

Telehealth Webinar Series: Suicide Risk Assessment for EMS

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Presenters



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Jeremiah D. Simmons, PhD (Navajo/Yankton Sioux) is a licensed clinical psychologist and Assistant Professor in the Division of Community Behavioral Health within the Department of Psychiatry and Behavioral Sciences at the University of New Mexico Health Sciences Center. Dr. Simmons' clinical, teaching, and research efforts focus on improving behavioral health outcomes for Native American communities, with an emphasis on youth and school-based mental health systems. Dr. Simmons specializes in culturally responsive adaptations of evidence-based practices, integrating community-based participatory approaches to enhance engagement, access, and effectiveness of care. His work spans direct clinical service delivery in tribal communities, supervision and training of interdisciplinary behavioral health providers, and the development of community-informed prevention and intervention models. He has contributed to state and federal initiatives focused on suicide prevention, systems of care development, and behavioral health workforce capacity building. His long-term goal is to advance culturally grounded behavioral health systems that reduce disparities and promote resilience among American Indian and Alaska Native populations.

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Dr. Christoph Isbjorn brings a multidisciplinary background in emergency medicine, public health, psychiatry, and nonprofit leadership. He spent 10 years as an EMT, including 911 ALS ambulance service in Denver and several years in Iraq. He earned his MPH from St. George's University and his DO from Rocky Vista University. He founded Vital Start, creating healthcare pathways for at-risk youth, and served as CEO of House Lucky Bear, supporting migrant women. He is currently completing his psychiatry residency, with interests in trauma prevention and recovery, Child and Adolescent Psychiatry, justice-involved youth, and interpersonal relationships following traumatic experiences.

Training Purpose & Learning Objectives

Training Purpose:

This webinar will provide structured, field-appropriate tools for suicide risk recognition and brief assessment within the constraints of prehospital care. Participants will review warning signs, protective factors, documentation considerations, and coordination pathways with crisis response and behavioral health services.

Learning Objectives:

1. Identify suicide risk indicators during EMS encounters.
2. Perform a standardized suicide risk screening and apply stabilization actions (such as environmental safety checks, verbal de-escalation, or supportive engagement), documented in all applicable situations.
3. Accurately describe and use the appropriate referral pathway for suicide risk and complete compliant handoff during transfers to higher-level of care.

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There is no commercial interest support for this educational activity.

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Why the EMS Encounter Matters

48,824

U.S. suicide deaths in 2024

In 2024, the highest suicide rates occurred among non-Hispanic American Indian and Alaska Native people and non-Hispanic White people. EMS may meet people at a brief, high-stakes point when medical danger and emotional crisis overlap.

(Centers for Disease Control and Prevention, 2026)

Composite Field Scene

- **Dispatch:** Possible overdose. Family reports recent goodbye messages.
- **On arrival:** The patient is drowsy. Medication bottles are nearby. A family member reports a firearm in the home. Police are on scene and report that they have secured the firearm.
- **Competing demands:** Medical stabilization, scene safety, collateral information, privacy, and suicide inquiry all matter.
- **Question:** What requires action before a formal suicide screen?

Composite teaching case; not a real patient

Immediate Priorities

- **Scene safety:** Identify weapons, medications, environmental hazards, bystander escalation, and responder risk.
- **Medical threats:** Address airway, breathing, circulation, injury, overdose, hypoxia, hypoglycemia, delirium, an acute and fluctuating disturbance in attention and cognition, and other reversible causes.
- **Observation:** Maintain the level of observation required by the patient's condition and local protocol.
- **Calm contact:** Use one primary communicator and explain each next step.

(Inouye et al., 2014; National Association of State EMS Officials [NASEMSO], 2022)

Medical Causes and Consequences

- A suicide-related call can also be a toxicologic, traumatic, neurologic, metabolic, or cardiopulmonary emergency.
- Alert and oriented responses alone do not establish decision-making capacity. Assess understanding, appreciation of consequences, reasoning about options, and ability to communicate a choice.
- Treat injuries and reversible causes while continuing safety precautions.
- Reassess after meaningful changes in consciousness, pain, oxygenation, agitation, or intoxication.

(Appelbaum, 2007; NASEMSO, 2022; Powsner et al., 2023)

A Calm, Private, Direct Approach

- **Introduce:** State your name, role, and immediate concern.
- **Reduce stimulation:** Limit the audience and move to a safer, quieter space when feasible.
- **Explain:** Tell the patient why you are asking direct questions and what may happen next.
- **Listen:** Use brief questions, allow silence, and reflect the patient's words without arguing.

(NASEMSO, 2022)

Asking Directly About Suicide

- “Have you been thinking about killing yourself?”
- “Are you thinking about killing yourself right now?”
- “Did you do anything today with the intention of dying?”
- “What did you think would happen when you took those pills?”

(Blades et al., 2018; Horowitz et al., 2012)

Warning Signs in the Encounter

- **Current signals:** Suicidal statements, recent attempt, preparatory behavior, goodbye messages, seeking means, severe hopelessness, or escalating agitation.
- **Behavioral change:** Withdrawal, giving away possessions, sudden risk-taking, abrupt mood change, or unusual calm after intense distress.
- **Scene evidence:** Pills, weapons, ligatures, notes, searches, interrupted actions, or witness reports.
- **Clinical change:** Intoxication, psychosis, severe anxiety, insomnia, pain, loss, humiliation, or acute conflict.

(Grover et al., 2023; Substance Abuse and Mental Health Services Administration [SAMHSA], 2025)

Risk Context and Protective Factors

- **Risk context:** Past attempts, recent escalation, feasible access to means, serious mental illness, substance use, pain, loss, and reduced impulse control.
- **Protective factors:** Supportive relationships, cultural and spiritual connection, responsibilities, coping skills, treatment engagement, and willingness to accept help.
- **Clinical use:** Protective factors guide engagement and stabilization. They do not cancel current intent, a recent attempt, or an unsafe environment.

(Allen et al., 2022; Franklin et al., 2017; Grover et al., 2023)

Screen, Brief Assessment, Full Evaluation

Screen

Brief validated questions identify who needs more assessment. Examples include the ASQ, C-SSRS, and agency-approved tools accessed through MDCalc.

Field Assessment

Clarifies current danger, medical needs, and immediate action.

Full Evaluation

A qualified clinician develops a broader formulation and disposition plan.

(MDCalc, n.d.; National Institute of Mental Health [NIMH], n.d.; Powsner et al., 2023)

Validated Tools and Local Protocol

- **C-SSRS:** Structures questions about suicidal ideation and behavior across levels of severity.
- **ASQ:** A brief screen validated in medical settings, with separate youth and adult pathways.
- **Agency decision:** Training, documentation, response steps, age range, and medical direction should be defined before field implementation.
- **Limitation:** Asking directly does not increase suicide risk, and no scale can reliably predict who will die by suicide.

(Blades et al., 2018; Carter et al., 2017; Horowitz et al., 2012; Posner et al., 2011)

Six Domains for a Field Inquiry

1. **Current thoughts:** Presence, frequency, intensity, and last occurrence.
2. **Intent and expectation:** Desire to die, expected outcome, and whether the patient feels relieved or disappointed that the attempt was interrupted or did not have the expected outcome.
3. **Plan and access:** Method, preparation, feasibility, and access to means.
4. **Recent and past behavior:** Attempts, interrupted acts, rehearsal, and nonsuicidal self-injury.
5. **State and context:** Medical status, intoxication, psychosis, agitation, loss, and collateral information.
6. **Supports and collaboration:** Reasons for living, trusted people, treatment, and willingness to accept help.

Structured teaching framework informed by SAFE-T and the C-SSRS; not a separate validated scale (Posner et al., 2011; SAMHSA, 2025)

Language for the Six Domains

- “When did the thoughts last happen, and are they happening now?”
- “Did you expect or want the action to end your life?”
- “What method have you considered, and can you get to it now?”
- “Have you started, practiced, or prepared in any way?”
- “What has changed today, including alcohol, drugs, pain, voices, or a major loss?”
- “Who can help you through the next several hours?”

(NIMH, n.d.; Posner et al., 2011; SAMHSA, 2025)

Formulate Action, Do Not Predict

- **Describe:** What the patient said, what happened, what others observed, and what the scene showed.
- **Identify:** Immediate medical danger, suicide-related danger, access to means, and barriers to collaboration.
- **Act:** Choose the safest next step using protocol, consultation, available resources, and reassessment.
- **Avoid:** Do not rely on a single label such as low, moderate, or high risk without the supporting facts.

(Carter et al., 2017; Franklin et al., 2017; Grover et al., 2023)

Action Threshold: Immediate Danger

- Current intent, a recent attempt, an interrupted act, severe medical injury, or access to a feasible lethal method.
- Inability to participate safely because of intoxication, delirium, psychosis, agitation, or impaired consciousness.
- Maintain observation, address medical threats, reduce access to hazards when safe, and activate transport or medical direction per protocol.
- Treat every attempt seriously, regardless of apparent lethality. Communicate the urgency before arrival and at handoff.

(Cai et al., 2022; CDC, 2026; Isaacs et al., 2022; NASEMSO, 2022; Powsner et al., 2023)

Action Threshold: Concern without Current Intent

- A denial of current intent does not erase a recent attempt, preparatory behavior, collateral report, or dangerous scene evidence.
- Clarify timing, sobriety, access to means, reliability of the interview, and willingness to accept evaluation.
- Use medical direction and the local pathway when the need for transport or further evaluation is uncertain.
- If the patient remains in the community, use a warm connection and document the specific safety plan and responsible supports.

(Powsner et al., 2023; SAMHSA, 2025)

Stabilization during the Encounter

- **Lower arousal:** Use one calm voice, simple explanations, physical space, and fewer stimuli.
- **Increase control:** Offer limited choices that remain clinically safe.
- **Validate:** Acknowledge pain and effort without endorsing hopeless conclusions.
- **Connect:** Identify one trusted support and one next step the patient can tolerate.
- **Reassess:** Repeat safety and medical checks after changes in behavior or condition.

(NASEMSO, 2022)

Lethal Means Safety

- Ask about the method used, planned, or available, including firearms and medications.
- Create time and distance between the patient and lethal means when this can be done safely and within policy.
- Use collaborative, temporary language focused on the current crisis.
- Do not handle weapons outside training and policy. Coordinate with law enforcement, family, or another authorized person.
- Include access and any storage action in the handoff and documentation.

(Marcus et al., 2025; Stanley & Brown, 2012)

Intoxication, Psychosis, and Agitation

- Treat reversible medical causes and monitor for evolving toxicity or injury.
- Answers may be incomplete or unreliable when attention, perception, consciousness, or impulse control is impaired.
- Use verbal de-escalation first when feasible. Know what the agency defines as restraint and follow protocol for indication, application, monitoring, and reassessment. Use the least restrictive intervention that safely meets the need.
- Reassess suicide-related statements after clinical change, while preserving the original report and objective scene observations.

(NASEMSO, 2022; Powsner et al., 2023)

Youth and Developmental Considerations

- Use concrete, age-appropriate questions and avoid relying only on the caregiver's report.
- Interview the young person privately when feasible, safe, and consistent with policy.
- Ask caregivers separately about behavior change, access to medications or firearms, supervision, and their ability to maintain safety.
- A positive youth screen requires a defined pathway for further assessment and disposition.

(Horowitz et al., 2012; NIMH, n.d.)

Culturally Responsive Engagement

- Ask how the patient understands the crisis and who should be involved.
- Invite family, kinship, cultural, spiritual, and community supports when the patient agrees and safety permits.
- Do not assume that identity, family, spirituality, or community connection functions as protection for this individual.
- Coordinate with tribal, IHS, urban Indian, and local services through the established pathway.
- Pair concern about disparities with recognition of community strengths and cultural continuity.

(Allen et al., 2022)

Refusal, Capacity, and Involuntary Transport

- A refusal form does not substitute for assessing decision-making capacity and immediate danger.
- Consider intoxication, delirium, head injury, hypoxia, severe pain, psychosis, and other impairments.
- Use medical direction early when capacity or the transport pathway is uncertain.
- Follow state law, tribal jurisdiction, agency protocol, and local agreements. If refusal persists, complete the required refusal documentation and record the capacity assessment, risks explained, consultations, and witnesses.

(Appelbaum, 2007; NASEMSO, 2022; Powsner et al., 2023)

Documentation that Supports Continuity

- **Patient report:** Use brief quotations for suicidal thoughts, intent, expected outcome, and willingness to accept help.
- **Observed facts:** Mental status, injuries, substances, behavior, means, and changes over time.
- **Collateral:** Identify the source and distinguish report from direct observation.
- **Actions:** Treatment, observation, means safety, consultations, transport decision, and response.
- **Handoff:** Receiving person, destination, time, and unresolved safety concerns.

(SAMHSA, 2025; Troyer & Brady, 2020)

Sample EMS Narrative

Partner called 911 after receiving a goodbye text at 18:10. Patient stated, “I took the pills because I wanted to die,” and reported continuing suicidal thoughts. Patient was drowsy but arousable and oriented to person and place. Partner reported a firearm in a locked bedroom safe. EMS did not handle the firearm. Law enforcement confirmed that the safe remained secured. Poison Control recommended continuous monitoring and emergency department evaluation; online medical direction concurred. Patient transported with continuous observation. Receiving RN accepted handoff at 19:02 and received the ingestion details, consultation recommendations, current intent, collateral report, and firearm access.

Composite documentation example

Safe Handoff: SBAR with Risk Detail

- **Situation:** Reason for contact, current medical status, and immediate suicide concern.
- **Background:** Event timeline, patient statements, past behavior, substances, treatment, and collateral report.
- **Assessment:** Mental status, intent, plan, access, observed behavior, response to care, and limits of the interview.
- **Recommendation:** What the patient needs next, precautions in place, and unresolved medical or safety issues.
- **Close the loop:** Confirm the receiving clinician heard the critical risk information.

(Troyer & Brady, 2020)

Referral and Coordination Pathways

- **Medical emergency or immediate physical danger:** Activate emergency transport and destination notification according to protocol.
- **Behavioral health crisis:** Use local mobile crisis, tribal or IHS behavioral health, crisis receiving, or emergency department pathways.
- **988 Lifeline:** Call, text, or chat 988 for crisis counseling and connection to local resources.
- **Warm connection:** When remaining in the community is permitted, confirm the accepting service, responsible support, and backup plan.

(988 Suicide & Crisis Lifeline, n.d.)

Common Pitfalls

- Relying on “Are you safe?” or accepting a denial without clarifying the event.
- Treating a score, diagnosis, or protective factor as proof of safety.
- Using a “no-suicide contract” instead of collaborative safety planning and appropriate disposition.
- Ignoring medical causes, intoxication, scene evidence, or collateral information.
- Giving a phone number without confirming the next contact or responsible support.

(Bryan et al., 2017; Carter et al., 2017; Stanley & Brown, 2012)

Key Takeaways

- Direct, respectful suicide questions improve clarity and do not increase suicide risk.
- A brief field assessment supports immediate action. It does not predict the future or replace a full evaluation.
- Medical stabilization, observation, means safety, and reassessment occur alongside the suicide inquiry.
- The safest handoff carries patient statements, observed facts, collateral information, access to means, and unresolved concerns.
- Local protocol, medical direction, tribal policy, and community pathways shape the final response.

(Blades et al., 2018; Powsner et al., 2023; Troyer & Brady, 2020)

Practice Resources

- **988 Suicide & Crisis Lifeline:** Call or text 988, or chat at 988lifeline.org.
- **NIMH ASQ Toolkit:** Validated screening tools and clinical pathways for medical settings.
- **SAMHSA SAFE-T:** Framework for inquiry, formulation, intervention, and documentation.
- **NASEMSO Guidelines:** National model guidance for universal care, behavioral emergencies, and refusals.
- **MDCalc:** Point-of-care access to the C-SSRS and other clinical tools. Use agency-approved versions and pathways.
- **Poison Help:** Call 1-800-222-1222 to reach the local poison center.
- **Local resource map:** Add tribal, IHS, mobile crisis, crisis receiving, ED, law enforcement, and medical direction contacts before delivery.

Resources verified September 16, 2026 (Health Resources and Services Administration [HRSA], n.d.; MDCalc, n.d.)

Questions and Discussion

Thank you!

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