



How to identify dynamic and static risk factors in suicidal patients

Suicide is a complex and tragic public health issue, and its prevention requires a multifaceted approach involving people in the patient's immediate circle as well as clinicians.

Knowing how to identify and categorize dynamic and static risk factors for suicide is essential for health care professionals — those within mental health care who are developing effective intervention plans for at-risk patients and providers outside of that specialty who nonetheless are often the first to screen their patients for suicide risk.

To effectively treat those at risk of suicide, it is also important to understand and be able to use available simple screening tools; learn how to deploy short- and long-term care; understand the role of inpatient and outpatient treatment; approach patients with non-judgmental empathy; and document when caring for suicidal patients.

Understanding the difference between dynamic and static risk factors for suicide

There are many ways of distinguishing risk factors for suicide, but one of the most common separates them into two groups: dynamic and static.

As [Dr. Randon S. Welton described in *Psychiatry*](#), “Static factors are based on the actuarial facts of who commits suicide.” These are “variables that the provider would be unable to change,” including race, gender, age, the patient's personal history of suicide attempts, and whether suicide runs in their family. He notes that some of these static factors — namely a history of a suicide attempt — present problems of “stability; once someone has attempted suicide, this risk factor will be positive every day for the rest of their lives. It does correctly denote that this person is at higher risk than the general population, but it does not help the provider make decisions regarding the patient sitting in his or her office on a particular day.”

Dynamic factors for suicide are, as the name implies, modifiable. This category of risk factors includes mental health diagnoses, social support, substance use or abuse, psychiatric symptoms, “emotional turmoil,” and suicidality.

Dynamic risk factors can exacerbate suicide risk in individuals with existing static risk factors and because of that, both types of risk factors are meant to be understood in tandem. Dr. Welton explains, “Considering the dynamic risk factors in light of the static risk factors will more finely focus the clinician's assessment and will help shape the interventions.”

Evaluation and screening tools used to assess the patient

Clinicians can play a critical role in identifying suicidality in patients and helping connect them with the treatment they need. There are several different options for evaluating whether a patient is experiencing suicidal thoughts or is at risk of suicide, including various kinds of questionnaires and screening tools specifically tailored to pediatric patients at risk of suicide.

Routine suicidal risk screenings can be conducted for all patients using common, accessible tools like the following:

- **Columbia Suicide Severity Rating Scale (C-SSRS)** — An evidence-based questionnaire that assesses for the presence and severity of suicidal ideation and behavior as well as suicidal plans or attempts both across a patient's lifetime and within the last three months. Also known as the Columbia Protocol, it is widely [used or recommended by organizations](#) including the FDA, the WHO, the NIH, the CDC, and others.
- **Patient Health Questionnaire (PHQ-9)** — A short questionnaire completed by the patient to gauge suicidality and depressive symptoms ([based on DSM-IV depression diagnostic criteria](#)) as well as their degree of severity. The PHQ-9 also includes a follow-up screener meant to assess the extent to which depressive symptoms have affected the patient's functioning.
- **Ask Suicide-Screening Questions (ASQ)** — A four-question tool created by the NIMH for screening of suicide risk in both youth and adult patients. The ASQ is part of a prevention strategy built on "[an evidence-based clinical pathway](#)" to identify at-risk patients and manage those who screen positive with a referral to a full evaluation or outpatient care if necessary.

In addition to using these tools, a comprehensive evaluation of suicide risk should include a detailed clinical interview and a review of the patient's medical and psychiatric history, including assessing family history of suicide to identify any static risk factors.

There is increasing evidence that frequent screening, especially of patients in [at-risk groups such as veterans](#), can "identify missed chances to save lives."

Recognizing how physicians are perceived by the patient

A strong physician-patient relationship is foundational in the prevention and management of suicide risk. There are many socioeconomic, individual, and [cultural](#) conditions that can come into play to affect this relationship and determine whether or not a patient feels safe and comfortable confiding in a health care provider.

It has been shown that patient satisfaction and success depends on establishing trust and [demonstrating empathy](#). Patients who perceive their physicians as judgmental or dismissive may be less likely to seek help, and many at risk of suicide may be reticent to obtain mental health care and therefore are much more likely to be screened by a family physician if at all. A [2003 report in American Family Physician](#) noted that half of people "who commit suicide saw a physician in the preceding month," emphasizing the opportunity that general practitioners have to screen for suicide and intervene when patients are at risk.

Unfortunately, there still remains a gap between those who have suicidal ideation or plans and those who tell their doctors about these feelings. There are a number of different reasons patients cited for withholding this information from their doctor in a [2018 study by Julie Richards et al.](#) published in *Psychiatric Services*,



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ranging from not feeling suicidal at the moment, to fearing the repercussions of disclosing suicidality (e.g., stigma, loss of autonomy, confidentiality) to not knowing how to enunciate complex emotional feelings:

"One participant said, 'I guess just, like, I'm really bad with words it seems like, and when I get anxious, I get fumbled. So, I just try to avoid talking as much, especially with stuff that's gonna make me emotional and stuff.' One participant described feelings of embarrassment and stigma around disclosing suicidal thoughts: 'It's really embarrassing, you know what I mean? Especially in my world, where no one would expect me to do that. I just was so embarrassed. And I hate when they put it on record and it doesn't look good and it looks like I'm crazy. I just didn't wanna deal with that.'"

Some patients also express doubt at the prospects for the outcome of their treatment: “Everybody just freaks out and wants to get you [hospitalized], and acts like you’re a danger, and that doesn’t really make me feel better. I don’t like that as soon as I say that that they want me to be monitored or so closely watched. I don’t want my privileges taken away or anything.” Said another, “I don’t feel they would have done anything.”

The burden of establishing a strong relationship with the patient is on the clinician — not just so patients open up about suicidal thoughts or plans, but so they also follow through with the appropriate treatment recommendations. Because of this, it’s crucial for health care providers to establish a therapeutic alliance with their patients, be aware of their own personal biases/stereotypes, and use empathetic and non-judgmental language.

Caring for patients

In [The Suicidal Patient: Evaluation and Management](#), caring for suicidal patients is broken down into three categories: acute management, pharmacotherapy, and long-term management.

Acute management of suicidal patients can take two different forms, outpatient or inpatient care. Outpatient care, including therapy, is mentioned as appropriate for “patients who have expressed suicidal ideation but deny current suicidal intent, have no plan or means in place, and have good social support.” This may involve (with permission) a patient’s “close family or friends [...] to ensure patient safety and adherence to follow-up care instructions” and usually addresses crisis planning, developing coping skills, locating social support, and identifying resources. For



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patients in outpatient care, treatment can include a combination of psychotherapy (often cognitive-behavioral or dialectical behavioral therapies) and medication management.

Inpatient care “should be offered to patients with specific plans for suicide who have the means to complete their plan. Where available, treatment options may also include intensive outpatient treatment or partial hospitalization programs.” Inpatient care should provide a safe and supportive environment, with close monitoring of suicide risk, regular psychiatric evaluations, and close collaboration with the patient’s outpatient treatment team.

Clinicians may also choose to refer patients for pharmacotherapeutic treatment, such as antidepressants or anxiolytics,

with a psychiatrist. As Drs. David Norris and Molly Clark [explained](#), “Research has demonstrated that a combination of psychological therapy and pharmacotherapy is more effective than either alone for the treatment of suicidal ideation.”

Appropriate long-term follow-up to treatment, especially for those who experienced inpatient hospitalization, is necessary for ensuring continued patient safety:

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Importance of documentation

It is essential to document every interaction with a suicidal patient. This helps ensure continuity of care for the patient as well as liability protection for the clinician.

Documentation should include a comprehensive assessment of suicide risk, including identification of both static and dynamic risk factors, as well as a detailed plan for intervention and follow-up. All interventions — including hospitalizations, medications, and psychotherapy sessions — should be documented in the patient’s medical record. [Other things that should be documented](#) include the decision-making process, consultations/second opinions, confidentiality, and informed consent about treatment risks/benefits as well as alternative options. **Coursework on caring for suicidal patients**

It’s important to stay up-to-date on the latest evidence-based approaches to caring for patients at risk of suicide. By pursuing continuing medical education courses on suicidality, you can better understand how to identify risk of suicide in patients and care for individuals in that group.

Here are several CME courses for clinicians on caring for suicidal patients:

1. [Suicide Risk and Physician Liability](#) — Recognize dynamic and statistic risk factors, identify suicidality, and improve the care of suicidal patients while avoiding litigation
2. [Suicide and Guns in the United States](#) — Improve the reduction of firearm suicide
3. [Preventing Suicide in Children and Adolescents](#) — Identify risk and resilience factors for suicide in children and adolescents and learn to intervene to prevent youth suicide
4. [Assessment of Suicide Scales](#) — Improve use of assessment tools in identifying suicidal patients
5. [Risk Assessment and Management, Part 1: Assessing for Suicidality](#) — Improve assessment and management of suicidality, including identifying protective factors from suicide and effective treatment approaches
6. [Risk Assessment and Management, Part 2: Assessing for Suicidality](#) — Improve risk assessment for suicidality, covering gun safety, substance abuse, and “the staircase pattern of thoughts”

Identifying dynamic and static risk factors for suicide is essential when developing an effective intervention plan for patients at risk of suicide — but it’s only the start. Health care providers should be knowledgeable about the patient evaluation and screening process, establish a therapeutic alliance with their patients, provide appropriate care, and document every interaction. With a comprehensive approach, health care providers can play a crucial role in helping to prevent suicide and improve the quality of life for their patients.

Want to learn more? [Explore CME lectures on mental health.](#)