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To: **All Providers**

From: **PerformCare**

Date: **May 1, 2025**

Subject: **Suicide Prevention #23: Considerations for Predicting Suicide Risk and Assessment**

For this month's communication on managing suicide risk, PerformCare would like to convey findings from a recent study conducted with members of the American Indian population. The goal is to evoke a thoughtful approach to screening for suicide in a culturally competent manner, understanding that commonly used screening tools can have limitations, as well as to shed light on possible future directions for predicting risk. When used in isolation, without consideration of individual factors including possible cultural factors, and an in -depth complex understanding of the individual's risk presentation, these tools may be limiting. Additionally, other factors about the person's interaction and presentation within the healthcare system could shed light on heightened risk.

Of note, the American Indian/ Alaskan Native Population are at 91% greater risk of suicide than all other racial/ ethnic groups, according to 2022 CDC data. A recent NIH funded study, conducted by Adams et. al (2024) found that in a sample of 16,835 individuals from an Indian Health System population, they were better able to predict suicide attempts and deaths from analysis of electronic health record (EHR) data than typical screening. This was at a rate of 83% EHR analysis versus 64% of use of screening tools (just a slightly above chance). This is consistent with other studies in general populations, addressed in prior communications where the Columbia – Suicide Severity Rating Scale (C-SSRS) was found to have limitations in predicting suicide in emergency room patients (Simpson et al., 2020) (Bjureberg et al., 2021). As noted, suicide screening tools have value in an overall assessment process, but they have limitations in predictive validity.

Adam's et al. (2024) found that in their models of EHR analysis, various factors from EHR analysis did better at predicting suicide than screening tools. Top factors that predicted heightened risk included: a healthcare visit within 90 days; younger age (18-29); having suicidal ideation in the past 5 years, diminishing only slightly over time; having Medicaid insurance; alcohol use concerns in the last year; and having an emergency department visit in the past three months. Patients in the study who had recent inpatient admissions within three months were less likely to attempt or die by suicide. This suggests the possibility that receiving prompt targeted intervention was protective for this sample. Please note, the findings on risk factors gleaned from an EHR analysis cannot be generalized, as this study was conducted on an

American Indian population. You can access the full article at: https://www.nature.com/articles/s44184-024-00088-5

While this study's findings are limited to a very specific population, it is representative of possible future directions for risk prediction. It also gives us additional factors to consider beyond the use of screening tools and highlights their limitations. In other words, it is not best practice to use a rating scale alone, in the assessment of risk. Rating scales are best used in combination of a suicide specific clinical interview and a historical review of the individual's physical and mental health history and interaction with the healthcare system. Last, it reminds us of the very individual and specific approach that needs to be taken when assessing risk among subpopulations. This includes the importance of understanding how risk factors vary among different groups.

References

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