SUICIDE RISK ASSESSMENT

SUSAN L. PRIETO-WELCH, PH.D., HSPP

JULY 28, 2023

Objectives

- Explore personal beliefs, feelings about, and experiences with, suicide and suicide ideation
- Explore professional responsibilities as a therapist
- Information/data about suicide
- How to assess, intervene and document in cases involving suicidal ideation and/or intent
- Increase knowledge/information, confidence and skill in dealing with suicidal clients

Presentation Overview

- Personal Experiences with Suicide
- Beliefs about Suicide
- Assessment of Suicide: Why do it & how to do it?
- Documentation
- Treatment Considerations
- Support and Self-Care

Self-Exploration Questions

- Why do people kill themselves?
- Is it ever acceptable to suicide?
- Can suicide be prevented?
- Do people who access care want to die?
- What are your individual responsibilities to suicidal clients?

Impact of Personal/Professional Experiences and Attitudes on:

- **Conceptualization**
- **Therapy alliance**
- **Suicide assessment**
- **Treatment & management of symptoms**

INTERESTING FACTS ABOUT SUICIDE

Suicide is the ___ leading cause of death in the U.S.	**Suicide risk can be highest when a person has just been discharged from the hospital. T or F?**	**People who seek treatment are more/less likely to complete suicide?**	**Which group attempts suicide more often—men or women?**	**Suicide is the ___ leading cause of death for youths between the ages of 15 and 24.**
What are two risk factors for attempted suicide in adults?	The lowest suicide rate for all ages combined is _____ women.	The gender ratio for suicide completion is _____.	Substance use increases the likelihood of suicide risk. T or F	More than 90% of people who kill themselves have some diagnosable mental health or substance abuse disorder. T or F?
What is the most common method of suicide? For men? For women?	College students are more/less at risk for suicide than non-students the same age?	People with personality disorders are ___x as likely to die by suicide than those without.	LGBTIQ issues and gender identity concerns are risk factors for suicide. T or F	People who die by suicide are often suffering from undiagnosed, undertreated, or untreated depression. T/F?
What percentage of people diagnosed w/ schizophrenia die by suicide?	What are two warning signs of suicide in the college population?	APA has developed practice guidelines for assessing and treating patients with suicidal behaviors. T or F	In depth discussion of suicidal ideation increases the likelihood of follow through by the client. T or F?	Creating a no-suicide contract with a client decreases the likelihood of an attempt or suicide. T or F?

Assessment: Why Do It?

- **Formally assess suicide at <u>every</u> initial evaluation, and as clinically indicated in follow-up contacts.**
- **Treatment consistency**
- **Standards of Care**
- **Liability protections**

Helpful Process Tips

- **Engage; Listen well (active listening)**
- **Collaboration and honesty**
- **Watch for discrepancies; listen with "third ear"**
- **Strong eye contact**
- **Terminology is key!**
- **Specificity**
- **Acknowledge resistance and normalize it**

Rudd's framework:
Static, Aggravating, and Protective Factors

Overall risk is determined by the following formula:

STATIC + AGGRAVATING FACTORS

PROTECTIVE FACTORS

Chronic vs. Acute

- **Multiple attempters (2 or more)**
- **More severe, enduring crises (triggered and spontaneous)**
- **Greater frequency of instrumental suicide behavior**
- **"Acute" status is determined by aggravating factors that elevate client's baseline risk**
- **Based on current symptom profile**

Assessment: What to Ask on the front end

"OVER THE PAST TWO WEEKS, HOW OFTEN HAVE YOU HAD THOUGHTS ABOUT WANTING TO COMPLETE SUICIDE?"

0 = NEVER 1 = RARELY 2 = SOMETIMES 3 = FREQUENTLY 4 = ALWAYS

IF 2 OR ABOVE, PROCEED WITH COMPREHENSIVE SUICIDE ASSESSMENT.

USE CLINICAL JUDGMENT TO DETERMINE IF A MORE IN-DEPTH ASSESSMENT OF SUICIDE NEEDS TO BE MADE WHEN CLIENT SCORES BELOW 2.

Intent to Die

SUBJECTIVE

- Contemplation
- Desire to suicide/die?
- Plan A? Plan B?

OBJECTIVE

- Behavioral prep—implementation of plan
  - Pill gathering
  - Wills/letters
  - Give away belongings
  - Not attending usual activities
  - Saying goodbye

Motivation & Meaning of Thoughts/Behaviors

- **Why now?** Assess precipitants, aggravating factors
- **Does past affect the present?** Assessing predisposing, static factors
- **Meaning of suicide ideation, intent, or plan**:
  - Hopeless? Helpless?
  - Burdensome?
  - Reasons for dying?
  - Intensity of thoughts (frequency/duration)

Plans & Rehearsals

- **When, where, how?**
- **Access to method of suicide?**
- **Does client have enough knowledge to implement this plan?**
- **How lethal?**
- **Attempts to prevent rescue**
- **Has client practiced this plan or done a "dry run" of his/her suicide?**

Instrumental Suicide Behavior

- **Potentially self-injurious behavior where motivation is *not* death**
- **Non-suicidal self-injurious behavior**
- **Injury, no injury, or death**

Past Attempts

- **"Have you ever made a suicide attempt before?"**
  - **Assess recent and distant past**
- **Assess intent**
  - **"What was your goal in attempting suicide?"**
  - **"What did you hope would happen?"**
- **"Attempt with or without injuries"**
- **Help-seeking behavior? (therapy, meds, hospital)**

IMPULSIVITY!!!!

- **Objective and subjective markers**
  - **Subjective: "I'm usually very planful."**
  - **Objective: risky hypersexuality; previous suicide attempt occurred without warning; client frequently acts on emotions**
- **Evidence that client can delay gratification or show restraint?**

Physiological, Cognitive, Affective States

- **Medical illnesses**
- **Disorders associated with suicide**
  - **Mood disorders (bipolar, depression, dysthymia)**
  - **Substance abuse/dependence**
  - **Schizophrenia (psychosis, command hallucinations)**
  - **Anorexia Nervosa**
  - **Severe/unrelenting/agitated anxiety**
- **Personality Disorders and/or traits**
- **Assess for reality testing/thought disorders**

Life Stressors

- **What other stressors exist in client's life?**
  - **Significant losses**
  - **Relationship issues**
  - **Legal issues**
  - **Financial issues**
  - **Job/school issues (e.g., failure)**
  - **Transitions**
  - **Possible multicultural issues**

Treatment-related Stressors

- **Termination**
- **Your (therapist) vacations**
- **Client vacations**
- **Change in therapy format or frequency**
- **Has client just been released from hospital?**

Protective Factors

- **Quality and quantity of social support**
- **Ability to problem-solve**
- **How has client handled crises before?**
- **Assess joy, religious beliefs, reasons for living**

DOCUMENTATION

Elements to include in documentation:

- **Specific suicide inquiry**
- **Static Risk, aggravating/acute factors, protective factors**
- **Chronic risk, based on history?**
- **Clinical observations**
- **Rationale for treatment or for the options considered but not taken**

(ALL BASED ON ASSESSMENT OF CLIENT'S OVERALL RISK)

- **Follow-up plans**
- **Response plan if client is at increased risk for suicide**

Example of Rating Model

- Mild/Low Risk: threats with no plan; no prior attempts; no alcohol/drug problems; satisfactory social support
- Moderate Risk: threats with low lethal plan, or consideration of high lethal attempt with no specific plan; history of low lethal attempts; drug/substance use for stress relief; ambivalence about life and death
- Severe/High Risk: current high lethal plan; available means; previous attempts; alcohol/substance problems; depression; wanting to die.
- Very High/Extreme Risk: all Severe/High Risk criteria, plus impending loss or social crisis; using alcohol and/or other substances to excess; history of high lethal attempts.

Sample note framework to start from

- After performing a careful suicide assessment, taking into account protective (good therapeutic alliance, good support system, religious beliefs, future oriented thinking, lack of prior suicide attempts) and risk factors (gender, age, access to weapons, diagnosis, substance abuse, prior attempts), I conclude that this patient is/is not an imminent suicide risk. This led to the following treatment plan to mitigate risk: patient will contract for treatment engagement and safety, will check with supports daily, will increase frequency of sessions, will remove weapons from his/her environment, I will refer for psychiatric evaluation/reassessment, etc.

SAP (suicide assessment plan), NIRI (no immediate risk identified). Treatment interventions discussed and agreed to are as follows: _____.

Treatment

- **Suicidality becomes focus of treatment**
- **Rationale for treatment must be based on assessment of client**
- **Limit-setting: Refer out if unable to treat client appropriately. Follow up with referral.**

For the client we keep on our caseload . . .

Points to cover/include:

- **Hospitalization, if needed**
- **Previous records**
- **Emergency plans/after-hour care**
- **Commitment to Treatment/Crisis Response Plans**
- **Interventions based on client's concerns**
- **Relaxation, affect tolerance, thought records**
- **Follow up each session (rating scales)**
- **Get thee to consultation/supervision!!**

Problems with No-Suicide Contracts

- **Limited value and meaning**
- **Limited to no empirical support**
- **Potential liability (why do only suicidal people get them if they don't really work?)**
- **Not therapeutic**
- **Hidden messages of blame, control, poor communication**

Why Commitment to Treatment is the way to go…

- **Can be individualized and tailored to the client**
- **Is concrete and specific**
- **Enhances individual responsibility**
- **Commitment to treatment, rather than promising not to die**

Crisis Response Plan

Can be summarized in small, easy to carry card (or on cell phone):

- **Small card that clients can keep with them at all times/take picture with phone**
- **Provides suggestions, self-soothing activities**
- **Includes emergency telephone numbers**
- **Is specific, concrete, accessible**
- **Is reviewable, updatable**
- **Go through this in detail with client!/Develop with client**

Collaborative Assessment and Management of Suicidality (CAMS)

- Model of assessment and intervention developed by David Jobes, Ph.D.
- Is both a method of assessment and organizing information, and a move from assessment into intervention
- Based on research
- Takes into consideration protective elements of risk management in situations where active suicidality is present and needs attention
- Tries to streamline things for the clinician, and help with documentation

Tools to consider when working with children and adolescents

- Pediatric Symptom Checklist: https://www.brightfutures.org/mentalhealth/pdf/professionals/ped_sympton_chklst.pdf
- Columbia- Suicide Severity Rating Scale (C-SSRS)

  https://cssrs.columbia.edu/wp-content/uploads/C-SSRS_Pediatric-SLC_11.14.16.pdf
- PHQ-9 Modified for Adolescents (PHQ-A)

  https://www.childrenshospital.org/sites/default/files/2022-03/PHQ%20Form.pdf

Therapist self-reflection and self-care

WHAT DO YOU *REALLY* THINK WHEN THE CLIENT ENDORSES SUICIDAL THOUGHTS?

Countertransference

- **Therapist thoughts:**
  - **This is just talk!!!**
  - **I don't have time for this**
  - **I'll be held responsible**
- **Feelings**
  - **Guilt**
  - **ANXIETY**
  - **Fear**
  - **Shame**
  - **Anger, annoyance, hate**

- **Behavior indicative of negative countertransference**
  - **Late to appointments, ending early**
  - **Rescheduling**
  - **Taking phone calls in session**
  - **Not returning phone calls**
  - **Daydreaming in session**
  - **Forgetting critical information**

Support and Supervision are critical

- **Supervision and Consultation**
- **Emergency case conferences**
- **Wrap-around therapy (Communication!)**
- **Learning to deal with provocation by clients in adaptive ways**

Malpractice Vulnerability areas in Outpatient Treatment

- **Failure to address possible need for pharmacotherapy**
- **Failure to specify criteria for and implement hospitalization**
- **Failure to maintain appropriate therapist-client relationship**
- **Failure to evaluate for suicide risk: intake, transition points, termination**
- **Failure to secure previous records**
- **Inadequate history taking**
- **Failure to monitor mental status and changes**
- **Failure to diagnose**
- **Failure to establish formal treatment plan**
- **Failure to safeguard environment**
- **Failure to document judgment, rationale, observations**

References

- APA Recommendations to the USPSTF on Suicide Risk for Adolescents and Older Adults (May 20, 2013). http://www.apa.org/pi/about/adolescent-suicide.aspx
- Brown, G., Brenner, L., Galfalvy, H., Currier, G., Knox, K., Chaudhury, S., Bush, A., Green, K. (2018). Comparison of Safety Planning Intervention with follow-up vs usual care of suicidal patients treated in the Emergency Department. JAMA Psychiatry, 2018, 75(9), 894-900.
- Chung, D.T., Ryan, C.J., Hadzi-Pavlovic, D., Singh, S.P., Stanton, C., and Large, M.M. (2017) Suicide rates after discharge from Psychiatric facilities: A systematic review and meta-analysis. JAMA Psychiatry, 74(7), 694-702.
- Cwik, M.F.; O'Keefe, V.M.; Haroz, E.E. Suicide in the pediatric population: Screening, risk assessment and treatment. *Int. Rev. Psychiatry* **2020**, *32*, 254–264.
- DeCou CR, Comtois KA, Landes SJ. Dialectical behavior therapy is effective for the treatment of suicidal behavior: a meta-analysis. *Behav Ther*. 2019;50(1):60-72. doi:10.1016/j.beth.2018.03.009
- Fowler, J. C. (2012). Suicide risk assessment in clinical practice: Pragmatic guidelines for imperfect assessments. Psychotherapy, 49(1), 81–90.
- Jacobs, D. and Brewer, M. (2004). APA practice guidelines provides recommendations for assessing and treating patients with suicidal behaviors. Psychiatric Annals, 34(5), 373-380.
- Jobes, David A., (2016) Managing Suicidal Risk (2nd Edition): A Collaborative Approach. New York, NY: The Guilford Press.
- Lewis, L. M. (2007). No-harm contracts: A review of what we know. *Suicide and Life-Threatening Behavior,* 37(1), 50-57.
- O'Connor E, Perdue LA, Coppola EL, Henninger ML, Thomas RG, Gaynes BN. Depression and suicide risk screening: updated evidence report and systematic review for the US Preventive Services Task Force. *JAMA*. Published June 20, 2023. doi:10.1001/jama.2023.7787

- Rossom RC, Richards JE, Sterling S, et al. Connecting research and practice: implementation of suicide prevention strategies in learning health care systems. *Psychiatr Serv*. 2022;73(2):219-222. doi:10.1176/appi.ps.202000596
- Rudd, M.D. (2006) The Assessment and Management of Suicidality. Sarasota, FL: Professional Resource Press.
- Rudd. M.D., Cukrowicz, K. and Bryan, C.J. (2008). Core competencies in suicide risk assessment and management: Implications for supervision. Training and Education in Professional Psychology, 2(4), 219-228.
- Rudd, M.D. (2005) Clinical Core Competencies Curriculum: Resource Sheet. Resource Sheet #2: The Language of Suicide, p. 1-2.
- Rudd, M.D. (2005) Clinical Core Competencies Curriculum: Resource Sheet. Resource Sheet #6: The Phenomenology of Suicide: First Person Narratives, p. 1-4.
- Rudd, M.D., Joiner, Jr., T.E. & Rajab, M.H. (2004). *Treating suicidal behavior: An effective, time-limited approach*. New York: The Guilford Press.
- Simon GE, Shortreed SM, Rossom RC, et al. Effect of offering care management or online dialectical behavior therapy skills training vs usual care on self-harm among adult outpatients with suicidal ideation: a randomized clinical trial. *JAMA*. 2022;327(7):630-638. doi:10.1001/jama.2022.0423
- Simon GE, Richards JE, Whiteside U. Reframing the Key Questions Regarding Screening for Suicide Risk. *JAMA*. 2023;329(23):2026–2027. doi:10.1001/jama.2023.7241

Suicide Information Websites that may be helpful:

- http://cams-care.com/cams/
- American Association of Suicidology: http://www.suicidology.org
- American Foundation of Suicide Prevention: http://www.afsp.org
- Suicide Prevention Action Network (SPAN): http://www.spanusa.org
- Suicide Prevention Resource Center: http://www.sprc.org
- US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA): www.samhsa.gov