Suicide Risk Assessment & Prevention

National Psychology Training Consortium

Kristen Thompson, PhD, LP

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Objectives

- Participants will identify their own strengths and weaknesses with regard to suicide assessment
- Participants will demonstrate understanding of individual and environmental characteristics that impact suicide risk
- Participants will review standardized suicide assessment tools and their applications
- Participants will describe key components of documentation for risk assessment
- Participants will characterize suicidality based on severity and will identify interventions based on severity

Overview

- Introductions
- Self assessment
- Suicide by the numbers
- Characteristics of suicidality
  - BREAK (930 AM)
- Assessment strategies
  - Break (1030 AM)
- Level of risk and intervention plans
- Means restriction
- Documentation
- Conclusions
  - End (1130 AM)

Name

Internship site and track

Graduate School

What ideas do you have about living in Missouri?

Introductions

Self Assessment

- What has your training in risk assessment been like to date?
- What are your strengths?
- What are your weaknesses?
- How confident are you in your ability?

Human Error

- Regehr et al (2016). Mock patient. Clinicians conduct suicide assessment, determine risk and recommendation re. hospitalization
  - Highly variable in outcomes re. risk level and need for hospitalization
  - Yet, overall high confidence ratings, regardless of recommendation
  - We need standardized assessment tools; our instincts are not enough

Human Error

- Bermen et al. (2016). Vignette; 79 yo and 39 yo versions of client. Clinicians rate risk and hospitalization need. *
  - Young clinicians rated clients risk and hospitalization needs higher when he was older
  - Older clinicians rated clients risk and hospitalization needs as higher when he was younger
  - Similarity bias? Client who is different is at higher risk?
  - What do the stats tell us? Who is at higher risk?

Suicide by the numbers

Suicide Data: Missouri

Suicide is a public health problem and leading cause of death in the United States. Suicide can also be prevented – more investment in suicide prevention, education, and research will prevent the untimely deaths of thousands of Americans each year. Unless otherwise noted, this fact sheet reports 2020 data from the CDC, the most current verified data available at time of publication (March 2022).

11th leading cause of death in Missouri

3rd leading cause of death for ages 10-24

3rd leading cause of death for ages 25-34

4th leading cause of death for ages 35-44

5th leading cause of death for ages 45-54

10th leading cause of death for ages 55-64

18th leading cause of death for ages 65+

Suicide Death Rates

	Number of Deaths by Suicide	Rate per 100,000 Population	State Rank
Missouri	1,125	18.13	15
Nationally	45,979	13.48	

See full list of citations at afsp.org/statistics.

94.07% of communities did not have enough mental health providers to serve residents in 2021, according to federal guidelines.

Almost **five times** as many people died by suicide in 2019 than in alcohol related motor vehicle accidents.

The total deaths to suicide reflected a total of **24,079 years** of potential life lost (YPLL) before age 65.

49% of firearm deaths were suicides.

63% of all suicides were by firearms.

afsp.org/statistics

5 Leading Causes of Death, United States

2020, Both Sexes, All Ages, All Races

5-9	10-14	15-19	20-24	25-34	35-44	45-54
Unintentional Injury 46.8 %	Unintentional Injury 38.2 %	Unintentional Injury 45.3 %	Unintentional Injury 53.6 %	Unintentional Injury 57.5 %	Unintentional Injury 46.1 %	Malignant Neoplasms 28.1 %
Malignant Neoplasms 26.1 %	Suicide 25.2 %	Homicide 25.0 %	Homicide 19.9 %	Suicide 15.5 %	Heart Disease 18.1 %	Heart Disease 27.8 %
Congenital Anomalies 11.7 %	Malignant Neoplasms 17.8 %	Suicide 21.5 %	Suicide 19.7 %	Homicide 13.1 %	Malignant Neoplasms 15.9 %	Unintentional Injury 22.6 %
Homicide 11.6 %	Homicide 12.4 %	Malignant Neoplasms 5.3 %	Malignant Neoplasms 3.9 %	Heart Disease 7.3 %	Suicide 10.9 %	Covid-19 13.8 %
Heart Disease 3.8 %	Congenital Anomalies 6.5 %	Heart Disease 2.9 %	Heart Disease 2.9 %	Malignant Neoplasms 6.6 %	Covid-19 9.0 %	Liver Disease 7.7 %

Characteristics of Suicidality

Groups at higher risk

- LGBTQIA+ youth
- Youth in Juvenile Justice or foster care systems
- American Indian and Alaska natives
- Veterans, active military
- Men in middle age
- Chronically ill
- Race
  - Between 2019 & 2020, suicide rates decreased 4.5% among non-Hispanic white persons but increased 4.0% among non-Hispanic black people and 6.2% among non-Hispanic AI/AN people (CDC, 2022)

Source: suicide prevention resource network

Risk factors are characteristics of a person or their environment that increase suicide risk; may be malleable or permanent

Risk factors:

- Prior suicide attempt(s), self-injurious behaviors
- Substance abuse
- Psychiatric disorders
  - *particularly mood disorders, psychotic disorders, PTSD, conduct disorders, Cluster B personality.*
  - *Comorbidity + recent onset increase risk*
- Access to lethal means
- Family history of psychiatric hospitalization, suicide; suicide of close associate
- Social isolation
- Chronic disease and disability
- Lack of access to behavioral health care

Source: suicide prevention resource network

Precipitating factors are stressful events that can trigger a suicidal crisis in a vulnerable person

Precipitating factors

- Interpersonal conflict, end of a relationship
- Death of a loved one
- Legal trouble, an arrest
- Serious financial problems
- Bullying events
- *33% of minors reported crisis w/in 24 hours of completed suicide*

Source: suicide prevention resource network; Holt et al., 2015

Protective factors are personal or environmental characteristics that minimize suicide risk

Protective Factors

- Effective behavioral health care
- Connectedness to individuals, family, community, and social institutions
- Life skills (including problem solving skills and coping skills, ability to adapt to change)
- Self-esteem and a sense of purpose or meaning in life (“mattering”)
- Cultural, religious, or personal beliefs that discourage suicide

Source: suicide prevention resource network

Break

Assessing Suicidality

When is suicide screening warranted?

- First time seeing any patient age 12 and up
- Periodically for all patients age 12 and up
- Regularly for depression clients and any client with a history of suicidality
- Anytime things change that could result in increase in risk
- **When clinical judgement indicates**

Source: Cheung et al., 2007

Discussion

– What is the most frequently used tool to assess suicidality?

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: ______________________ DATE: __________

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns	+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	
	Not difficult at all ______
	Somewhat difficult ______
	Very difficult ______
	Extremely difficult ______

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PHQ

- PHQ2: Asks 1-2; doesn't directly ask about suicide.
  - *If screen positive (score of 2 or more), follow-up*
  - *However, client with suicidality may not have a positive PHQ2*
- PHQ9/PHQA: "In the past two weeks have you had thoughts that you would be better off dead or of hurting yourself in some way"
  - *Answer 1-2 = more assessment warranted*
  - *Answer 0 = no further assessment needed*

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add columns		___ +	___ +	___

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL: ____

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Not difficult at all	___
Somewhat difficult	___
Very difficult	___
Extremely difficult	___

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PHQ

- *Single-item assessment of suicidal ideation leads to misclassification, with 10% false negatives (Milner, Lee, & Nock, 2015)*
- When does a zero constitute sufficient screening?
- When is more needed?
- Remember - the PHQ is NOT a suicide screener

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*: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, held a gun but changed your mind, cut yourself, tried to hang yourself, etc.		**High Risk**

Columbia-Suicide Severity Rating Scale (C-SSRS)

- Brief assessment screening, over 100 languages, formatted for widespread use
- Endorsed, recommended, or adopted by: SAMHSA, CDC, NIH, WHO, DOD
- Available for free download: http://cssrs.columbia.edu/

SAFE-T

Suicide Assessment Five-step Evaluation and Triage

1
IDENTIFY RISK FACTORS
Note those that can be modified to reduce risk

2
IDENTIFY PROTECTIVE FACTORS
Note those that can be enhanced

3
CONDUCT SUICIDE INQUIRY
Suicidal thoughts, plans, behavior, and intent

4
DETERMINE RISK LEVEL/INTERVENTION
Determine risk. Choose appropriate intervention to address and reduce risk

5
DOCUMENT
Assessment of risk, rationale, intervention, and follow-up

Suicide Assessment Five-step Evaluation and Triage (SAFE-T)

- Tool provides:
  - quick access to risk/protective factors to consider
  - specific points to guide clinical interview
  - guidelines for determining risk/intervention
  - recommendations for documentation

Fowler, C. (2012)

SAFE-T Protocol with embedded C-SSRS

Step 4: Guidelines to Determine Level of Risk and Develop Interventions to LOWER Risk Level

"The estimation of suicide risk, at the culmination of the suicide assessment, is the quintessential **clinical judgment**, since no study has identified one specific risk factor or set of risk factors as specifically predictive of suicide or other suicidal behavior."
From The American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors, page 24.

RISK STRATIFICATION	TRIAGE
High Suicide Risk ☐ Suicidal ideation with intent or intent with plan **in past month** (C-SSRS Suicidal Ideation #4 or #5) **Or** ☐ Suicidal behavior **within past 3 months** (C-SSRS Suicidal Behavior)	☐ Initiate local psychiatric admission process ☐ Stay with patient until transfer to higher level of care is complete ☐ Follow-up and document outcome of emergency psychiatric evaluation
Moderate Suicide Risk ☐ Suicidal ideation with method, **WITHOUT plan, intent or behavior in past month** (C-SSRS Suicidal Ideation #3) **Or** ☐ Suicidal behavior more than 3 months ago (C-SSRS Suicidal Behavior Lifetime) **Or** ☐ Multiple risk factors and few protective factors	☐ Directly address suicide risk, implementing suicide prevention strategies ☐ Develop Safety Plan
Low Suicide Risk ☐ Wish to die or Suicidal Ideation **WITHOUT method, intent, plan or behavior** (C-SSRS Suicidal Ideation #1 or #2) **Or** ☐ Modifiable risk factors and strong protective factors **Or** ☐ No reported history of Suicidal Ideation or Behavior	☐ Discretionary Outpatient Referral

Step 5: Documentation

Risk Level :
[ ] High Suicide Risk
[ ] Moderate Suicide Risk
[ ] Low Suicide Risk

- Combine tools for assessing suicidality, stratifying risk, determining interventions, and guiding documentation

Determine Level of Risk and Intervention Plan

Low

- No identifiable suicidal ideation or minimal risk factors
- Response:
  - No particular changes in ongoing treatment
  - Continue to monitor

Mild

- Suicidal ideation of limited frequency, intensity, and duration: no identifiable plans, no intent, mild dysphoria/symptoms, good self control, few risk factors, and identifiable protective factors
- Response:
  - *Crisis numbers*
  - *Consider means restriction*
  - *Consider safety plan*
- Consult/Initial Assessment:
  - *Consider referral to outpatient treatment*
- Outpatient:
  - *Ongoing monitoring for change in risk*
  - *Modifications to treatment plan as necessary*

Moderate

- Frequent suicidal ideation with limited intensity and duration; some specific plans, no intent, good self-control, limited dysphoria/symptoms, some risk factors present, and identifiable protective factors
- Response:
  - *Crisis numbers*
  - *Safety plan*
  - *Means restriction*
  - *Professional consultation as indicated*
- Consult:
  - *f/u with patient or refer for outpatient treatment*
- Outpatient:
  - *Increase of frequency of contact (in person, phone)*
  - *Active involvement of family – support systems*
  - *Frequent reevaluation of suicide risk, noting specific changes that reduce or elevate risk*

Severe

- Frequent, intense, and enduring suicidal ideation: specific plans, some markers of intent (choice of lethal method), available/accessible, some limited preparatory behavior, evidence of impaired self-control, severe dysphoria/symptoms, multiple risk factors present and few if any protective factors.

- Response:
  - *Referral for ED evaluation for psychiatric hospitalization (voluntary/involuntary)*
  - *Consider consultation and/or brief assessment by another provider*
    - Can be helpful if involuntary is needed; two affidavits are stronger than one
  - *Initiate one-to-one in inpatient medical setting*

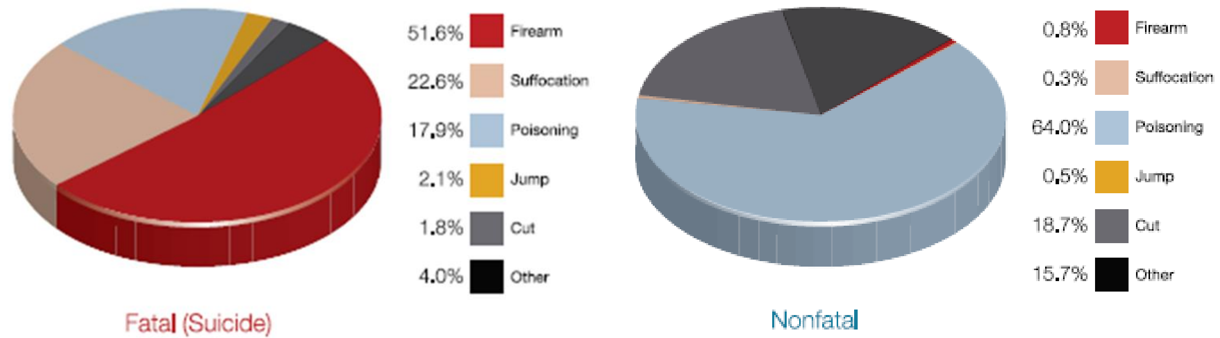
Extreme

- Frequent, intense, and enduring suicidal ideation: specific plan, clear intent, impaired self-control, severe dysphoria/symptoms, many risk factors and no protective factors.

- Response:
  - *Psychiatric hospitalization*
  - *Do not leave alone (initiate one-to-one in inpatient setting)*

Break

Means Restriction



Source: Harvard Injury Control Research Center; meansmatter.org

Means Matter

- Suicidal *ideation* may be ongoing but the transition to *intent* and *action* can be rapid and short lived
- The deadliness of the attempt depends directly on the lethality of the means
- 90% of those who survive and attempt do *not* go on to complete suicide
- Means restriction may not prevent an attempt, but can *dramatically* increase odds of survival

Source: Harvard Injury Control Research Center; meansmatter.org

Assess Means

- What does the plan look like?
- What do they think about (schema)?
- What do they have access to?

Lock, Limit, Remove

- Create barriers between the individual and the identified means
  - Firearms: Trigger lock or safe; have a family member take the key; store off-sight; disassemble the gun; separate ammunition from the firearm
  - Medication: restrict access so clients are not able to self-administer during times of increased risk
  - Other?

Source: Harvard Injury Control Research Center; meansmatter.org

Document

"Robust documentation helps to create institutional knowledge about the specific patient, thereby allowing for more patient-centered care across presentations and individual providers." (Stanley et al. 2019, pg 306)

Low

- Brief statement documenting the assessment you completed:
  - "pt denied suicidal ideation/plan/intent"
- Assessment:
  - Note if a specific assessment tool/screener used; report outcome
  - "PHQ-A = 2"

Mild Risk

- Statement about pt's report:
  - "Pt endorsed occasional passive suicidal ideation without plan or intent. He described sometimes wishing he would go to bed and not wake-up. A couple of weeks ago, fantasized about dying in an accident; denied ideation about active suicidal behavior"
- Document risk/protective factors if not already included in note
- Assessment:
  - Note if a specific assessment tool/screener used; report outcome
  - "PHQ-A = 6"
- Document steps you took in session summary/plan section as appropriate
  - Completed safety plan, provided crisis numbers, counseled on means restriction
  - Note plan for ongoing monitoring of risk; note any changes to general treatment plan

Moderate Risk

- **Detail pt's report re. ideation, plan, intent:**
  - "Pt reported daily thoughts of wishing he were dead and frequent thoughts of suicide. Imagines that he would use a gun to shoot himself. Father keeps hunting rifles in the home, unlocked. Pt reports that he doesn't want to kill himself, wants thoughts to stop. Has not made specific plans"
- **Document risk/protective factors**
  - "Pt has no history of attempts; no family history of attempts. Positive for depression, hopelessness. Parents recently separated, feels alone. Access to firearms. Identifies family and religion as strong reasons why he would not commit suicide.
- **Assessment:**
  - Note if a specific assessment tool/screener used; report outcome
- **Document steps you took in session summary/plan section as appropriate**
  - Completed safety plan, provided crisis numbers, counseled on means restriction
  - When risk is moderate or greater, provide more details re. safety plan, plan for means restriction
- **Note when plan for f/u, increase contact, etc…**
- **Note plan for monitoring risk moving forward, any changes in treatment planning**
- **Document consultation if utilized**

Extreme/Severe

- Everything included in Moderate

PLUS

- Note behavioral observations
- Pt's response to/agreement with hospitalization
- Clearly document any other staff/providers/family members involved, both internal and external
- Plan for communicating with hospital
- Plan for f/u with pt. post hospitalization

Conclusions

Youth

– Need to get reports from parents and patients
– Parents role in risk, prevention
– Parents anxiety about suicide screening
  – *Screening DOES NOT increase SI*
– Need to assess parents' ability to maintain safety

Malpractice Considerations

– You *cannot* predict suicide
– You are not responsible for preventing suicide; you are responsible for *trying* to prevent suicide
– Most important:
  – Empirically supported treatment
  – Ongoing assessment
  – Timely and complete documentation
– Document!
  – "When a lawyer initially reviews a potential case, all he or she typically has are the medical records. Accordingly, nothing will stop a malpractice lawyer dead in his or her tracks quicker than a well-documented chart reflecting careful and thoughtful suicide assessments (Simpson and Stacy, 2004, p. 185).

Follow the Steps

- Identify risk and protective factors
- Assess comprehensively
  - Clinical Interview
  - Assessment tools
- Determine level of risk
- Identify appropriate interventions
- Document

Goal Setting

- What do you want to work on re. risk assessment this year?
- Set a Goal!

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