic mood changes
- Giving away prized possessions or seeking long-term care for pets

https://sprc.org/wp-content/uploads/2023/09/Warning-Signs-of-Suicide-a-Fact-Sheet-for-Clinicians.pdf

Step 2 - Identify **Protective** Factors

Internal

- Sense of responsibility
- Life satisfaction
- Positive Coping and Problem-solving Skills
- Reality Testing Ability

External

- Children in the home and/or pregnancy
- Religiosity
- Positive Social Support
- Positive Therapeutic Relationship

https://store.samhsa.gov/product/safe-t-pocket-card-suicide-assessment-five-step-evaluation-and-triage-clinicians/sma09-4432
http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/suicide-guide.pdf

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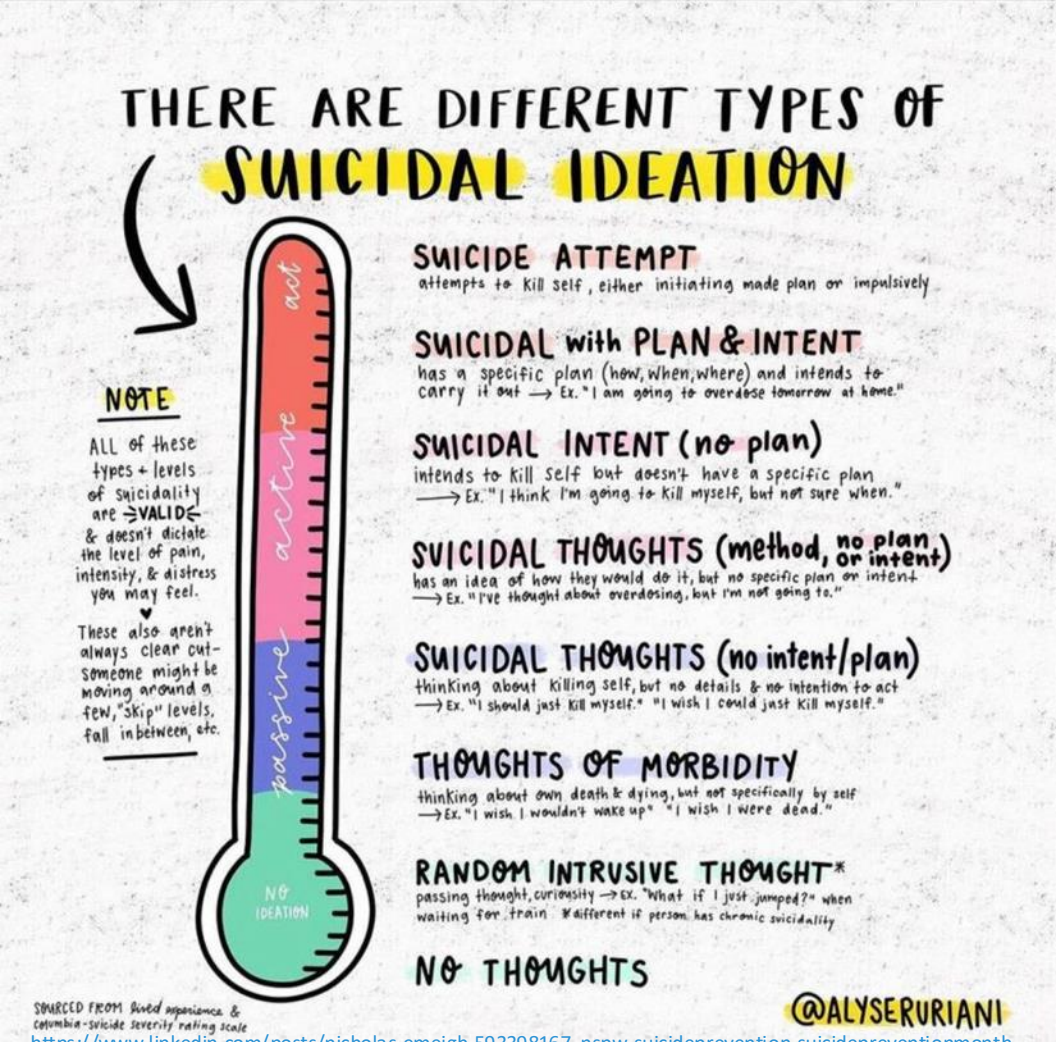

https://www.linkedin.com/posts/nicholas-emeigh-593398167_nspw-suicideprevention-suicidepreventionmonth-activity-7107694559026900995-hTzR

Step 3 - Conduct a Suicide Inquiry

- Ask the person *directly* if they
  - Are having suicidal thoughts/ideas
  - Have a plan to do so
  - Have access to lethal means
- "Are you thinking about killing yourself?"
- "Have you thought of ways that you might hurt yourself?"
- Focus on specifics: who, what, when, where, how, why?

Asking does *not* increase risk!

https://store.samhsa.gov/product/safe-t-pocket-card-suicide-assessment-five-step-evaluation-and-triage-clinicians/sma09-4432

Step 4
Determine 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 disorders 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

https://store.samhsa.gov/product/safe-t-pocket-card-suicide-assessment-five-step-evaluation-and-triage-clinicians/sma09-4432

Determine Risk Level / Intervention

- Columbia-Suicide Severity Rating Scale
  https://cssrs.columbia.edu/wp-content/uploads/Columbia_Protocol.pdf
  https://cssrs.columbia.edu/documents/safe-t-c-ssrs/
  https://dphhs.mt.gov/assets/suicideprevention/basicscoringguideforclinicians.pdf
- CSUS Suicide Risk Assessment
  http://www.csus.edu/indiv/b/brocks/Workshops/District/2.Suicide%20Risk%20Assessment%20Summary.pdf
- Harvard Risk Management Guidelines
  https://www.rmf.harvard.edu/News-and-Blog/Newsletter-Home/News/2023/Insights-September
- NIMH Ask Suicide-Screening Questions (ASQ) Toolkit
  https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials
- NSW Suicide Risk Assessment
  https://www.health.nsw.gov.au/mentalhealth/resources/Publications/framework-suicide-risk-assess.pdf

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C-SSRS

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? *Examples*: Took pills, tried to shoot yourself, cut yourself, tried to hang yourself, 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, collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, etc. **If yes, was this within the past 3 months?**		**High Risk**

988 SUICIDE & CRISIS LIFELINE

If YES to 2 or 3, seek behavioral healthcare for further evaluation.
If the answer to 4, 5 or 6 is YES, get immediate help: Call or text 988, call 911 or go to the emergency room.
STAY WITH THEM until they can be evaluated.

Download Columbia Protocol app

ASQ

NIMH TOOLKIT

asQ Suicide Risk Screening Tool

Ask Suicide-Screening Questions

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

asQ Suicide Risk Screening Toolkit | NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH) | 2/8/2024

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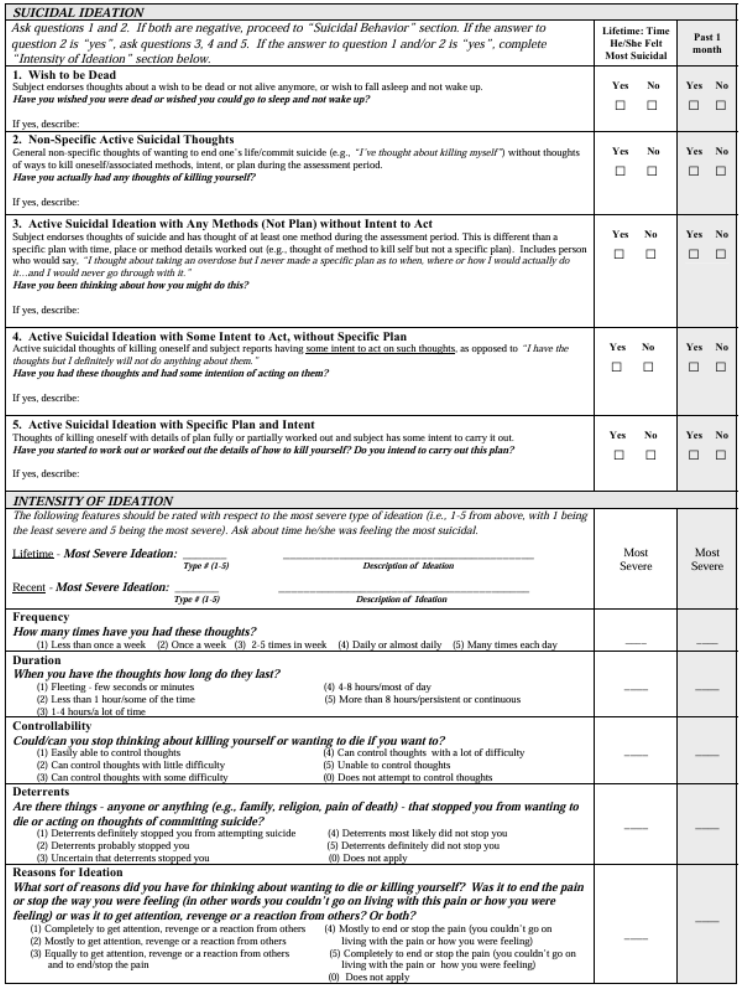
Full C-SSRS



SUICIDAL IDEATION

Ask questions 1 and 2. If both are negative, proceed to "Suicidal Behavior" section. If the answer to question 2 is "yes", ask questions 3, 4 and 5. If the answer to question 1 and/or 2 is "yes", complete "Intensity of Ideation" section below.

	Lifetime: Time He/She Felt Most Suicidal	Past 1 month
1. 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. ***Have you wished you were dead or wished you could go to sleep and not wake up?*** If yes, describe:	Yes ☐ No ☐	Yes ☐ No ☐
2. Non-Specific Active Suicidal Thoughts General non-specific thoughts of wanting to end one's life/commit 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. ***Have you actually had any thoughts of killing yourself?*** If yes, describe:	Yes ☐ No ☐	Yes ☐ No ☐
3. 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."* ***Have you been thinking about how you might do this?*** If yes, describe:	Yes ☐ No ☐	Yes ☐ No ☐
4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan Active suicidal thoughts of killing oneself and subject reports having some intent to act on such thoughts, as opposed to *"I have the thoughts but I definitely will not do anything about them."* ***Have you had these thoughts and had some intention of acting on them?*** If yes, describe:	Yes ☐ No ☐	Yes ☐ No ☐
5. 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. ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*** If yes, describe:	Yes ☐ No ☐	Yes ☐ No ☐

INTENSITY OF IDEATION

The following features should be rated with respect to the most severe type of ideation (i.e., 1-5 from above, with 1 being the least severe and 5 being the most severe). Ask about time he/she was feeling the most suicidal.

Lifetime - ***Most Severe Ideation:*** _____ (*Type # (1-5)*) _____ (*Description of Ideation*) — Most Severe

Recent - ***Most Severe Ideation:*** _____ (*Type # (1-5)*) _____ (*Description of Ideation*) — Most Severe

Frequency
How many times have you had these thoughts?
(1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day

Duration
When you have the thoughts how long do they last?
(1) Fleeting - few seconds or minutes
(2) Less than 1 hour/some of the time
(3) 1-4 hours/a lot of time
(4) 4-8 hours/most of day
(5) More than 8 hours/persistent or continuous

Controllability
Could/can you stop thinking about killing yourself or wanting to die if you want to?
(1) Easily able to control thoughts
(2) Can control thoughts with little difficulty
(3) Can control thoughts with some difficulty
(4) Can control thoughts with a lot of difficulty
(5) Unable to control thoughts
(0) Does not attempt to control thoughts

Deterrents
Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of committing suicide?
(1) Deterrents definitely stopped you from attempting suicide
(2) Deterrents probably stopped you
(3) Uncertain that deterrents stopped you
(4) Deterrents most likely did not stop you
(5) Deterrents definitely did not stop you
(0) Does not apply

Reasons for Ideation
What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?
(1) Completely to get attention, revenge or a reaction from others
(2) Mostly to get attention, revenge or a reaction from others
(3) Equally to get attention, revenge or a reaction from others and to end/stop the pain
(4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling)
(5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling)
(0) Does not apply

SUICIDAL BEHAVIOR

(Check all that apply, so long as these are separate events; must ask about all types)

	Lifetime	Past 3 months
Actual Attempt: A potentially self-injurious act committed with at least some wish to die, *as a result of act.* Behavior was in part thought of as method to kill oneself. Intent does not have to be 100%. If there is ***any*** intent/desire to die associated with the act, then it can be considered an actual suicide attempt. ***There does not have to be any injury or harm***, just the potential for injury or harm. If person pulls trigger while gun is in mouth but gun is broken so no injury results, this is considered an attempt. Inferring Intent: Even if an individual denies intent/wish to die, it may be inferred clinically from the behavior or circumstances. For example, a highly lethal act that is clearly not an accident so no other intent but suicide can be inferred (e.g., gunshot to head, jumping from window of a high floor/story). Also, if someone denies intent to die, but they thought that what they did could be lethal, intent may be inferred. ***Have you made a suicide attempt?*** ***Have you done anything to harm yourself?*** ***Have you done anything dangerous where you could have died?*** ***What did you do?*** ***Did you_____ as a way to end your life?*** ***Did you want to die (even a little) when you_____?*** ***Were you trying to end your life when you _____?*** ***Or Did you think it was possible you could have died from_____?*** ***Or did you do it purely for other reasons / without ANY intention of killing yourself (like to relieve stress, feel better, get sympathy, or get something else to happen)?*** (Self-Injurious Behavior without suicidal intent) If yes, describe:	Yes ☐ No ☐ Total # of Attempts: ____	Yes ☐ No ☐ Total # of Attempts: ____
Has subject engaged in Non-Suicidal Self-Injurious Behavior?	Yes ☐ No ☐	Yes ☐ No ☐
Interrupted Attempt: When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act *(if not for that, actual attempt would have occurred).* Overdose: Person has pills in hand but is stopped from ingesting. Once they ingest any pills, this becomes an attempt rather than an interrupted attempt. Shooting: Person has gun pointed toward self, gun is taken away by someone else, or is somehow prevented from pulling trigger. Once they pull the trigger, even if the gun fails to fire, it is an attempt. Jumping: Person is poised to jump, is grabbed and taken down from ledge. Hanging: Person has noose around neck but has not yet started to hang - is stopped from doing so. ***Has there been a time when you started to do something to end your life but someone or something stopped you before you actually did anything?*** If yes, describe:	Yes ☐ No ☐ Total # of interrupted: ____	Yes ☐ No ☐ Total # of interrupted: ____
Aborted or Self-Interrupted Attempt: When person begins to take steps toward making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behavior. Examples are similar to interrupted attempts, except that the individual stops him/herself, instead of being stopped by something else. ***Has there been a time when you started to do something to try to end your life but you stopped yourself before you actually did anything?*** If yes, describe:	Yes ☐ No ☐ Total # of aborted or self-interrupted: ____	Yes ☐ No ☐ Total # of aborted or self-interrupted: ____
Preparatory Acts or Behavior: Acts or preparation towards imminently making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note). ***Have you taken any steps towards making a suicide attempt or preparing to kill yourself (such as collecting pills, getting a gun, giving valuables away or writing a suicide note)?*** If yes, describe:	Yes ☐ No ☐ Total # of preparatory acts: ____	Yes ☐ No ☐ Total # of preparatory acts: ____

	Most Recent Attempt Date:	Most Lethal Attempt Date:	Initial/First Attempt Date:
Actual Lethality/Medical Damage: 0. No physical damage or very minor physical damage (e.g., surface scratches). 1. Minor physical damage (e.g., lethargic speech; first-degree burns; mild bleeding; sprains). 2. Moderate physical damage; medical attention needed (e.g., conscious but sleepy, somewhat responsive; second-degree burns; bleeding of major vessel). 3. Moderately severe physical damage; *medical* hospitalization and likely intensive care required (e.g., comatose with reflexes intact; third-degree burns less than 20% of body; extensive blood loss but can recover; major fractures). 4. Severe physical damage; *medical* hospitalization with intensive care required (e.g., comatose without reflexes; third-degree burns over 20% of body; extensive blood loss with unstable vital signs; major damage to a vital area). 5. Death	Enter Code	Enter Code	Enter Code
Potential Lethality: Only Answer if Actual Lethality=0 Likely lethality of actual attempt if no medical damage (the following examples, while having no actual medical damage, had potential for very serious lethality: put gun in mouth and pulled the trigger but gun fails to fire so no medical damage; laying on train tracks with oncoming train but pulled away before run over). 0 = Behavior not likely to result in injury 1 = Behavior likely to result in injury but not likely to cause death 2 = Behavior likely to result in death despite available medical care	Enter Code	Enter Code	Enter Code

https://suicidepreventionlifeline.org/wp-content/uploads/2016/09/Suicide-Risk-Assessment-C-SSRS-Lifeline-Version-2014.pdf

Many Risk Tools

- BHS – ED
- MHTS
- MSHR
- ReACT Self Harm Rule
- Beck's SIS
- DSI – SS
- GDS
- RAM
- SIQ
- SIQ – JR
- VASA
- NGASR
- RSQ

Sensitivity 52-100%

Specificity 60-98%

None examined in more than 1 study

https://www.uspreventiveservicestaskforce.org/Home/GetFileByID/1899

https://cmit.cms.gov/cmit/#/ search "suicide"

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High Risk?

- Do not leave the person unattended
- Call County Crisis Line or 988
- Arrange for transport to the nearest available hospital for evaluation

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https://suicidepreventionlifeline.org

Legal – ORS 426.231

1) A licensed independent practitioner may hold a person for transportation to a treatment facility for up to 12 hours in a health care facility licensed under ORS chapter 441 and approved by the Oregon Health Authority if:

   (a) The licensed independent practitioner believes the person is dangerous to self or to any other person and is in need of emergency care or treatment for mental illness;

   (b) The licensed independent practitioner is not related to the person by blood or marriage; **and**

   (c) A licensed independent practitioner with admitting privileges at the receiving facility consents to the transporting.

https://oregon.public.law/statutes/ors_426.231

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Legal – ORS 426.231, continued

2) Before transporting the person, the licensed independent practitioner shall prepare a written statement that:

   (a) The licensed independent practitioner has examined the person within the preceding 12 hours;

   (b) A licensed independent practitioner with admitting privileges at the receiving facility has consented to the transporting of the person for examination and admission if appropriate; **and**

   (c) The licensed independent practitioner believes the person is dangerous to self or to any other person and is in need of emergency care or treatment for mental illness.

3) The written statement required by subsection (2) of this section authorizes a peace officer, an individual authorized under ORS 426.233 (Authority of community mental health program director and of other individuals) or the designee of a community mental health program director to transport a person to the treatment facility indicated on the statement. [1993 c.484 §3; 1997 c.531 §3; 2009 c.595 §403; 2013 c.360 §39; 2015 c.461 §12]

https://oregon.public.law/statutes/ors_426.231

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Step 5 - Documentation

- Document the following
  - ✓ Your assessment of risk (and why)
  - ✓ Your treatment plan (and actions taken)
  - ✓ Firearm instructions, if relevant
  - ✓ Follow-up plans
  - ✓ For adolescents, include role of parent/guardian

- "No-suicide Contracts" do ***not*** work

https://store.samhsa.gov/product/safe-t-pocket-card-suicide-assessment-five-step-evaluation-and-triage-clinicians/sma09-4432
http://www.ccsme.org/wp-content/uploads/2017/01/NoSuicideContracts.pdf

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Photo by Annie Spratt on Unsplash.com

What Is Non-suicidal Self Injury?

- Intentionally hurting oneself without meaning to die
- If you can imagine a form of self harm, someone somewhere is probably using it

Why Do People Do It?

- If you can imagine a reason, someone somewhere is probably using it
- NSSI is a way of dealing with stress

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What Should You NOT Do?

- Don’t focus on stopping self-injury
- Don’t trivialize the feelings or situations that have led to self-injury
- Don’t dismiss self harm as “attention-seeking”
- Don’t punish the person
- Don’t agree to keep secrets about self-harm

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What Should You Do?

- Let them know you're concerned
- Address urgent health problems
- Be curious!
  - "How did that happen?"
  - "What does it do for you?"
- Make sure someone helpful knows
  - Involve them in decisions about what to do
  - Help think of less harmful ways to meet their needs

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Helping with NSSI

- Be Curious
  - Especially when explanations don't match
- Stay Curious
  - Especially about what NSSI achieves
- Focus on reducing harm
  - And maybe build relationship?

Assessment of Risk for Violence

Dangerousness to Others

- Violence is *very* hard to predict
- Those with SPMI are much more likely to be victims
- Oregon assumes Tarasoff
- *Use low threshold for transport*

Risk of Violence	
General population	7%
Severe Mental Illness	16%
Substance Use Disorders	35%
SPMI + SUD	43%

Risk Factors for Serious Violence
Male gender
Younger age
Childhood conduct problems
High arrest history
Positive symptoms

Specific Symptoms of Concern	
Delusions	Paranoia/grandiosity
Hallucinations	Command/obeyed
Hostility	Anger/resentment
Excitement	Agitation

https://pubmed.ncbi.nlm.nih.gov/23457754/
https://pubmed.ncbi.nlm.nih.gov/32032557/
https://pubmed.ncbi.nlm.nih.gov/3348040/

Additional Resources

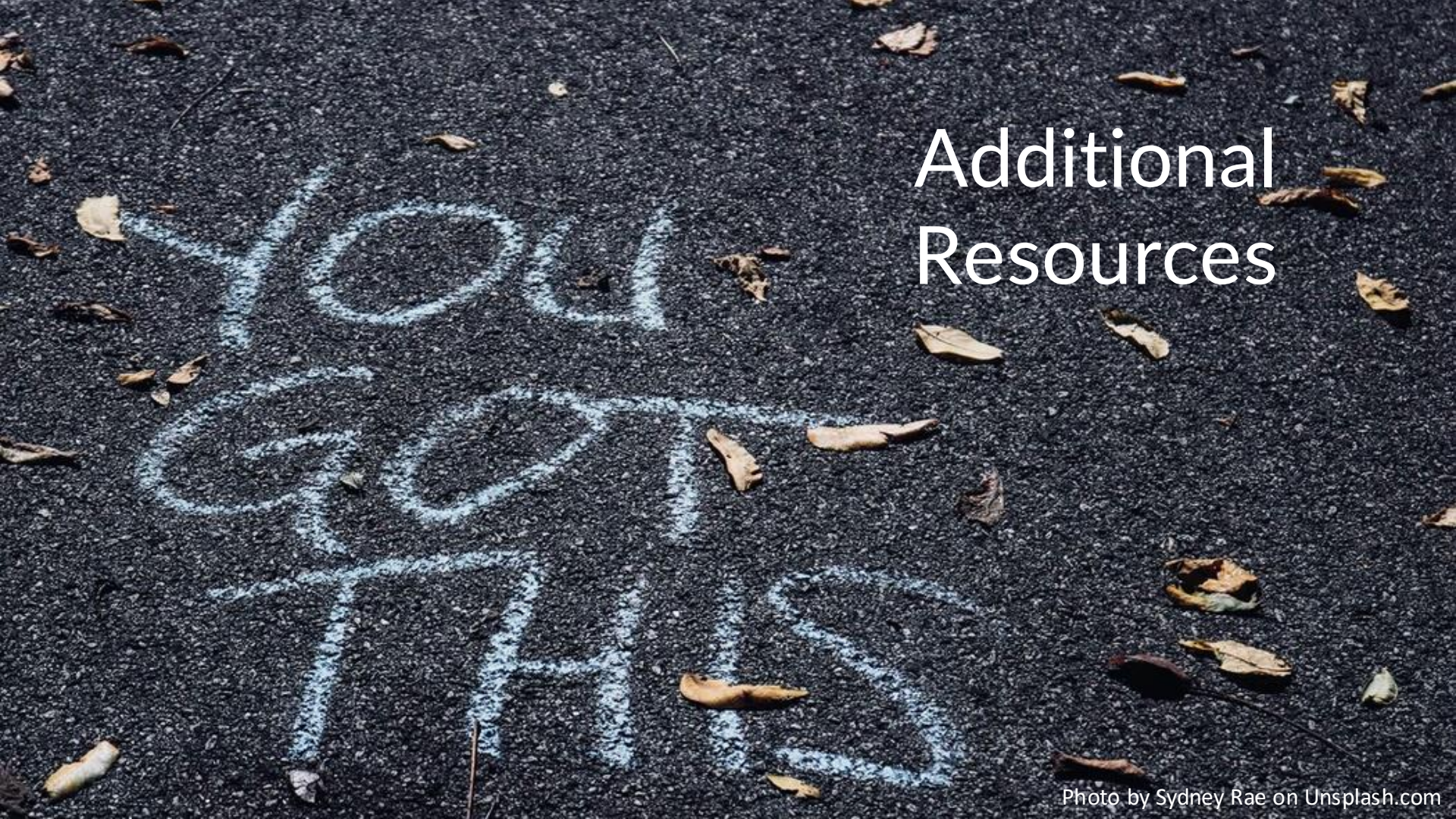

Photo by Sydney Rae on Unsplash.com

Additional Resources

Gunowner-friendly information

www.oregonfirearmsafety.org/firearm-safety/

Suicide Prevention Resources for Older Adults

https://e4center.org/wp-content/uploads/2024/07/E4-Center-Equity-Focused-Suicide-Prevention-Resources-for-Older-Adults-1.pdf

Suicide Prevention Toolkit for Primary Care

http://www.sprc.org/settings/primary-care/toolkit

Oregon Health Authority Suicide Prevention

https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/SAFELIVING/SUICIDEPREVENTION/Pages/index.aspx

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Welcome to the Oregon Psychiatric Access Line (OPAL)

OPAL-K about Kids

OPAL-A about Adults

Phone

Toll-Free: 1-855-966-7255

Portland Metro: 503-346-1000

OPAL call center hours

9 a.m. – 5 p.m.

Monday through Friday, excluding major holidays

OPAL is not a walk-in clinic or in-person referral site

www.ohsu.edu/opal

Call for Backup!

Oregon ECHO Network Behavioral Health programs

Fall 2025 programs:

- Addiction Medicine Community of Practice
- Adult Mental Health I
- Behavioral Health Essentials
- Child Psychiatry
- Foundations of Substance Use Disorder I
- Hepatitis C Community of Practice
- Methadone in Carceral Facilities Community of Practice
- Psychiatry in Primary Care Community of Practice
- Substance Use Disorders in Adolescents
- Substance Use Disorder in Pregnancy and Postpartum Care
- Substance Use Disorders in Hospital Care
- Substance Use Disorders in Jails

Winter 2026 programs:

- Adult Mental Health II
- Chronic Pain and Opioids
- Foundations of Substance Use Disorder Care II
- Hepatitis C: Treatment and Elimination
- Substance Use Disorder Prevention and Early Intervention
- Pain Management and Substance Use Disorder in Dental Settings
- Substance Use Disorder in Emergency Departments

***Pre-Register now!**

Scan the QR code or go to **connect.oregonechonetwork.org** to learn more or get signed up!

Summary

- Suicide rates are increasing
- Most people with SI do not die by suicide
- Prediction strategies are generally lousy
- Best strategy is to be gentle and direct, AND use an established screening tool such as SAFE-T + CSSRS
- Call for help!
- Be sure to document your rationale

- Stick around for SKA2 blood test?

https://pubmed.ncbi.nlm.nih.gov/30906829/
https://pubmed.ncbi.nlm.nih.gov/38722562/

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Thank you!

Jonathan Betlinski, MD
betlinsk@ohsu.edu

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Questions

Comments

What about Civil Commitment?

- HB 2005 updated ORS 426.070 - 426.170
- Now 4 criteria for Civil Commitment for those who have a mental illness and are in need of treatment
  - Is a danger to self
  - Is a danger to others
  - Is unable to provide for basic personal needs
  - Has a chronic mental disorder

https://olis.oregonlegislature.gov/liz/2025R1/Measures/Analysis/HB2005

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