Suicide Assessment and Prevention in Early Psychosis

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Disclosures

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LEARNING OBJECTIVES

- Participants will understand the difference between proactive versus reactive risk management
- Participants will learn to systematically assess suicide risk through conducting the CRSS
- Participants will identify at least 5 risk and protective factors related to suicidal ideation and behaviors.

Before we begin…

- People in on this webinar have lived experience
  - Know someone who died by suicide
  - Have experienced thoughts of suicide or have a suicide behavior history – or know someone who has.
  - Let's have an honest conversation, but also be aware and respectful!

- Language is powerful!
  - NO: "committed suicide" or "killed themselves" → alludes to criminal or immoral view of suicide (e.g. "committed a crime" or "killed someone")
    - Perceived as blaming and stigmatizing
  - YES: "died by suicide" or "suicide death"
    - Factual and similar to how we discuss other illnesses (e.g. "died from cancer")

Outline for Today

- “Proactive” Suicide Risk Management
    - Initial and ongoing risk assessment (e.g. CSSRS, SBQ-R, ASQ)
    - Proactive interventions - Psychoeducation, Safety planning intervention (SPI)

- “Reactive” Suicide Risk Management
    - Crisis Management, including Safety Planning and increased monitoring

Suicide Risk

- In 2017, 1.4 million US adults attempted suicide
  - Attempts are serious and can result in permanent damage or disability.

- 25-31% of individuals will make a second suicide attempt in the 10 years following the first attempt, with the greatest risk (~88%) in the subsequent 2 years. (Tejedor et al., 1999; Gibb et al. 2005; Parra-Uribe et al., 2017)

Suicide Risk in Mental Health

- In general, serious mental illness is associated with elevated suicide risk
- For these disorders, rates vary between 8-15% for death by suicide
- Suicide is the 10th leading cause of death in US
  - In 2017, there were 47,000 deaths from suicide = 1 death every 11 minutes
- 2nd leading cause of death among individuals ages 10-34 years
- These are premature and preventable deaths

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https://www.cdc.gov/violenceprevention/suicide/fastfact.html

Suicide in Schizophrenia

- Of individuals with schizophrenia, 25-50% attempt suicide, which is serious and can result in permanent damage or disability (Cassidy et al., 2018).
  - Many individuals make repeated attempts
  - 5% die by suicide
- More likely in first year of illness, but risk is ongoing throughout illness (Ventriglio et al., 2016; Haining et al., 2020)
  - 34-90% of clinical high risk individuals report suicidal ideation, 70+% FEP report SI
  - Longer DUP = increased risk
- Early identification and intervention should focus on suicide to reduce rates (Kurdyak et al., 2021)

Challenges of Suicide Assessment

- Risk is determined by a variety of factors: biological, psychological, familial, environmental, cultural…
  - Hard to determine which key factors you need to assess

- Risk is not always predictive of behavior
  - Many people have “thoughts” of suicide, but many never attempt

- While most people who make attempts or die by suicide have discussed their suicidal thoughts, most do not tell anyone right before they act.

Key Points in Conducting a Risk Assessment

- Not based on any one risk factor (or set of risk factors)
- Risk and protective factors are assessed together to provide an overall picture
- Identifies factors that are modifiable with intervention
- Identifies and distinguishes between Acute/Proximal risk factors and warning signs from the ongoing, Chronic/Distal risk factors
- Guides treatment decisions
- In an ongoing care situation, risk assessment is not a single event; it must be evaluated over time → risk fluctuates
- Risk assessment supports, does not replace, clinician decision-making

Types of Risk Factors
Proximal vs. Distal vs. Warning Signs

- Distal (chronic, background) risk factors
  - Lifetime general characteristics or ongoing factors that are known to be associated with an elevated longer term risk for suicide; they exist in the individual's background
  - Examples:
    - Male
    - Suicide attempt 10 years ago;
    - Family history of suicide

Distal/Background Variables

- Demographics
- Aggression/ Impulsivity
- Cognitive Inflexibility & Poor Decision making
- Head Injury
- Genetics – Stress sensitivity
- Low Serotonergic Function
- Premorbid Social Adjustment
- Family History of suicide
- Childhood Abuse/Trauma
- Early Loss
- Chronic Physical/Mental Illness
- Prior suicide attempts
- Chronic Substance Abuse
- Treatment difficulties

Source: American Foundation for Suicide Prevention

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Types of Risk Factors
Proximal vs. Distal vs. Warning Signs

- Proximal (acute) risk factors
  - Recent events or exacerbations of ongoing characteristics that can indicate increasing or more imminent risk
  - Example:
    - Suicide attempt within the last 3 months
    - Current major depressive episode

<u>Proximal Variables</u>

- Acute Psychiatric Episode (e.g., MDE, Psychosis)
- Acute Medical Illness
- Stressful Life Event
- Poor social support / Family conflict
- Acute Substance Use
- Access to Means

Types of Risk Factors
Proximal vs. Distal vs. Warning Signs

- Warning Signs (most acute risk factors)
  - Events or behaviors that precede a spike in suicide risk in a particular individual, according to individual's history; time frames varies from individual to individual, from minutes to days
  - Examples:
    - Active, escalating suicidal ideation that is similar to the type of ideation present directly preceding a previous suicide attempt;
    - Recent increase in substance use
    - Recent loss or interpersonal conflict (e.g. job loss, divorce, removal of children)

Warning Signs

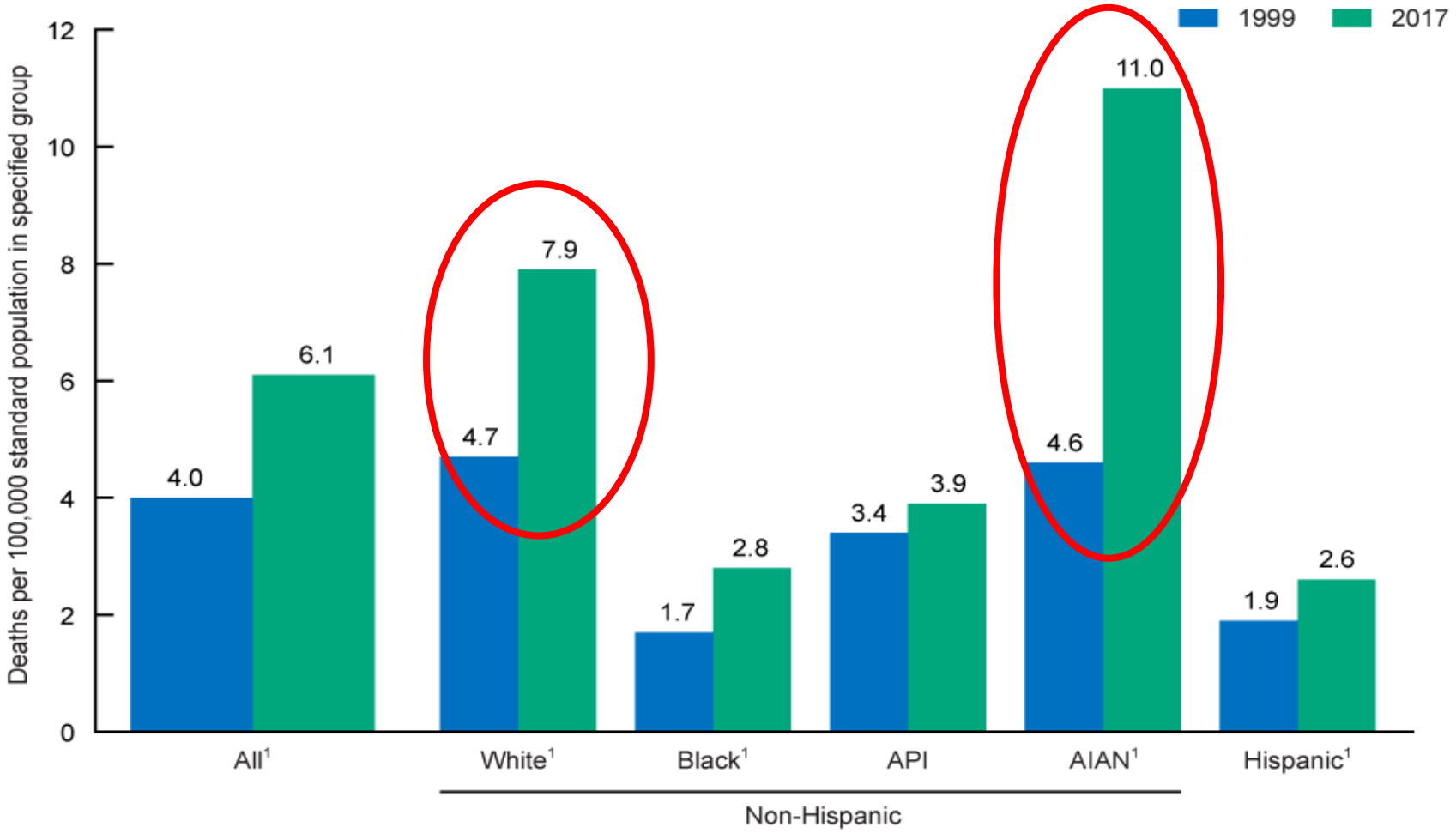
- Behavior
  - Increased use of alcohol or drugs.
  - Acting recklessly.
  - Isolating and withdrawing from activities.
  - Change in sleep, appetite, energy level.
  - Visiting or calling people to say goodbye.
  - Giving away prized possessions.
  - Aggression or agitation.
  - Discomfort due to psychosis/psychiatric symptoms.
  - Discomfort due to medication side effects.
- Things they Say:
  - Killing themselves
  - Having no reason to live
  - Being a burden to others
  - Feeling trapped
  - Unbearable pain
  - Hopelessness
- Mood:
  - Depression, despair
  - Loss of interest
  - Rage
  - Irritability
  - Humiliation
  - Anxiety

Other Considerations

- More males than females die by suicide
  - Females with psychosis at higher risk than general population OR other risk groups
- Sexual minority youth have higher risk than non-minority youth
- Certain occupations associated with higher risk: veterans/military, construction, arts/design, entertainment/food, sports and media

US Rates for Females by Race/Ethnicity

(Curtin & Hedegaard, 2019)



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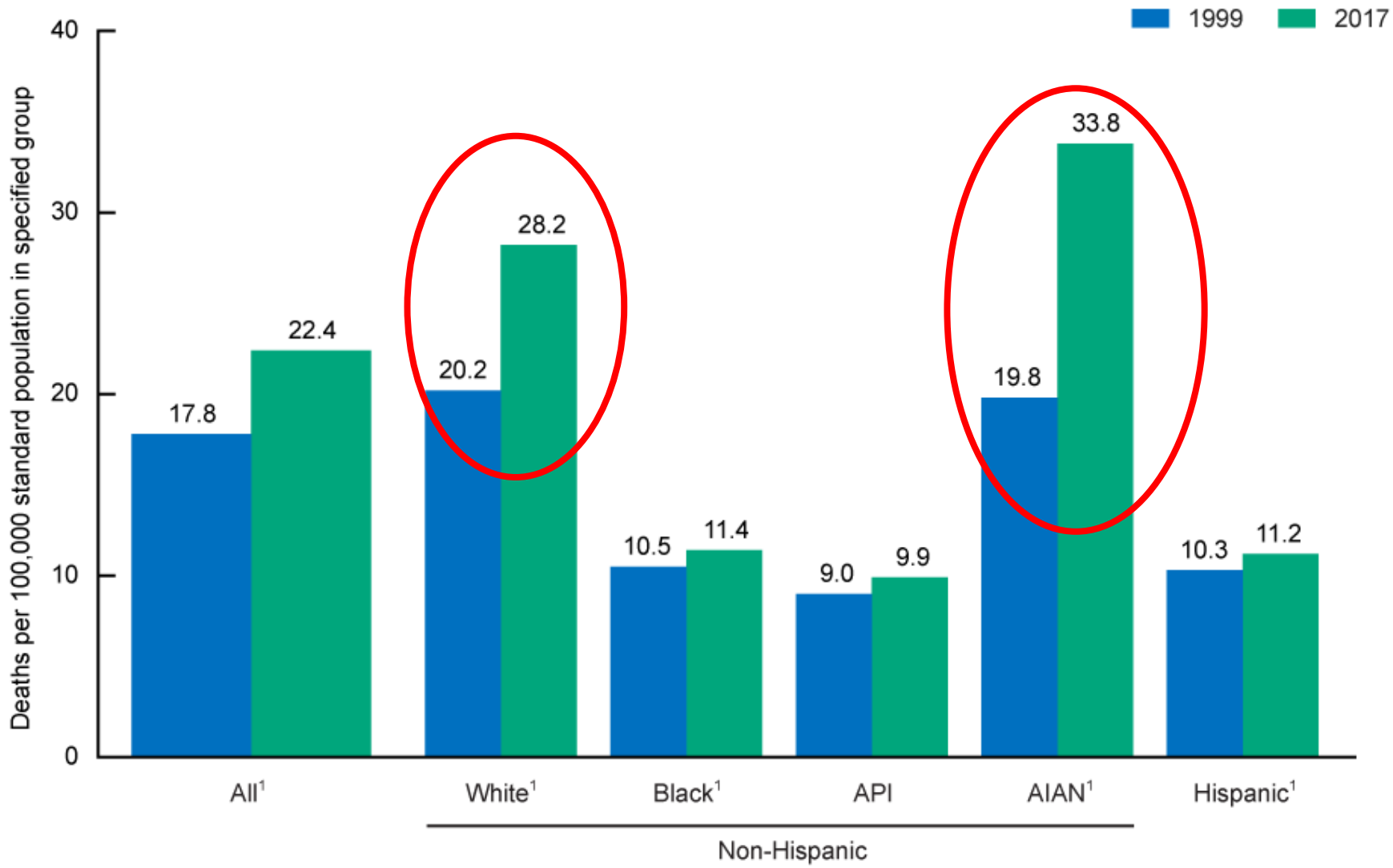
US Rates for Males by Race/Ethnicity (Curtin & Hedegaard, 2019)



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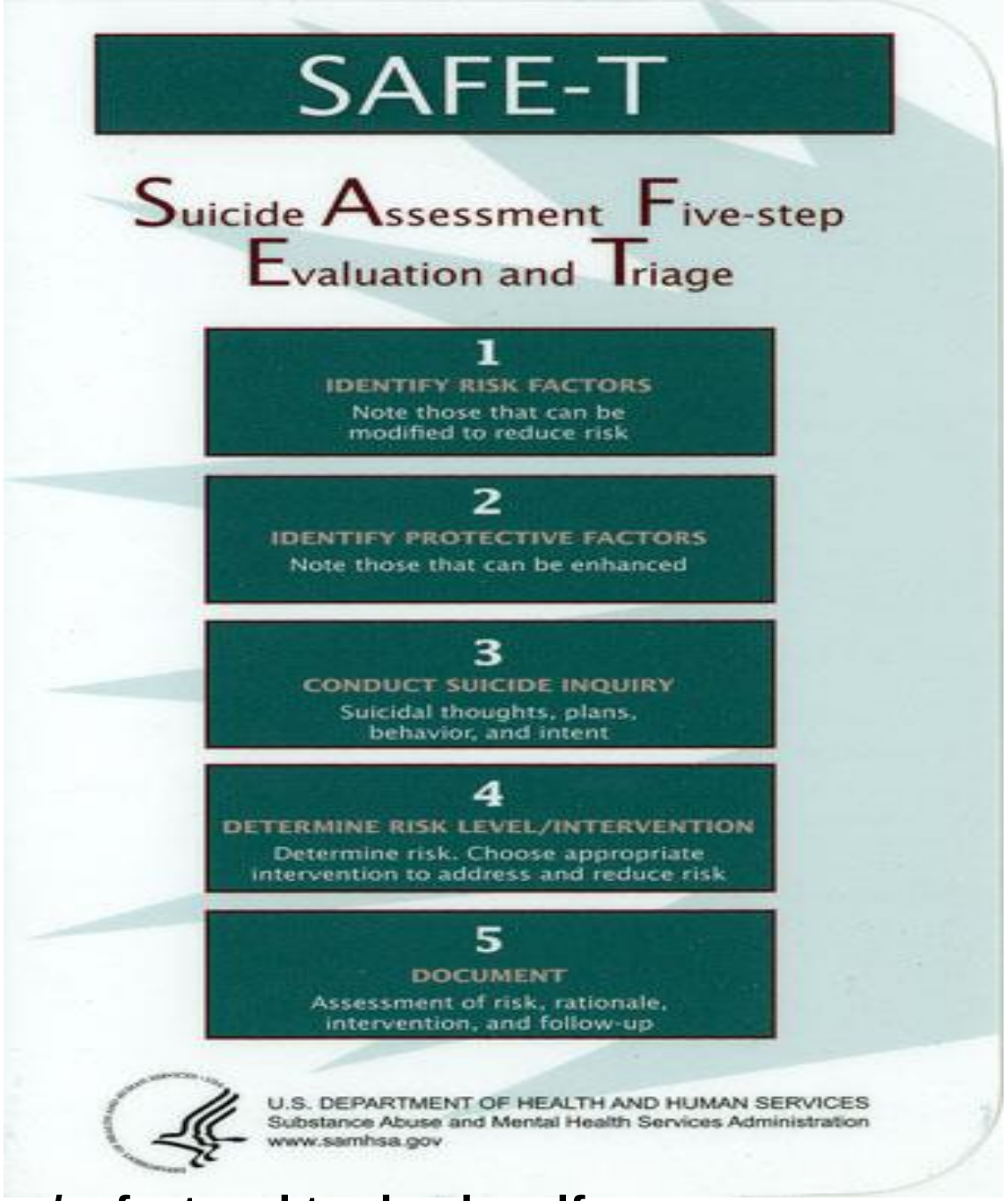
Other Considerations

- Unemployment or lack of meaningful regular activities associated with higher risk
- Single individuals die by suicide more than those in relationships
  - Poor social functioning and lack of social support are risk factors
- Risk higher when individuals are 1) bothered by their psychosis or 2) have psychotic symptoms compelling them (ie. command hallucinations, thought insertion)
- Risk higher 3-6 mths post-hospitalization (esp. if not returning home)

Potential Protective Factors

- Have access to mental health treatment
- Positive attitude towards mental health treatment
- Feeling connected with others
- Effective problem solving skills
- Accepting and supportive social environment
- Reasons for living
- Limited access to lethal means



www.sprc.org/library/safe_t_pcktcrd_edc.pdf

Suicide assessments should be conducted at first contact, with any subsequent suicidal behavior, increased ideation, or pertinent clinical change; for inpatients, prior to increasing privileges and at discharge.

1. RISK FACTORS

- **Suicidal behavior:** history of prior suicide attempts, aborted suicide attempts or self-injurious behavior
- **Current/past psychiatric disorders:** especially mood disorders, psychotic disorders, alcohol/substance abuse, ADHD, TBI, PTSD, Cluster B personality disorders, conduct disorders (antisocial behavior, aggression, impulsivity).
  Co-morbidity and *recent onset of illness increase risk*
- **Key symptoms:** anhedonia, impulsivity, hopelessness, anxiety/panic, insomnia, command hallucinations
- **Family history:** of suicide, attempts or Axis 1 psychiatric disorders requiring hospitalization
- **Precipitants/Stressors/Interpersonal:** triggering events leading to humiliation, shame or despair (e.g., loss of relationship, financial or health status—real or anticipated). Ongoing medical illness (esp. CNS disorders, pain). Intoxication. Family turmoil/chaos. History of physical or sexual abuse. Social isolation.
- **Change in treatment:** discharge from psychiatric hospital, provider or treatment change
- **Access to firearms**

2. PROTECTIVE FACTORS *Protective factors, even if present, may not counteract significant acute risk*

- **Internal:** ability to cope with stress, religious beliefs, frustration tolerance
- **External:** responsibility to children or beloved pets, positive therapeutic relationships, social supports

3. SUICIDE INQUIRY *Specific questioning about thoughts, plans, behaviors, intent*

- **Ideation:** frequency, intensity, duration--in last 48 hours, past month and worst ever
- **Plan:** timing, location, lethality, availability, preparatory acts
- **Behaviors:** past attempts, aborted attempts, rehearsals (tying noose, loading gun), vs. non-suicidal self injurious actions
- **Intent:** extent to which the patient (1) expects to carry out the plan and (2) believes the plan/act to be lethal vs. self-injurious; Explore ambivalence: reasons to die vs. reasons to live

** For Youths: ask parent/guardian about evidence of suicidal thoughts, plans, or behaviors, and changes in mood, behaviors or disposition*
** Homicide Inquiry: when indicated, esp. in character disordered or paranoid males dealing with loss or humiliation. Inquire in four areas listed above.*

4. RISK LEVEL/INTERVENTION

- Assessment of risk level is based on clinical judgment, after completing steps 1-3
- Reassess as patient or environmental circumstances change

RISK LEVEL	RISK / PROTECTIVE FACTOR	SUICIDALITY	POSSIBLE INTERVENTIONS
High	Psychiatric disorders with severe symptoms, or acute precipitating event; protective factors not relevant	Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal	Admission generally indicated unless a significant change reduces risk. Suicide precautions
Moderate	Multiple risk factors, few protective factors	Suicidal ideation with plan, but no intent or behavior	Admission may be necessary depending on risk factors. Develop crisis plan. Give emergency/crisis numbers
Low	Modifiable risk factors, strong protective factors	Thoughts of death, no plan, intent or behavior	Outpatient referral, symptom reduction. Give emergency/crisis numbers

(This chart is intended to represent a range of risk levels and interventions, not actual determinations.)

5. DOCUMENT

Risk level and rationale; treatment plan to address/reduce current risk (e.g., setting, medication, psychotherapy, E.C.T., contact with significant others, consultation); firearm instructions, if relevant; follow up plan. For youths, treatment plan should include roles for parent/guardian.

So how should we assess suicide risk?

Suicide Risk Assessment
The Problem…

- Lack of conceptual clarity about suicidal behavior → corresponds to lack of well-defined terminology
- Same behaviors are called a variety of things
  - E.g. threat, gesture
- Often negative and based on incorrect notions about seriousness and lethality of methods
  - E.g. manipulative, non-serious, passive

C-SSRS

- Considered the “Gold Standard” for assessing suicidal thought and behavior in adolescents and young adults, but can be used for all ages (Posner et al., 2011)
  - Includes items that research has shown are strongly associated with suicide risk
  - Required by FDA for all new trials

NOT Designed to:

- Assess risk factors
- Assess protective factors in detail (reasons not to die)
- Assess supports
- Tell you how to respond → Need additional crisis plan

CSSRS is one part of your risk assessment!

Sources of Information

- Use any source of information that informs your clinical judgment and gets you the most clinically meaningful response

- Typically the client can provide best info about suicidal intent and thoughts, BUT also can be helpful to get collateral info (records, family, spouse, etc)
  - Client may refuse to talk about the event

Let’s look at the components of the C-SSRS…

Timeframes: Lifetime (at Baseline)

- Ideation and Intensity of Ideation - examine time he/she was feeling MOST suicidal EVER – not the “average” across life
  - “The time in your life when you were feeling the most suicidal, did you wish you were dead, have thoughts of actually killing yourself, etc…”
- Behavior is “ever”
  - Capture all lifetime occurrences, e.g. total number of attempts (may have accompanying ideation)

Suicidal Ideation

1. Wish to die:
   - “Have you wished you were dead or wished you could go to sleep and not wake up?”
2. Active thoughts of killing oneself:
   - “Have you actually had thoughts of killing yourself?”

- ** If “NO” to both of these questions, you are finished with Suicidal Ideation section.**

- ** If “YES” to #1 OR #2, then continue with Suicidal Ideation and then Intensity of Ideation sections…**

CSSRS - BASELINE

Name: _____	Date Completed: _____

Suicidal Ideation

BASELINE: Ask about LIFETIME and PAST MONTH

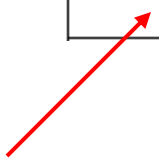
1. Wish to be Dead - Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.
Have you (EVER/IN THE PAST MONTH) wished you were dead or wished you could go to sleep and not wake up? If yes, describe:

LIFETIME	PAST MONTH	LIFETIME	PAST MONTH
		☐ Yes ☐ No	☐ Yes ☐ No

2. Non-Specific Active Suicidal Thoughts - General, non-specific thoughts of wanting to end one's life/commit suicide (e.g. "I've thought about killing myself") without thoughts of ways to kill oneself/associated methods, intent, or plan.
Have you (EVER/IN THE PAST MONTH) actually had any thoughts of killing yourself? If yes, describe:

LIFETIME	PAST MONTH	LIFETIME	PAST MONTH
		☐ Yes ☐ No	☐ Yes ☐ No

IF YES to CSSRS #1 OR #2, Continue in this section. IF NO TO BOTH, Go to Suicidal Behavior.



Suicidal Ideation

3. Associated Thoughts of Methods:
    - “Have you been thinking about how you might do this?”
4. Some Intent:
    - “Have you had these thoughts AND some intention of acting on them?”
5. Plan and Intent:
    - “Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?”

- NOTE: Suicidal content of psychotic symptoms (ie. Command hallucinations to kill self or delusional beliefs of need to die) COUNT as ideation!

3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act - Subject endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out (e.g. thought of method to kill self but not a specific plan). Includes person who would say, "I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it.....and I would never go through with it".

Have you (EVER/IN THE PAST MONTH) been thinking about how you might do this? If yes, describe:

LIFETIME	PAST MONTH	LIFETIME	PAST MONTH
		☐ Yes ☐ No	☐ Yes ☐ No

4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan – Active suicidal thoughts of killing oneself and subject reports having some intent to act on such thoughts, as opposed to "*I have the thoughts but I definitely will not do anything about them*".

Have you (EVER/IN THE PAST MONTH had these thoughts and had some intention of acting on them? If yes, then describe:

LIFETIME	PAST MONTH	LIFETIME	PAST MONTH
		☐ Yes ☐ No	☐ Yes ☐ No

5. Active Suicidal Ideation with Specific Plan and Intent - Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out

Have you (EVER/IN THE PAST MONTH) started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan? If yes, describe:

LIFETIME	PAST MONTH	LIFETIME	PAST MONTH
		☐ Yes ☐ No	☐ Yes ☐ No

Intensity of Ideation – Rate for all levels of Ideation above

Intensity of Ideation

- Once types of ideation are determined, ask a few follow up questions about most severe thought in specified timeframe:
  - Frequency
  - Duration
  - Controllability
  - Deterrents
  - Reasons for ideation: Stop the pain or make someone angry – stop the pain is worse

- All of these items are significantly predictive of death by suicide!

Clinical Monitoring Guidance

- For Intensity of Ideation, risk is greater when:
  - Thoughts are more frequent
  - Thoughts are of longer duration
  - Thoughts are less controllable
  - Have fewer deterrents to acting on thoughts
  - Stopping the pain is the reason

- Score of 4 (Some Intent) or 5 (Intent with Plan) → Indicates need for intervention

Suicidal Behavior

- Definition of Suicide Attempt = a self-injurious act committed with at least some intent to die as a result of the act
  - There does not have to be any injury or harm, just the potential for injury or harm (e.g. gun failing to fire, rope breaking)
  - Any “non-zero” intent to die – People often have mixed feelings. Does not have to be 100%, but has to be more than 0%
  - Intent to die and behavior must be linked → does not include non-suicidal self-injurious behavior
  - Intent can sometimes be inferred from the behavior or circumstances…
    - If they deny intent to die BUT they thought act could be lethal, intent can be inferred
    - “Clinically impressive” circumstances: highly lethal act where no other intent but suicide can be inferred (e.g. gunshot to head, jumping from bridge or high building, setting self on fire, taking 200 pills)

Suicidal Behavior

- A suicide attempt begins with the first act – the first pill ingested or scratch with the knife.
  - Even if they stop → aborted attempt
  - Are interrupted → interrupted attempt

- Questions to rate Actual Attempt:
  - Have you made a suicide attempt?
  - Have you done anything to harm yourself?
  - Have you done anything dangerous where you could have died?
  - *Ask the extra questions here → client may not consider something a suicide attempt*

As Opposed to Non-suicidal Self-injurious Behavior

- Engaging in behavior PURELY (100%) for reasons other than to end one's life:
  - Either to affect:
    - Internal state = feel better, relieve pain/distress.
    - "Self-mutilation"
    - AND/OR
    - External Circumstances = get sympathy, attention, make others angry, etc
  - BUT if even SMALL % of self wishes to die, then would be an attempt

Suicidal Behavior

- Important to ask the follow up “why?” questions in the Actual Attempt section!
  - Don’t just infer, ask them WHY they did it.
- Client may have multiple suicidal events that you need to assess
- May also have self-injurious behavior AND suicidal behavior
  - Need to ask “why” for each event → some may have intent (actual attempts) while other did not

Actual Attempt:

A potentially self-injurious act committed with at least some wish to die, as a result of act. Behavior was in part thought of as a method to kill oneself. Intent does not have to be 100%. If there is ***any*** intent/desire to die associated with the act, then it can be considered an actual suicide attempt. ***There does not have to be any injury or harm***, just the potential for injury or harm. If the person pulls trigger while gun is in mouth but gun is broken so no injury results, this is considered an attempt.

Inferring Intent: Even if an individual denies intent/wish to die, it may be inferred clinically from the behavior or circumstances. For example, a highly lethal act that is clearly not an accident so no other intent but suicide can be inferred (e.g. gunshot to head, jumping from window of a high floor/story). Also, if someone denies intent to die, but they thought that what they did could be lethal, intent may be inferred.

****Have you (EVER/IN THE PAST MONTH) made a suicide attempt?***

****Have you (EVER/IN THE PAST MONTH) done anything to harm yourself?***

****Have you (EVER/IN THE PAST MONTH) done anything dangerous where you could've died?***

What did you do?

Did you _____ as a way to end your life?

Did you want to die (even a little) when you _____?

Were you trying to end your life when you _____?

Or did you think it was possible you could have died from _____?

May help you infer intent

Or did you do it purely for other reasons/without ANY intention of killing yourself (like to relieve stress, feel better, get sympathy, or get something else to happen)? (Self-injurious behavior without suicidal intent)

If yes, describe:

LIFETIME	PAST MONTH	LIFETIME	PAST MONTH
		Yes ☐ No ☐ Total # of Attempts _____	Yes ☐ No ☐ Total # of Attempts _____
Has subject engaged in non-suicidal self-injurious behavior?		Yes ☐ No ☐	Yes ☐ No ☐

Ensures that you assessed all possibilities and determined what is suicidal vs what isn't

Let’s Practice via a Poll!

For each of the following, determine if there was:

1. An actual attempt
2. No attempt
3. Not enough information to determine

Suicide Attempt? Yes, No, Not Enough Info

- Young woman, after a fight with her girlfriend, felt like she wanted to die, impulsively took a kitchen knife and made a superficial scratch on her wrist. Before she actually punctured the skin or bled, she changed her mind and stopped.

YES – Actual Attempt. She said she wanted to die AND used the knife, even though no significant injury.

Suicide Attempt? Yes, No, Not Enough Info

- Client wanted to escape from her mother's home. She researched lethal doses of ibuprofen (Advil). She took the pills and felt certain from her research that this amount was not enough to kill her. She stated she did not want to die, only to escape her mother's home. She was taken to the ER where her stomach was pumped and she was admitted to the psychiatric ward.

NO – she didn't intend to kill herself and specifically said she did not want to die.

Suicide Attempt? Yes, No, Not Enough Info

- After an argument with his boyfriend, client went to his room and locked the door. He took a small razor out of his dresser and began to cut his arm.

NOT ENOUGH INFORMATION – insufficient information to determine intent. Know what he did, but not why he did it. Both suicidal behavior and self-mutilation can be triggered by stressors, so this tells you nothing.

Suicide Attempt? Yes, No, Not Enough Info

- Client had a big fight with her ex-husband about her stepson. She took 15-20 imipramine tablets and went to bed. She slept all night and until 5pm the next day. Stated she couldn’t stand up or walk upon waking. Called EMS and was taken to ER. Treated with Charcoal and admitted to hospital. Unable to verbalize clear intent, but states she was well aware of dangers of med overdose and the potential for death.

YES – Actual Attempt. Can infer risk due to her knowledge of risk/lethality for med overdose.

C-SSRS Suicidal Behavior Levels

- 3 Types of Attempts:
  - Actual Attempt
    - A self-injurious act committed with at least some intent to die
  - Interrupted Attempt:
    - Person starts to take steps to end their life BUT someone or something stops them → Hasn't acted yet (actual attempt)
  - Aborted Attempt
    - Person starts to take steps to end their life BUT stops themselves before they have engaged in any self-destructive behavior (Has not started to act)

- Preparatory Acts or Behavior
  - Any other behavior (beyond saying something) with suicidal intent

Administering Suicidal Behavior Section

- Select (check) all that apply
- BUT only select if discrete behaviors
  - Ex. If writing a suicide note is part of an actual attempt, do not make a separate rating for Preparatory Behavior (only rate the attempt)
- Every potential separate event should be described
- Use dates or numbers to keep individual events organized

Lethality Rating

- Only assesses the lethality for ACTUAL attempt(s) described in the previous section
  - Do not rate for ideation, aborted/interrupted attempts or preparatory behavior
- Assesses both:
  - Lethality of actual attempt(s) – what actually happened in terms of medical damage
  - Potential lethality for actual attempt(s) with no medical damage – ie. what could have happened?

Answer for Actual Attempts Only	Most Recent Attempt	Most Lethal Attempt	Initial/ First Attempt
Date of each Attempt:			
Actual Lethality/Medical Damage: Determine level of actual or potential lethality of attempt(s) recorded above. ***What happened?*** ***Where there any injuries or physical damage? If yes, please describe. (Ex. If there was a cut, did it require a Band-aid or stiches? Did it bleed a lot or a little?*** ***Was medical attention needed or sought? Describe treatment received and who provided it.*** 0. No physical damage or very minor physical damage (e.g. surface scratches). 1. Minor physical damage (e.g. lethargic speech; first degree burns; mild bleeding; sprains). 2. Moderate physical damage; *medical* attention needed (e.g. conscious but sleepy, somewhat responsive; second degree burns; bleeding of major vessel). 3. Moderately severe physical damage; medical hospitalization and likely intensive care required (e.g. comatose with reflexes intact; third-degree burns less than 20% of body; extensive blood loss but can recover; major fractures). 4. Severe physical damage; *medical* hospitalization with intensive care required (e.g. comatose without reflexes; third-degree burns over 20% of body; extensive blood loss with unstable vital signs; major damage to a vital area). 5. Death	Enter Code _____	Enter Code _____	Enter Code _____
Potential Lethality : Only Answer if Actual Lethality= 0) Likely lethality of actual attempt if no medical damage (the following examples, while having no actual medical damage, had potential for very serious lethality: put gun in mouth and pulled the trigger but gun fails to fire so no medical damage; laying on train tracks with oncoming train but pulled away before run over). 0= Behavior not likely to result in injury 1= Behavior likely to result in injury but not likely to cause death 2= Behavior likely to result in death despite available medical care	Enter Code _____	Enter Code _____	Enter Code _____

Why rate Potential Lethality?

- Likely lethality of attempt if no medical damage
- Examples:
  - Laying on tracks with an oncoming train BUT pulled away before run over → became an attempt when they laid on the tracks
  - Put gun in mouth and pulled trigger but it failed to fire → became an attempt when they put the gun in their mouth

Remember: Ideation & Behavior must be queried separately

- Just because they deny ideation, doesn't mean that there won't be suicidal behavior
- You need to ask questions in Behavior section regardless of lack of ideation
  - Clinician: "Have you wished you were dead or wished you could go to sleep and not wake up?"
  - Client: "Ummmm, no."
  - Clinician: "Have you actually had any thoughts of killing yourself?"
  - Client: "No."
  - Clinician: "Ok, but have you tried to harm yourself in order to end your life or because you wanted to die?"
  - Client: "I once impulsively tried to hang myself because I wanted to end it all, without even thinking about it."

Suicide Behavior Questionnaire- Revised

- Ages 13-18

Osman A, Bagge CL, Gutierrez PM, Konick LC, Kopper BA, Barrios FX. (2001).
The Suicidal Behaviors Questionnaire-Revised (SBQ-R): validation with clinical and nonclinical samples. Assessment. 8(4):443-54.

SBQ-R Suicide Behaviors Questionnaire-Revised

Patient Name _____ Date of Visit _____

Instructions: Please check the number beside the statement or phrase that best applies to you.

1. Have you ever thought about or attempted to kill yourself? (check one only)

- ☐ 1. Never
- ☐ 2. It was just a brief passing thought
- ☐ 3a. I have had a plan at least once to kill myself but did not try to do it
- ☐ 3b. I have had a plan at least once to kill myself and really wanted to die
- ☐ 4a. I have attempted to kill myself, but did not want to die
- ☐ 4b. I have attempted to kill myself, and really hoped to die

2. How often have you thought about killing yourself in the past year? (check one only)

- ☐ 1. Never
- ☐ 2. Rarely (1 time)
- ☐ 3. Sometimes (2 times)
- ☐ 4. Often (3-4 times)
- ☐ 5. Very Often (5 or more times)

3. Have you ever told someone that you were going to commit suicide, or that you might do it? (check one only)

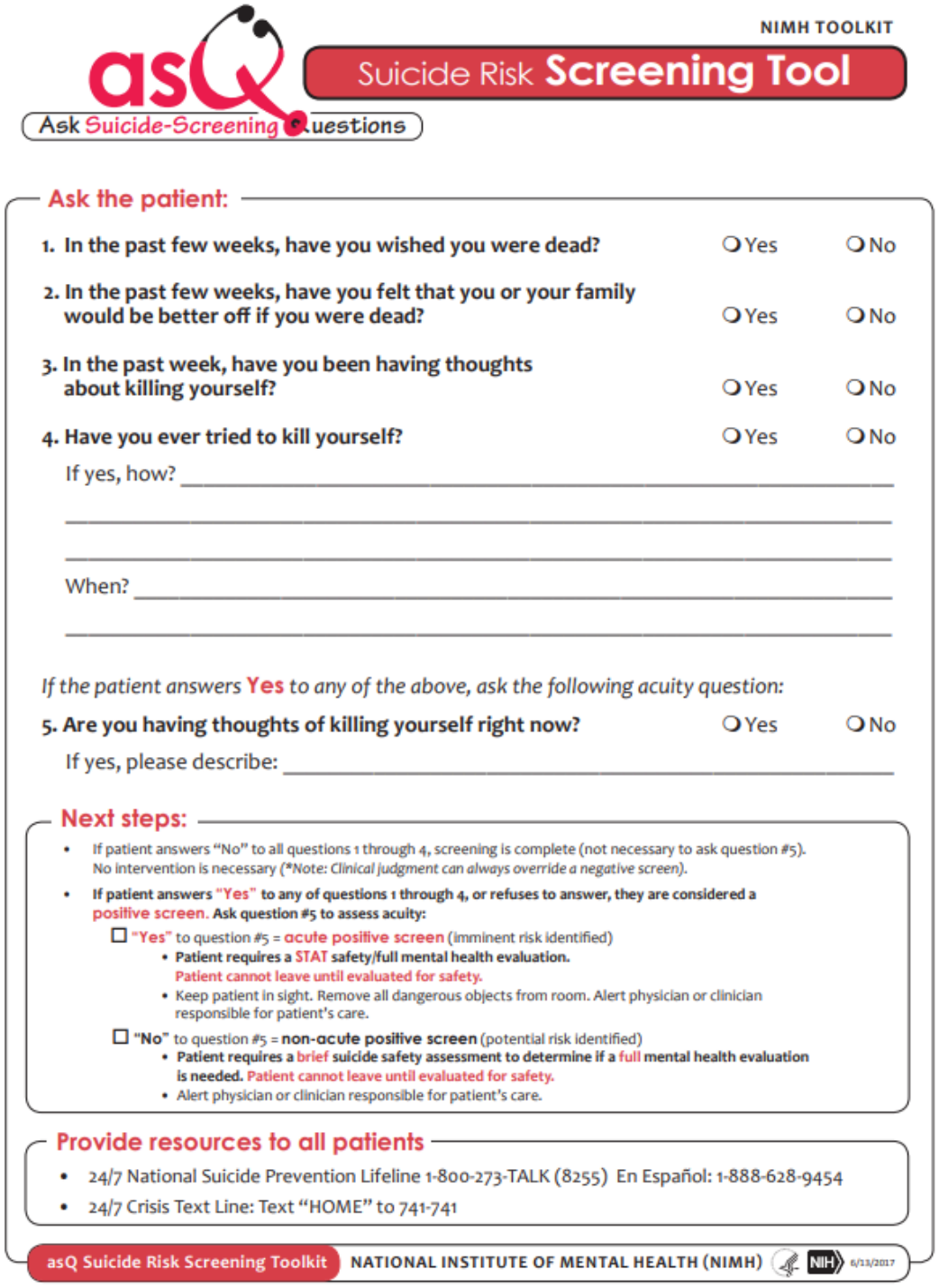
- ☐ 1. No
- ☐ 2a. Yes, at one time, but did not really want to die
- ☐ 2b. Yes, at one time, and really wanted to die
- ☐ 3a. Yes, more than once, but did not want to do it
- ☐ 3b. Yes, more than once, and really wanted to do it

4. How likely is it that you will attempt suicide someday? (check one only)

- ☐ 0. Never
- ☐ 1. No chance at all
- ☐ 2. Rather unlikely
- ☐ 3. Unlikely
- ☐ 4. Likely
- ☐ 5. Rather likely
- ☐ 6. Very likely

ASQ

- For ED, medical, outpatient/primary care settings
- Ages 10-21



NIMH TOOLKIT

asQ Suicide Risk Screening Tool

Ask Suicide-Screening Questions

Ask the patient:

1. **In the past few weeks, have you wished you were dead?** ❍ Yes ❍ No
2. **In the past few weeks, have you felt that you or your family would be better off if you were dead?** ❍ Yes ❍ No
3. **In the past week, have you been having thoughts about killing yourself?** ❍ Yes ❍ No
4. **Have you ever tried to kill yourself?** ❍ Yes ❍ No

   If yes, how? _____

   _____

   _____

   When? _____

   _____

If the patient answers **Yes** *to any of the above, ask the following acuity question:*

5. **Are you having thoughts of killing yourself right now?** ❍ Yes ❍ No

   If yes, please describe: _____

Next steps:

- If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (**Note: Clinical judgment can always override a negative screen*).
- **If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity:**
  - ☐ "Yes" to question #5 = **acute positive screen** (imminent risk identified)
    - **Patient requires a STAT safety/full mental health evaluation. Patient cannot leave until evaluated for safety.**
    - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.
  - ☐ "No" to question #5 = **non-acute positive screen** (potential risk identified)
    - **Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. Patient cannot leave until evaluated for safety.**
    - Alert physician or clinician responsible for patient's care.

Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text "HOME" to 741-741

asQ Suicide Risk Screening Toolkit | NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH) | NIH | 6/13/2017

Issues and Concerns?

- Asking about suicidality DOES NOT cause distress or suicidality (Gould et al., JAMA, 2005)
- Who can administer C-SSRS?
  - Anyone who has gone through this training and has some client contact experience
  - Do NOT have to be a mental health professional
- Where can it be used?
  - Clinical practice, schools, research, VA, hospitals/ERs… pretty much anywhere

Let’s Practice!

- Work with a few people near you to made determinations about each of these cases

- Determine if you have:
  - Ideation only – also think about what type?
  - Actual attempt
  - Aborted attempt
  - Interrupted attempt
  - Preparatory Behavior
  - Non-suicidal self-injurious behavior
  - Not clear/Need more information

Case #1

- Several weeks after being informed by her husband that he was having an affair, client went to Haiti to see him to discuss the situation. She became enraged during their discussion and grabbed his gun with the intention of shooting herself. However, her husband struggled with her, took the gun away before she was able to pull the trigger and hid it from her. She states that she was feeling pain and hurt, and she was so upset she wanted to die.

Interrupted Attempt

Case #2

- The client said she was feeling depressed about her problems with her boyfriend. She said she wished that one day she would just die in her sleep and not wake up in the morning.

Ideation Only – Level #1 (Wish to Die)
no attempt, no other behaviors

Case #3

- The client stated that she experienced heartbreak over the “loss of a guy” a week before the interview. She said she took 4 clonazepam, called a girlfriend, and talked/cried it out on the phone. She was dismissive of the seriousness of it, but indicated she wanted to die at the time she took the pills.

Actual Attempt – since first pill was ingested

Case #4

- The client's mother was checking the number of pills he had left to determine if a refill was necessary. She discovered that 6 tablets were missing. Upon questioning, her son stated that he was saving them up so he could take them all together at a later time to kill himself.

Preparatory Behavior

Case #5

- The client reported that he first started thinking about killing himself at age 12. He thought about how easy it would be to pretend to fall in front of a bus before it could stop so that it would look like an accident. Although he thought about it often, he said he did not have the courage to do it.

Active Ideation with Method, but no Plan or Behavior

Case #6

- The client put 5 prescription pills in his mouth then spit them out. He states he was alone at the time and was feeling lonely and isolated. He stated that he had been thinking about suicide daily and wanted to die. He did not tell anyone about this or receive any treatment.

Aborted Attempt –
would need to SWALLOW pills to count as the “act”

Case #7

- The voice commanded the 18 year old client to jump from the roof of a 10 story building. Although the client went to the roof, he did not jump. It was determined that he was a risk to himself and he was admitted to the hospital.

Aborted Attempt

NOTE: Within standard definition, suicidal content of psychotic symptoms counts as suicidal ideation

Case #8

- The client was feeling sad about her financial situation. Her rent was due and the landlord and threatened to evict her. She went to the bathroom and took a razor from the cabinet. She cut one of her wrists and began bleeding. She bandaged her wrist herself. During the interview, she said she had never cut herself before and was adamant she did not need to be hospitalized.

Not Enough Information about WHY

Case #9

- Approximately 10 days prior to hospitalization, the client had run away from home overnight because his father had obtained a recent “bad” report card. The client was fearful of his father’s reaction. Upon returning home, the client engaged in a 5-6 hour fight with his parents. The client went to his father’s room, got a hand gun, put it in his mouth and pulled the trigger. The gun jammed and did not fire.

Actual Attempt - Intent Assumed (due to lethality of attempt)

Case #10

- Young woman comes home from school after a fight with her best friend. She is upset and goes to be alone in her room. She uses a razor to cut small marks into her wrist. Afterwards, she feels better and she bandages the cuts. When questioned about this later, she denied any wish to die – just stated that the cutting "is a release."

Non-suicidal self-injurious behavior

Case #11

- The client, age 10, reported thoughts that she wanted to die while she was alone at home. She said she held a kitchen knife to her neck, but did not cut herself. She reported these events at her next appointment and was hospitalized.

Aborted Attempt

Intervention

- The Risk Assessment guides clinical management and triage
- After suicide risk assessment, comes appropriate intervention…
  - “Proactive” management = No ACUTE risk → Consider the Safety Planning Intervention
  - “Reactive” management = ACUTE RISK → Consider alternative options to maintain safety (including SPI in some cases)

Collaboration with Yael Holoshitz, MD

Psychiatrist, OnTrackNY/WHCS

“Reactive” Risk Management

- Individual is at ACUTE RISK based on:
  - Risk Assessment = increased ideation, intent, behaviors
  - Increased psychosis symptoms
  - Unable to engage in safety skills
  - Lack of family/collateral support
  - Not able/willing to engage in treatment

- Hospitalization or crisis treatment is necessary
  - Know the hospitalization protocol in your clinic!

Proactive Risk Management

- Integrate suicide risk assessment as standard part of care
  - Intake evaluation
    - Screening → Risk assessment for positive screen
  - Reassessments at standard intervals (e.g. every 6 months)

- Integrate safety planning as part of standard relapse plan
  - Re-visit it regularly as part of treatment

- For individuals with elevated risk
  - Integrate other treatment options as part of care

Evidence-Based Risk Reduction Strategies

- Means Restriction (esp. fire arms!)
- Brief problem solving and coping skills (including distraction)
- Enhancing social support, identifying emergency contacts
- Motivational Enhancement for further treatment

Specialized Therapy for Suicide Prevention

- Collaborative Assessment and Management of Suicidality (CAMS)
- Dialectical Behavioral Therapy (DBT)
- Cognitive Behavioral Therapy – Suicide Prevention (CBT-SP)
- Often require specialized training: visit sprc.org, SAMHSA

Theoretical Foundation of SPI

- Problem solving capacity diminishes during crisis →so repeated review and over-practice with a specific template can help coping when client is in distress.
  - Parallel to STOP-DROP-ROLL for fire safety.

- Clinician and suicidal individual collaborate to determine cognitive and behavioral strategies to use during suicidal crises
  - Step-wise increase in level of intervention: Starts “within self” and builds to seeking help in the psychiatric emergency room
  - HOWEVER individual can advance in steps without “completing” previous step…

Patient Safety Plan

Name: _____ Date Completed: _____

Collateral/Family: _____ Clinician: _____

Step 1: Triggers & Stressors (behaviors, situations and circumstances that put you at emotional risk):

1. _____
2. _____
3. _____

Step 2: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____
2. _____
3. _____

Step 3: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. _____
2. _____
3. _____

Step 4: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____ 4. Place_____

Step 5: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

Step 6: Professionals or agencies I can contact during a crisis:

1. Clinician Name_____ Phone_____

Clinician Pager or Emergency Contact # _____

2. Clinician Name_____ Phone_____

Clinician Pager or Emergency Contact # _____

3. Suicide Prevention Lifeline Phone 1-800-273-TALK (8255) or call Sacramento County Line (916) 368-3111
4. Text "CONNECT" TO 7417415.
5. Call 911 or go to Local Emergency room: _____

Step 7: Making the environment safe:

1. _____
2. _____

The one thing that is most important to me and worth living for is:

_____

*** Give copy to client, family members & put copy in chart ***

SPI: When to use

- Consider using for “crisis prevention” in addition to suicide prevention; consider for all clients beginning treatment
- For anyone with positive screen on C-SSRS
- Annual or semi-annual revision
- Whenever an event has occurred (hospitalization, suicide attempt, emergency room visit)

Other Interventions & Monitoring

- What additional interventions can be incorporated into care when SPI isn't enough?

- Skills training programs
- Family Involvement
- Medications
- Structured monitoring & follow up

SAMHSA funded training resources

- Suicide Prevention Resource Center, www.sprc.org Assessing and Managing Suicide Risk (AMSR)
- SAFE-T Card and SuicideSafe app walks clinicians through a suicide risk assessment
- Treatment Improvement Protocol 50-Suicide and Substance Abuse
- For FEP: http://www.nasmhpd.org/content/part-i-recognizing-suicidal-ideation-and-behavior-individuals-first-episode-psychosis

Link to SPI Training

- http://www.suicidesafetyplan.com/Home_Page.html
- http://www.sprc.org/resources-programs/safety-planning-guide-quick-guide-clinicians
- Safety Plan Template: www.suicidesafetyplan.com.

National Suicide Prevention Lifeline

- Joint Commission recommends giving those with suicidal ideation the Lifeline number - 1-800-273-TALK (8255)
  - Link to Veterans Crisis Line
- 160+ local crisis centers
  - WellSpace Health
- Local Lifeline crisis centers
  - The Effort: (916) 368-3111

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