Screening and Assessment for Suicide in Health Care Settings: A Patient-Centered Approach

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#zerosuicide

Zero Suicide

WHAT IS ZERO SUICIDE?

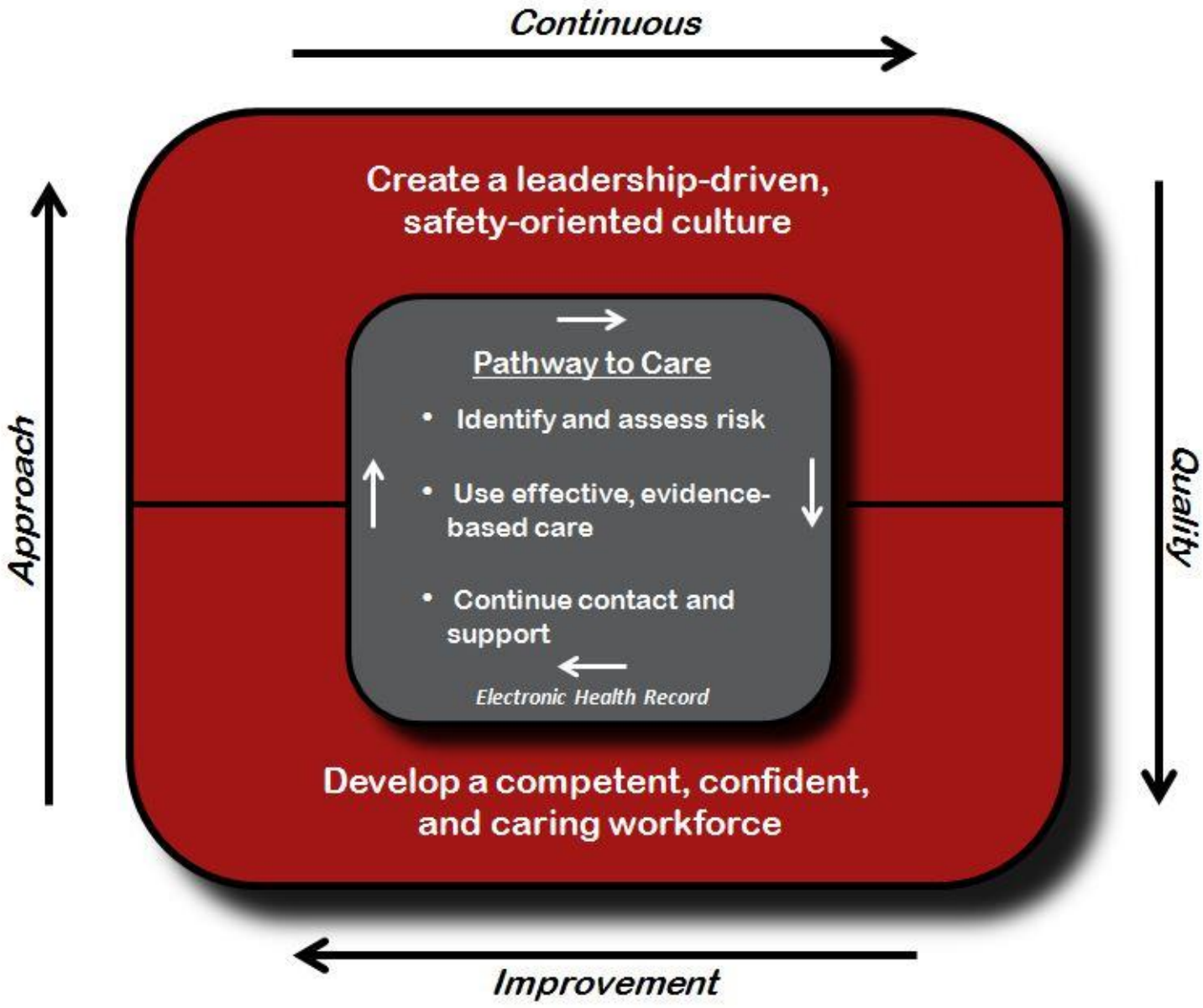
Zero Suicide is…

- Embedded in the National Strategy for Suicide Prevention.
- A priority of the National Action Alliance for Suicide Prevention.
- A focus on error reduction and safety in healthcare.
- A framework for systematic, clinical suicide prevention in behavioral health and healthcare systems.
- A set of best practices and tools including www.zerosuicide.com.

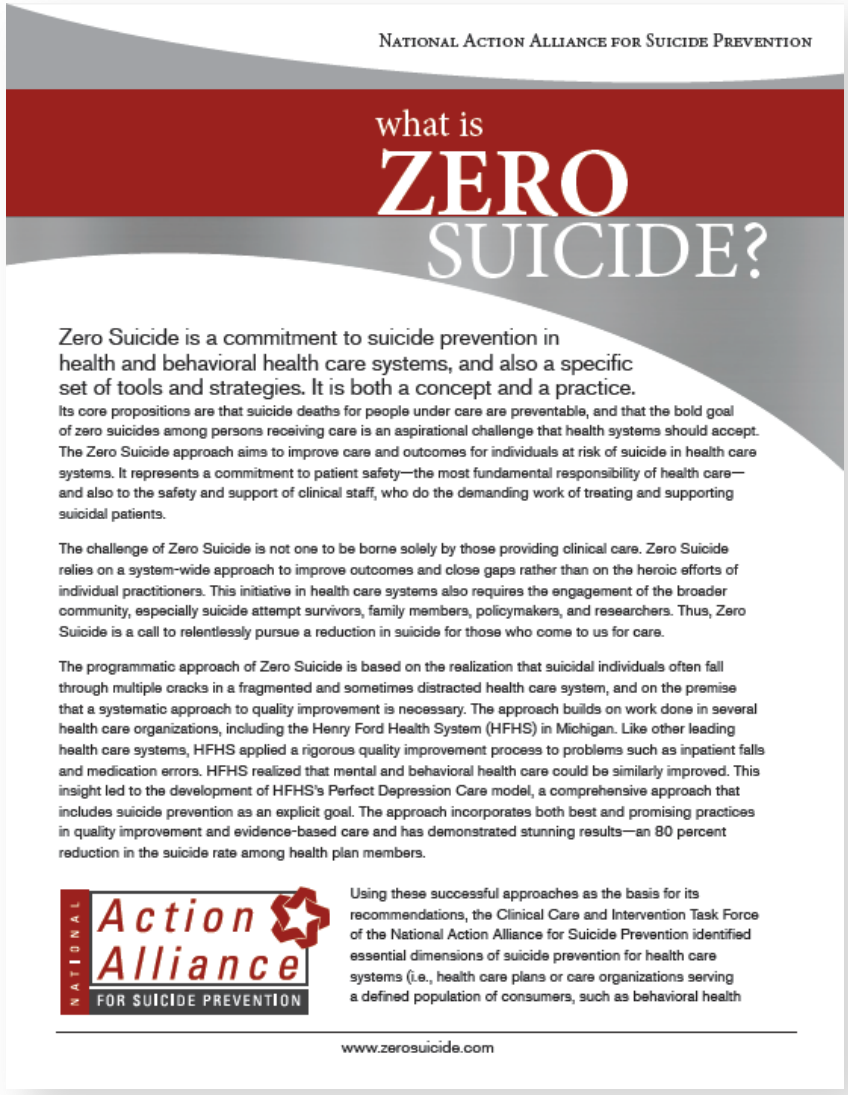
What is Different in Zero Suicide?

Shift in Perspective from:	To:
Accepting suicide as inevitable	Every suicide in a system is preventable
Assigning blame	Nuanced understanding: ambivalence, resilience, recovery
Risk assessment and containment	Collaborative safety, treatment, recovery
Stand alone training and tools	Overall systems and culture changes
Specialty referral to niche staff	Part of everyone's job
Individual clinician judgment & actions	Standardized screening, assessment, risk stratification, and interventions
Hospitalization during episodes of crisis	Productive interactions throughout ongoing continuity of care
"If we can save one life…"	"How many deaths are acceptable?"

The Dimensions of Zero Suicide



Resource: Explaining Zero Suicide



NATIONAL ACTION ALLIANCE FOR SUICIDE PREVENTION

what is
ZERO
SUICIDE?

Zero Suicide is a commitment to suicide prevention in health and behavioral health care systems, and also a specific set of tools and strategies. It is both a concept and a practice.

Its core propositions are that suicide deaths for people under care are preventable, and that the bold goal of zero suicides among persons receiving care is an aspirational challenge that health systems should accept. The Zero Suicide approach aims to improve care and outcomes for individuals at risk of suicide in health care systems. It represents a commitment to patient safety—the most fundamental responsibility of health care—and also to the safety and support of clinical staff, who do the demanding work of treating and supporting suicidal patients.

The challenge of Zero Suicide is not one to be borne solely by those providing clinical care. Zero Suicide relies on a system-wide approach to improve outcomes and close gaps rather than on the heroic efforts of individual practitioners. This initiative in health care systems also requires the engagement of the broader community, especially suicide attempt survivors, family members, policymakers, and researchers. Thus, Zero Suicide is a call to relentlessly pursue a reduction in suicide for those who come to us for care.

The programmatic approach of Zero Suicide is based on the realization that suicidal individuals often fall through multiple cracks in a fragmented and sometimes distracted health care system, and on the premise that a systematic approach to quality improvement is necessary. The approach builds on work done in several health care organizations, including the Henry Ford Health System (HFHS) in Michigan. Like other leading health care systems, HFHS applied a rigorous quality improvement process to problems such as inpatient falls and medication errors. HFHS realized that mental and behavioral health care could be similarly improved. This insight led to the development of HFHS's Perfect Depression Care model, a comprehensive approach that includes suicide prevention as an explicit goal. The approach incorporates both best and promising practices in quality improvement and evidence-based care and has demonstrated stunning results—an 80 percent reduction in the suicide rate among health plan members.

NATIONAL Action Alliance FOR SUICIDE PREVENTION

Using these successful approaches as the basis for its recommendations, the Clinical Care and Intervention Task Force of the National Action Alliance for Suicide Prevention identified essential dimensions of suicide prevention for health care systems (i.e., health care plans or care organizations serving a defined population of consumers, such as behavioral health

www.zerosuicide.com

Access at: http://www.zerosuicide.com

Presenters

Gregory K. Brown, PhD

Anthony R. Pisani, PhD

Leah Harris, MA

Learning Objectives

The objectives for this webinar are to:

1. Understand why screening is part of a comprehensive approach to suicide risk management;
2. Determine how to select a measure to screen for suicide;
3. Recognize the difference between screening and assessment;
4. Identify the problems with categorizing risk into levels and gain exposure to an alternative approach for formulating and communicating about risk in a health system; and
5. Identify a patient-centered approach to screening and assessment.

Presenter

Gregory K. Brown, PhD

Perelman School of Medicine at the University of Pennsylvania

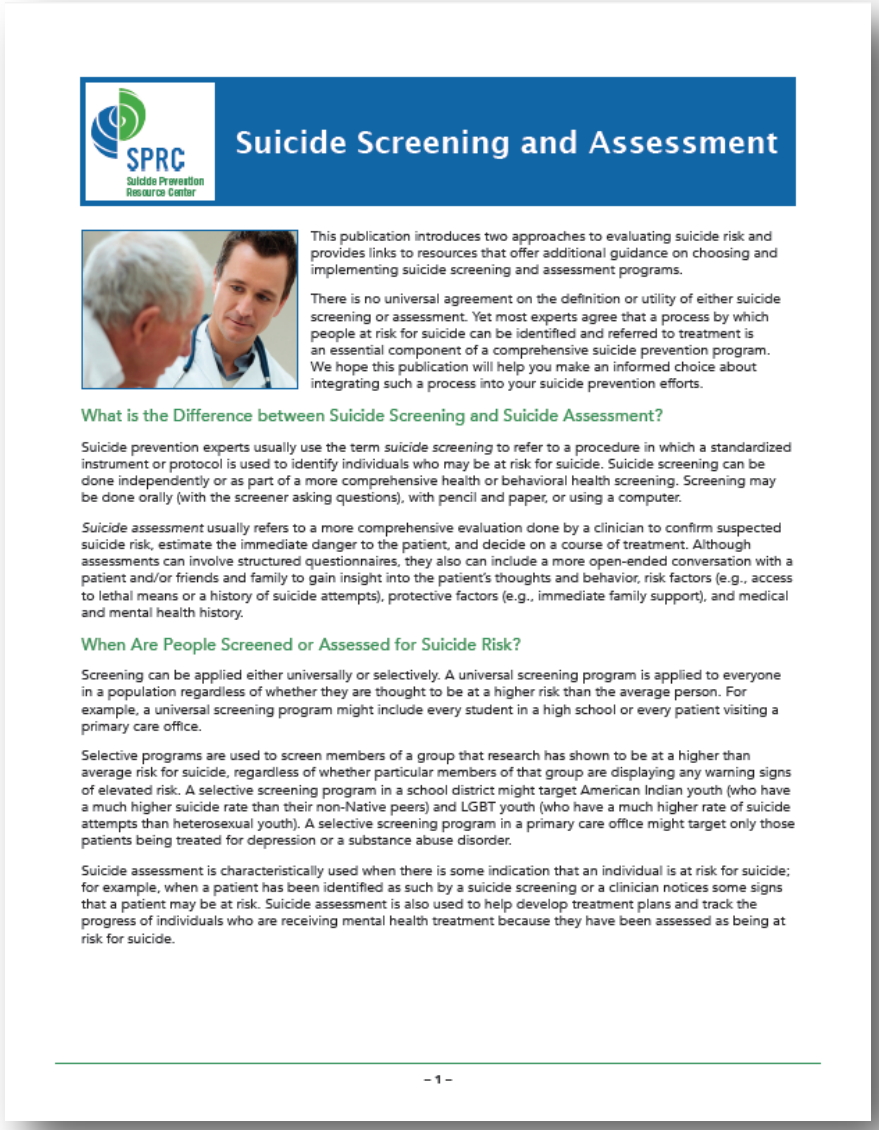
POLL QUESTION

Does your organization use a standardized screening measure for suicide risk?

TYPE IN THE CHAT

What screening tool(s) does your organization use, and how were they chosen?

Resource: Screening and Assessment



SPRC Suicide Prevention Resource Center

Suicide Screening and Assessment

This publication introduces two approaches to evaluating suicide risk and provides links to resources that offer additional guidance on choosing and implementing suicide screening and assessment programs.

There is no universal agreement on the definition or utility of either suicide screening or assessment. Yet most experts agree that a process by which people at risk for suicide can be identified and referred to treatment is an essential component of a comprehensive suicide prevention program. We hope this publication will help you make an informed choice about integrating such a process into your suicide prevention efforts.

What is the Difference between Suicide Screening and Suicide Assessment?

Suicide prevention experts usually use the term *suicide screening* to refer to a procedure in which a standardized instrument or protocol is used to identify individuals who may be at risk for suicide. Suicide screening can be done independently or as part of a more comprehensive health or behavioral health screening. Screening may be done orally (with the screener asking questions), with pencil and paper, or using a computer.

Suicide assessment usually refers to a more comprehensive evaluation done by a clinician to confirm suspected suicide risk, estimate the immediate danger to the patient, and decide on a course of treatment. Although assessments can involve structured questionnaires, they also can include a more open-ended conversation with a patient and/or friends and family to gain insight into the patient's thoughts and behavior, risk factors (e.g., access to lethal means or a history of suicide attempts), protective factors (e.g., immediate family support), and medical and mental health history.

When Are People Screened or Assessed for Suicide Risk?

Screening can be applied either universally or selectively. A universal screening program is applied to everyone in a population regardless of whether they are thought to be at a higher risk than the average person. For example, a universal screening program might include every student in a high school or every patient visiting a primary care office.

Selective programs are used to screen members of a group that research has shown to be at a higher than average risk for suicide, regardless of whether particular members of that group are displaying any warning signs of elevated risk. A selective screening program in a school district might target American Indian youth (who have a much higher suicide rate than their non-Native peers) and LGBT youth (who have a much higher rate of suicide attempts than heterosexual youth). A selective screening program in a primary care office might target only those patients being treated for depression or a substance abuse disorder.

Suicide assessment is characteristically used when there is some indication that an individual is at risk for suicide; for example, when a patient has been identified as such by a suicide screening or a clinician notices some signs that a patient may be at risk. Suicide assessment is also used to help develop treatment plans and track the progress of individuals who are receiving mental health treatment because they have been assessed as being at risk for suicide.

Access at: http://www.sprc.org/library_resources/items/suicide-screening-and-assessment

Why Screen for Suicide Risk?

- Screening for suicide risk is the first step in any suicide prevention program. Helps to raise awareness.
- Screening provides for a common language about suicide within a specific setting, agency, health system, or institution.
- Screening helps to ensure that staff are following a standardized, evidence-based protocol to identify individuals at risk.
- Screening offers guidance for developing an action plan to manage risk.
- Screening may serve as a “proxy” measure of program effectiveness.

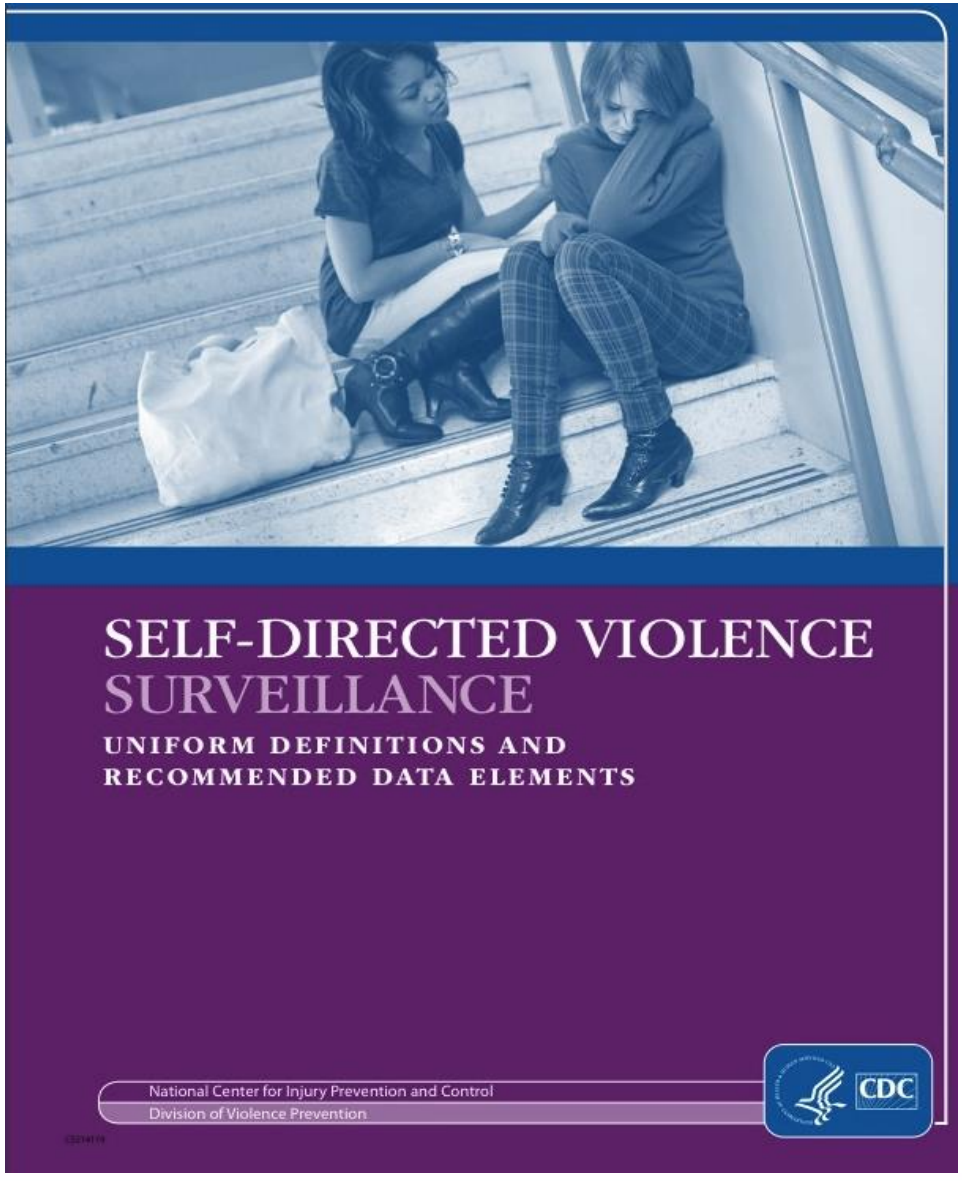
Zero Suicide

SUGGESTED GUIDELINES FOR SELECTING SCREENING MEASURES OF SUICIDE RISK

Suggested Guidelines for Selecting Measures for Suicide Risk

- Does the measure have face validity (content validity)?
- Is the measure consistent with a standardized nomenclature of suicidal behavior?

CDC Self-Directed Violence Surveillance: Uniform Definitions and Recommended Data Elements



Uniform Definitions

Definitions

Self-directed violence (analogous to self-injurious behavior)

Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself.

This does not include behaviors such as parachuting, gambling, substance abuse, tobacco use or other risk taking activities, such as excessive speeding in motor vehicles. These are complex behaviors some of which are risk factors for SDV but are defined as behavior that while likely to be life-threatening is not recognized by the individual as behavior intended to destroy or injure the self. (Farberow, N. L. (Ed.) (1980). The Many Faces of Suicide. New York: McGraw-Hill Book Company). These behaviors may have a high probability of injury or death as an outcome but the injury or death is usually considered unintentional. Hanzlick R, Hunsaker JC, Davis GJ. *Guide for Manner of Death Classification*. National Association of Medical Examiners. Available at: http://www.charlydmiller.com/LIB03/2002NAMEmannerofdeath.pdf. Accessed 1 Sept 2009.

Self-directed violence is categorized into the following:

Non-suicidal (as defined below)

Suicidal (as defined below).

Non-suicidal self-directed violence

Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself.

There is no evidence, whether implicit or explicit, of suicidal intent. Please see appendix for definition of implicit and explicit.

Suicidal self-directed violence

Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself.

There is evidence, whether implicit or explicit, of suicidal intent.

Undetermined self-directed violence

Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself.

Suicidal intent is unclear based on the available evidence.

Suicide attempt

A non-fatal self-directed potentially injurious behavior with any intent to die as a result of the behavior.

A suicide attempt may or may not result in injury.

Interrupted self-directed violence – by self or by other

By other - A person takes steps to injure self but is stopped by another person prior to fatal injury. The interruption can occur at any point during the act such as after the initial thought or after onset of behavior.

By self (in other documents may be termed "aborted" suicidal behavior) - A person takes steps to injure self but is stopped by self prior to fatal injury.

Source: Posner K, Oquendo MA, Gould M, Stanley B, Davies M. Columbia Classification Algorithm of Suicide Assessment (C-CASA): Classification of Suicidal Events in the FDA's Pediatric Suicidal Risk Analysis of Antidepressants. Am J Psychiatry. 2007; 164:1035-1043. http://cssrs.columbia.edu/

Suicide Attempt Definition

A non-fatal, self-directed potentially self-injurious behavior with any intent to die as a result of the behavior.

A suicide attempt may or may not result in injury.

- There does not have to be any injury or harm, just the ***potential*** for injury or harm (e.g., gun failing to fire)
- Any "non-zero" intent to die – does not have to be 100%
- Suicide intent and behavior must be linked

Does the Measure Screen for Other Types of Suicidal Behaviors?

1. Suicide Attempt
2. Interrupted Self-Directed Violence by Others (Interrupted Attempts)
3. Interrupted Self-Directed Violence by Self (Aborted Attempts)
4. Other Suicidal Behavior: Preparatory

Crosby AE, Ortega L, Melanson C. *Self-directed Violence Surveillance: Uniform Definitions and Recommended Data Elements, Version 1.0.* Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2011.

Columbia Suicide Severity Rating Scale

SUICIDAL BEHAVIOR *(Check all that apply, so long as these are separate events; must ask about all types)*	Lifetime	Past 3 months
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 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 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 made a suicide attempt?*** ***Have you done anything to harm yourself?*** ***Have you done anything dangerous where you could have 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_____?*** ***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:	Yes ☐ No ☐ Total # of Attempts _____	Yes ☐ No ☐ Total # of Attempts _____
Has subject engaged in Non-Suicidal Self-Injurious Behavior?	Yes ☐ No ☐	Yes ☐ No ☐
Interrupted Attempt: When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act *(if not for that, actual attempt would have occurred)*. Overdose: Person has pills in hand but is stopped from ingesting. Once they ingest any pills, this becomes an attempt rather than an interrupted attempt. Shooting: Person has gun pointed toward self, gun is taken away by someone else, or is somehow prevented from pulling trigger. Once they pull the trigger, even if the gun fails to fire, it is an attempt. Jumping: Person is poised to jump, is grabbed and taken down from ledge. Hanging: Person has noose around neck but has not yet started to hang - is stopped from doing so. ***Has there been a time when you started to do something to end your life but someone or something stopped you before you actually did anything?*** If yes, describe:	Yes ☐ No ☐ Total # of interrupted _____	Yes ☐ No ☐ Total # of interrupted _____
Aborted or Self-Interrupted Attempt: When person begins to take steps toward making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behavior. Examples are similar to interrupted attempts, except that the individual stops him/herself, instead of being stopped by something else. ***Has there been a time when you started to do something to try to end your life but you stopped yourself before you actually did anything?*** If yes, describe:	Yes ☐ No ☐ Total # of aborted or self-interrupted _____	Yes ☐ No ☐ Total # of aborted or self-interrupted _____
Preparatory Acts or Behavior: Acts or preparation towards imminently making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note). ***Have you taken any steps towards making a suicide attempt or preparing to kill yourself (such as collecting pills, getting a gun, giving valuables away or writing a suicide note)?*** If yes, describe:	Yes ☐ No ☐ Total # of preparatory acts _____	Yes ☐ No ☐ Total # of preparatory acts _____

Glossary of “Unacceptable Terms”

- Completed suicide
- Failed attempt
- Parasuicide
- Successful suicide
- Suicidality
- Nonfatal suicide
- Suicide gesture
- Manipulative act
- Suicide threat

Crosby AE, Ortega L, Melanson C. *Self-directed Violence Surveillance: Uniform Definitions and Recommended Data Elements, Version 1.0.* Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2011.

Suggested Guidelines for Selecting Measures for Suicide Risk

- Is the measure accurate? What is the sensitivity and specificity of the measure?
- Does the measure have predictive validity for suicide behavior? For short-term risk?
- Is the measure sensitive to change over time?

PHQ-9: Overview

- Brief and self-administered scale designed to assess depressive symptoms (based on DSM-IV criteria of Major Depressive Disorder)
- Used for screening, severity assessment, and treatment monitoring
- Measures symptom frequency during the *past two weeks**
- Each item measures frequency of symptoms using a 0 to 3 rating:
  - 0 = Not at all
  - 1 = Several days
  - 2 = More than half the days
  - 3 = Nearly every day

http://www.phqscreeners.com/instructions/instructions.pdf

PHQ-9

- Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully, and circle your response.

- Item 9. Thinking that you would be better off dead or that you want to hurt yourself in some way
  - 0 = Not at all
  - 1 = Several days
  - 2 = More than half the days
  - 3 = Nearly every day

http://www.phqscreeners.com/instructions/instructions.pdf

PHQ9 (MHA Version)

Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully, and circle your response.

1. Little interest or pleasure in doing things
   - o 1. Not at all
   - o 2. Several days
   - o 3. More than half the days
   - o 4. Nearly every day

2. Feeling down, depressed, or hopeless
   - o 1. Not at all
   - o 2. Several days
   - o 3. More than half the days
   - o 4. Nearly every day

3. Trouble falling asleep, staying asleep, or sleeping too much
   - o 1. Not at all
   - o 2. Several days
   - o 3. More than half the days
   - o 4. Nearly every day

4. Feeling tired or having little energy
   - o 1. Not at all
   - o 2. Several days
   - o 3. More than half the days
   - o 4. Nearly every day

5. Poor appetite or overeating
   - o 1. Not at all
   - o 2. Several days
   - o 3. More than half the days
   - o 4. Nearly every day

6. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down
   - o 1. Not at all
   - o 2. Several days
   - o 3. More than half the days
   - o 4. Nearly every day

7. Trouble concentrating on things such as reading the newspaper or watching television
   - o 1. Not at all
   - o 2. Several days
   - o 3. More than half the days
   - o 4. Nearly every day

8. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual
   - o 1. Not at all
   - o 2. Several days
   - o 3. More than half the days
   - o 4. Nearly every day

9. Thinking that you would be better off dead or that you want to hurt yourself in some way
   - o 1. Not at all
   - o 2. Several days
   - o 3. More than half the days
   - o 4. Nearly every day

10. If you checked off any problem on this questionnaire so far, 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?
   - o 1. Not Difficult at All
   - o 2. Somewhat Difficult
   - o 3. Very Difficult
   - o 4. Extremely Difficult

Predictive Validity of the PHQ-9 (Item 9)

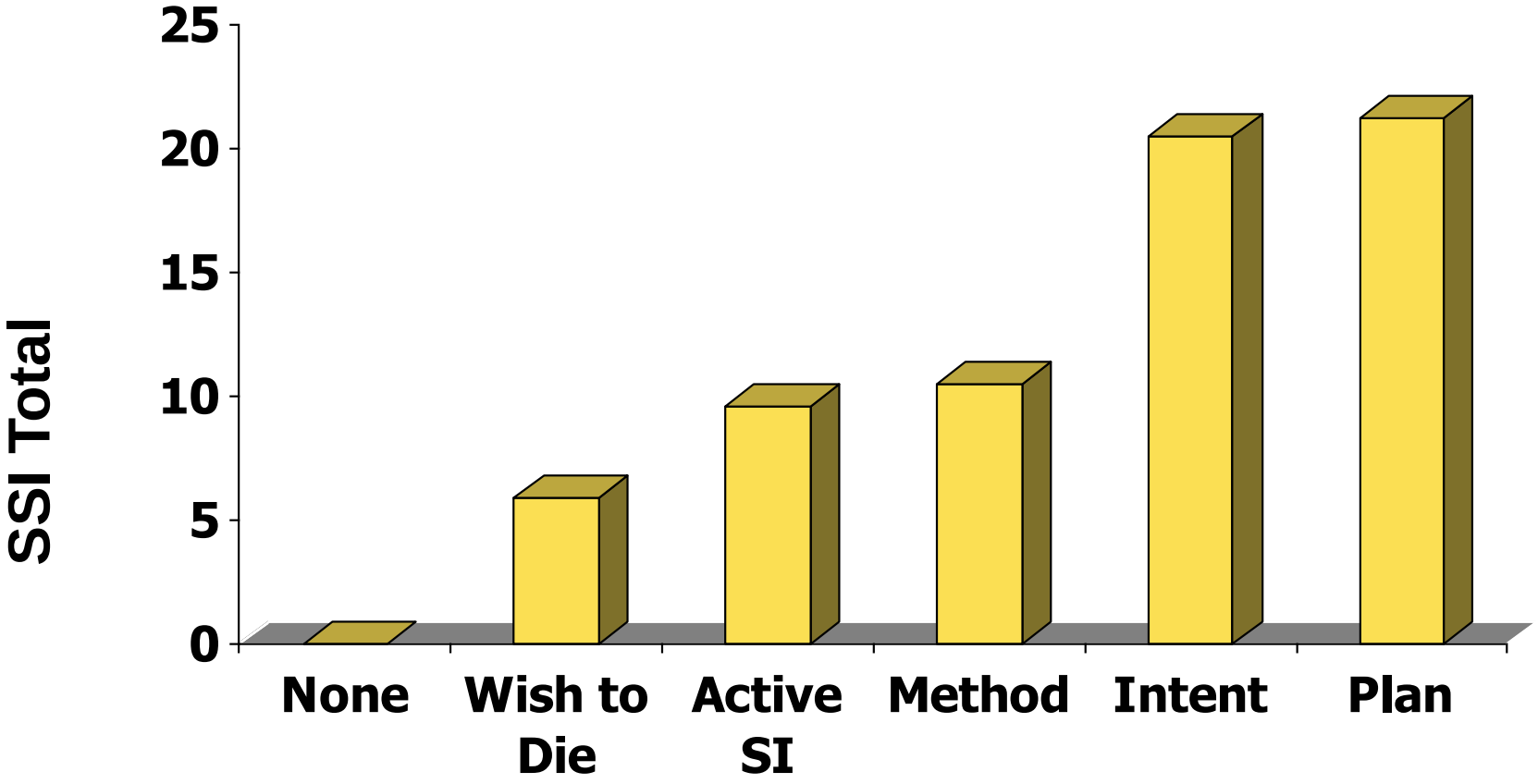
- Electronic records from a large integrated health system were used to link PHQ-9 responses from outpatient visits to subsequent suicide attempts and suicide deaths.
- A total of 84,418 outpatients age >13 completed 207,265 questionnaires
- Electronic medical records, insurance claims, and death certificate data documented 709 subsequent suicide attempts and 46 suicide deaths in this sample
- Cumulative risk of suicide attempt or suicide over one year increased from .4% among outpatients reporting thoughts of death or self-harm "not at all" to 4% among those reporting thoughts of death or self-harm "nearly every day."

Simon et al. (2013). *Psychiatric Services, 64,* 1195-1202.

Columbia Suicide Severity Rating Scale: Suicidal Ideation Subscale

SUICIDAL IDEATION		
Ask questions 1 and 2. If both are negative, proceed to "Suicidal Behavior" section. If the answer to question 2 is "yes", ask questions 3, 4 and 5. If the answer to question 1 and/or 2 is "yes", complete "Intensity of Ideation" section below.	**Lifetime: Time He/She Felt Most Suicidal**	**Past 1 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 wished you were dead or wished you could go to sleep and not wake up?*** If yes, describe:	**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 during the assessment period. ***Have you actually had any thoughts of killing yourself?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
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 been thinking about how you might do this?*** If yes, describe:	**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 had these thoughts and had some intention of acting on them?*** If yes, describe:	**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 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:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐

Scale for Suicide Ideation Total Score by Level of CSSRS Severity of Ideation



F (5,185) = 14.35, $p < 0.001$, n = 237

American Foundation for Suicide Prevention

Currier, Brown & Stanley, 2009, unpublished data

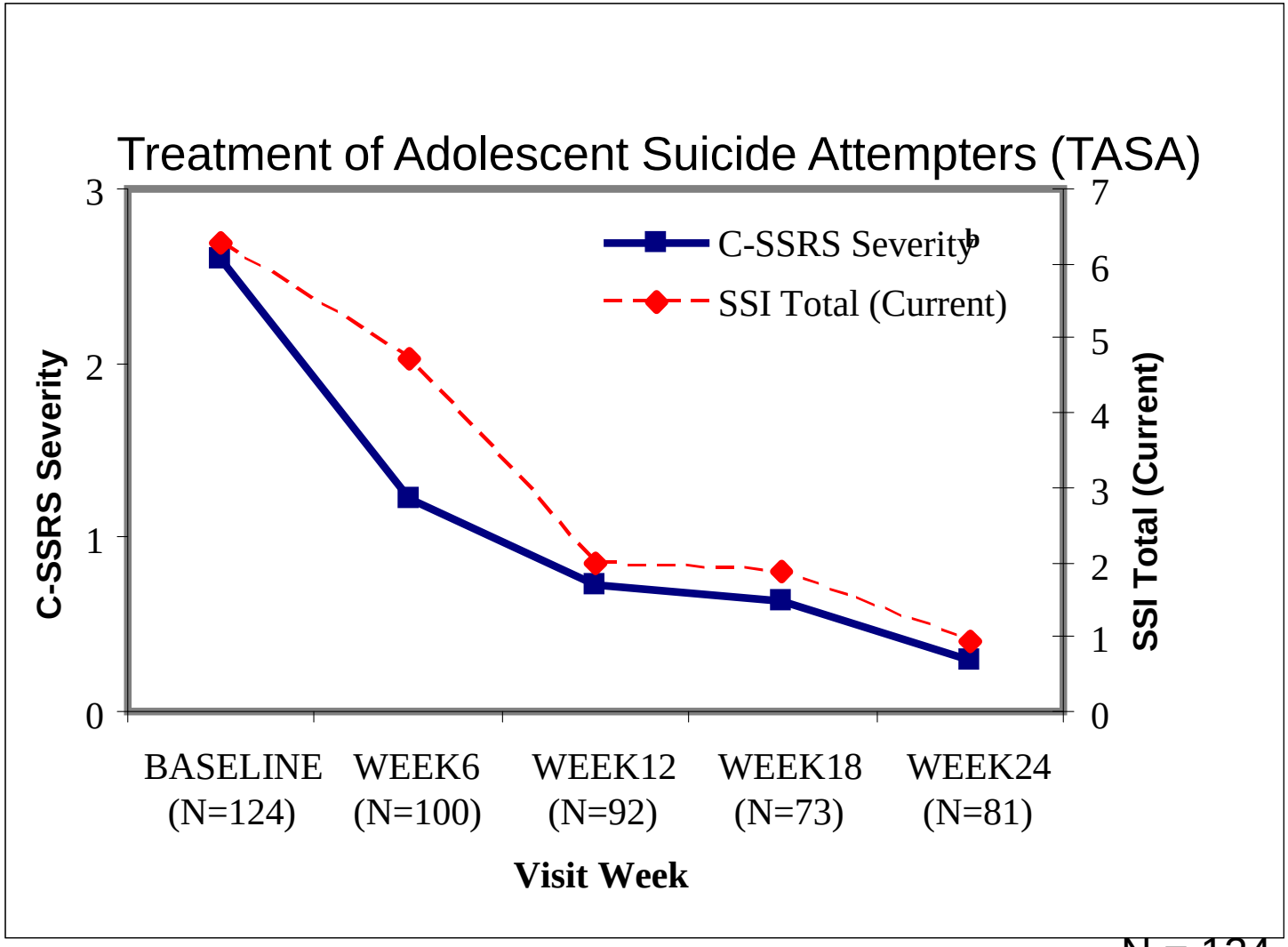
CSSRS Lifetime Severity of Ideation Predictive Validity

- Lifetime severity of ideation (0 -5) significantly predicted suicide attempts during 24 week follow-up (OR=1.45, 95% CI: 1.07-1.98, p<.001) in TASA study.

- Adolescents who endorsed lifetime ideation, with intent or intent and plan, significantly predicted suicide attempts over 24 weeks compared to those with no intent (OR = 3.26, 95% CI: 1.02-10.45, p = 0.047).

Posner K, Brown GK, Stanley B, et al., *Am J Psychiatry*. 2011;168:1266-77

Sensitivity to Change of CSSRS Severity of Ideation (0-5) and SSI



N = 124

Posner K, Brown GK, Stanley B, et al., *Am J Psychiatry*. 2011;168:1266-77

Suggested Guidelines for Selecting Measures for Suicide Risk

- Is it feasible to administer in the intended setting? Can it be used in an electronic medical record? Cost?
- Is the measure acceptable to staff and respondents in the intended setting?
- Is the administration of the measure harmful or have unintended consequences?
- In acute care settings where suicidal behavior is common, select measures that provide a comprehensive assessment of suicidal ideation and suicidal behavior.
- In psychiatric outpatient settings, select measures that can be used to screen for suicide risk at each and every visit.

If 1 and 2 are no, ideation section is done.

Columbia Suicide Severity Rating Scale

Screening Version

*Minimum of 3 Questions

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screening Version - Recent

	Past Month	
Ask questions that are bold and underlined	**YES**	**NO**
Ask Questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. **Have you wished you were dead or wished you could go to sleep and not wake up?**		
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/die by suicide, "*I've thought about killing myself*" without general thoughts of ways to kill oneself/associated methods, intent, or plan." **Have you actually had any thoughts of killing yourself?**		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. "*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 been thinking about how you might kill yourself?**		
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient 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 had these thoughts and had some intention of acting on them?**		
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. **Have you started to work out or worked out the details of how to kill yourself and do you intend to carry out this plan?**		

	Past 3 Months	
	YES	**NO**
6) Suicide Behavior **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, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.		

Suggested Guidelines for Selecting Measures for Suicide Risk

- Does the measure offer guidance for implementing an action plan?

Clinical Monitoring Guidance: Threshold for Next Steps

SUICIDAL IDEATION	
Ask questions 1 and 2. If both are negative, proceed to "Suicidal Behavior" section. If the answer to question 2 is "yes," ask questions 3, 4 and 5. If the answer to question 1 and/or 2 is "yes", complete "Intensity of Ideation" section below.	Lifetime: Time He/She Felt Most Suicidal
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 wished you were dead or wished you could go to sleep and not wake up?*** If yes, describe:	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 actually had any thoughts of killing yourself?*** If yes, describe:	Yes ☐ No ☐
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 been thinking about how you might do this?*** If yes, describe:	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 had these thoughts and had some intention of acting on them?*** If yes, describe:	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 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:	Yes ☐ No ☐

May Indicate Need for Action Plan

Example of Using the CSSRS for Developing an Action Plan: Reading Hospital

PROCEDURE:

Question	Trigger
Level 4/5 Yes to question 4 or 5	• Nursing Order to call MD for Psych Consult • Nursing Interventions (print on Kardex): • Pt Safety Monitor – 1:1 Observation • Pt Safety Monitor – Within arm's reach at all times • Complete Self Harm Safety Assessment every shift • Affix Suicide Risk Magnet to door • Revise Diet order to Safe tray • Alerts to ATC, Nutrition Services, Environmental Services and Security • Progress note for chart
Level 3 Yes to question 3 (and no to question 4 and 5)	• Consult to Care Team • Nursing Interventions (prints on kardex): • Pt Safety Monitor – 1:1 Observation • Pt Safety Monitor – Within arm's reach at all times • Complete Self Harm Safety Assessment every shift • Affix Suicide Risk Magnet to door • Revise Diet order to Safe Tray • Alerts to ATC, Nutrition Services, Environmental Services, Spruce Facilitator and Security • Progress note for chart

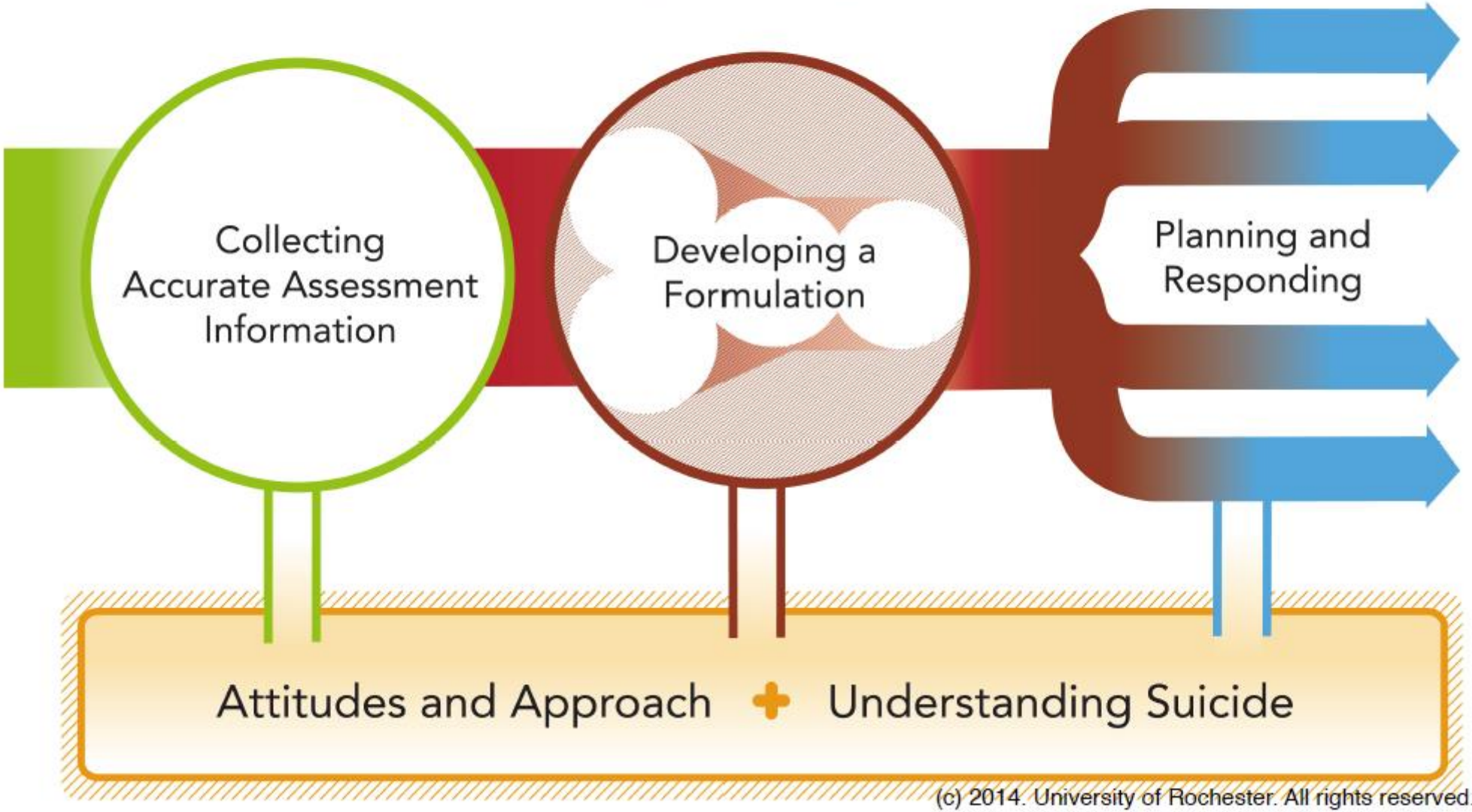
Presenter

Anthony R. Pisani, PhD

Center for the Study and Prevention of Suicide at the University of Rochester

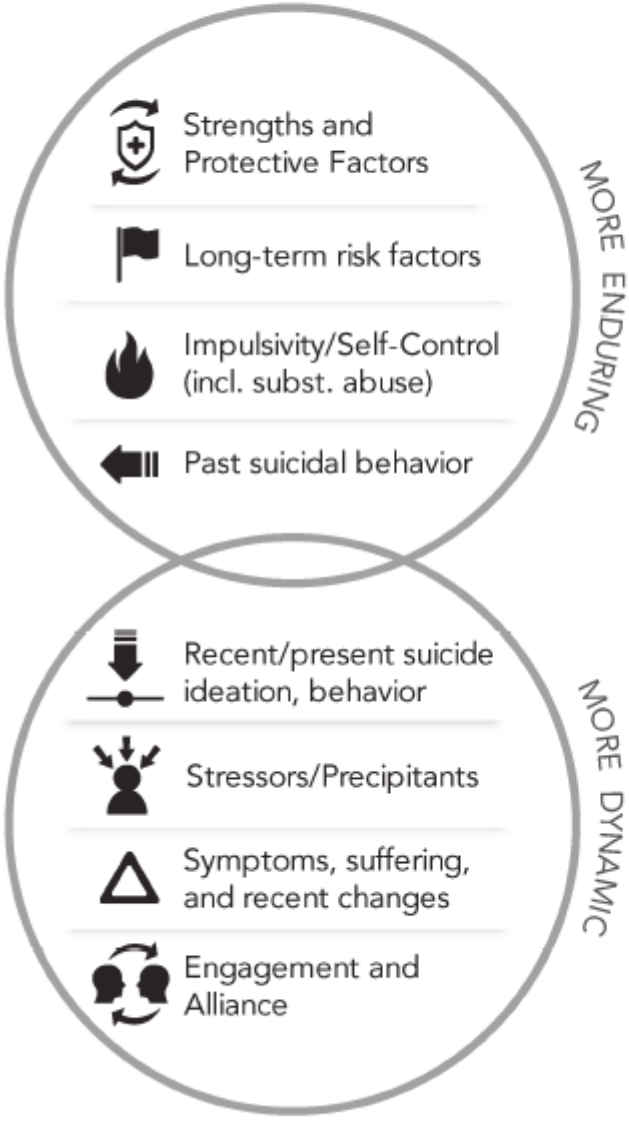
Core Competencies for Assessing and Managing Suicide Risk

(SPRC/AAS, 2006)



Clinical data

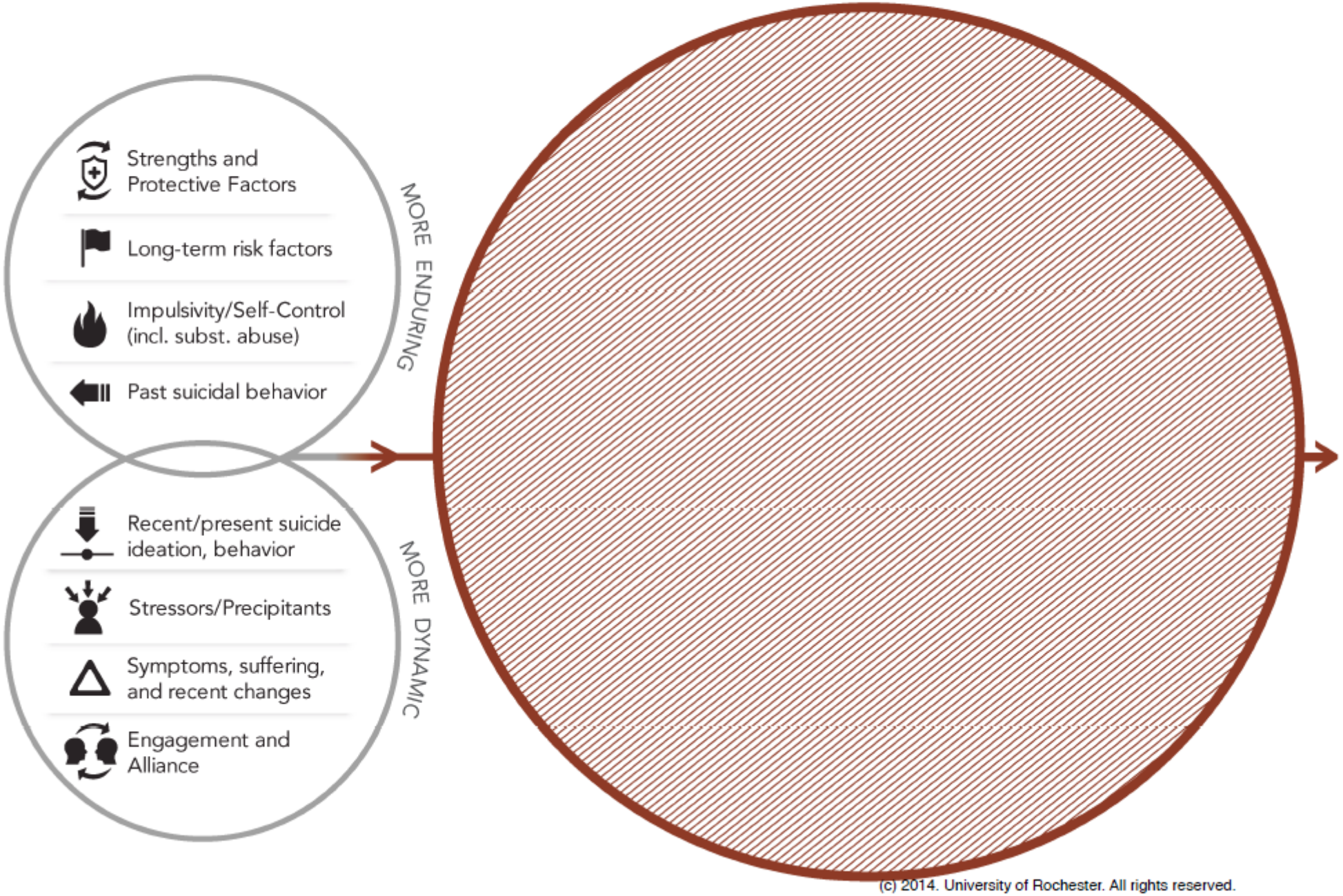
(Adapted from Bryan & Rudd, 2006)



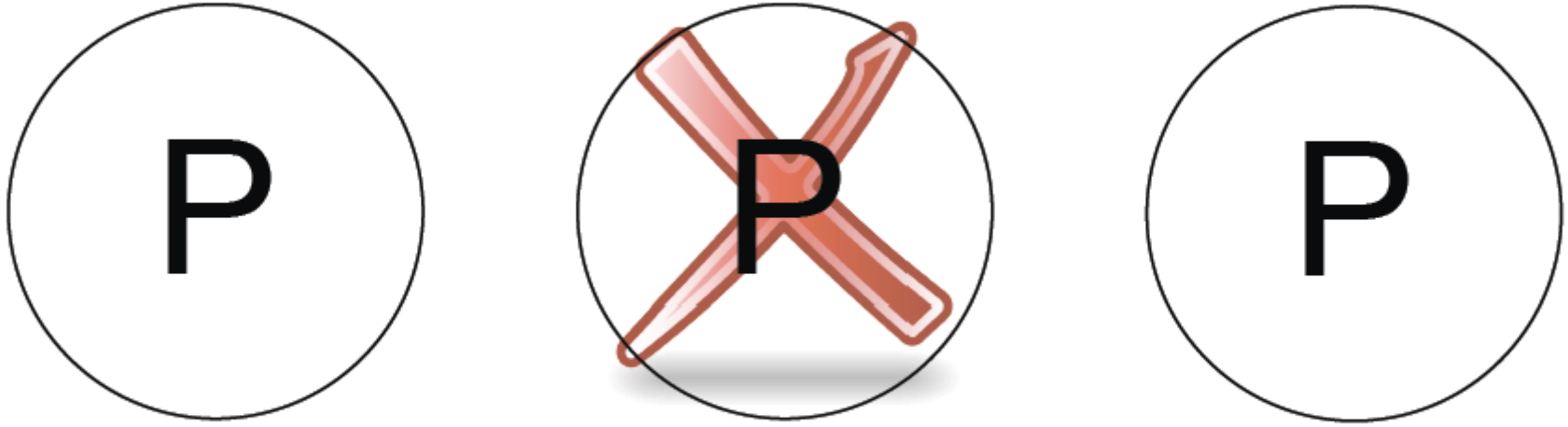
Clinical data

(Adapted from Bryan & Rudd, 2006)

Risk Formulation




LOW
MODERATE
CONSIDERABLE
HIGH
EXTREME



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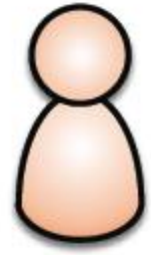

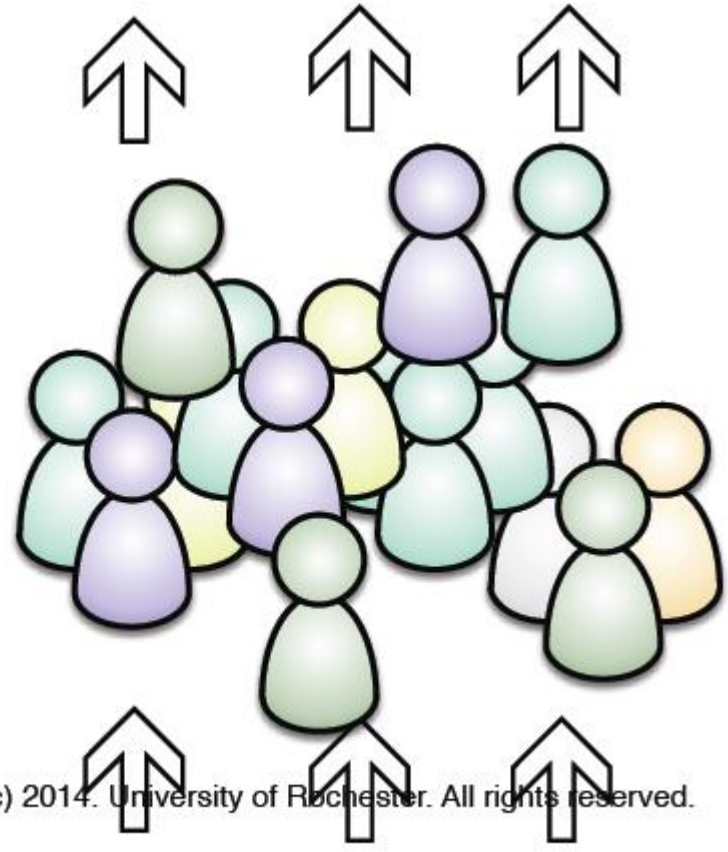

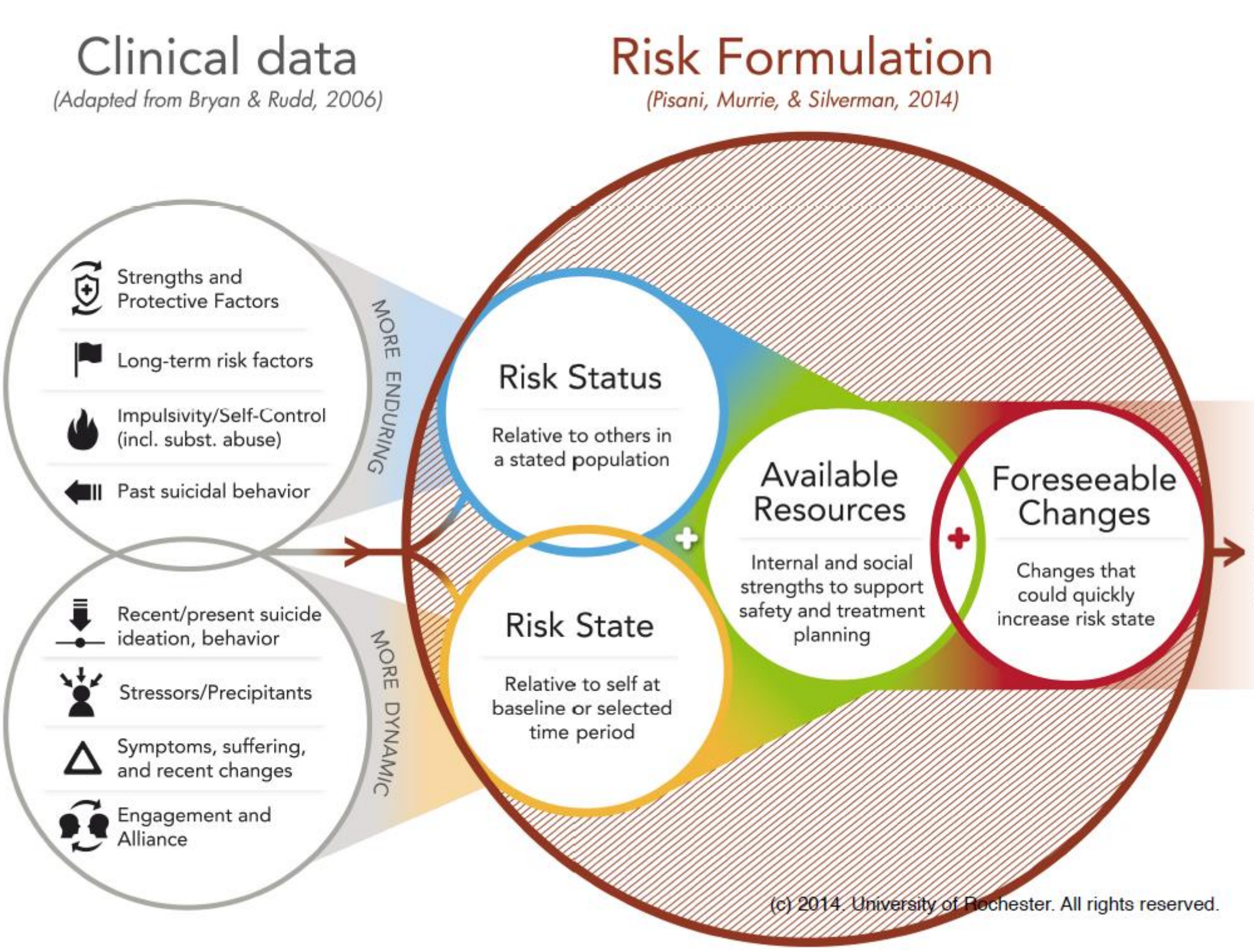
Clinical data
(Adapted from Bryan & Rudd, 2006)
Risk Formulation
(Pisani, Murrie, & Silverman, 2014)
Strengths and Protective Factors
Long-term risk factors
Impulsivity/Self-Control (incl. subst. abuse)
Past suicidal behavior
MORE ENDURING
Recent/present suicide ideation, behavior
Stressors/Precipitants
Symptoms, suffering, and recent changes
Engagement and Alliance
MORE DYNAMIC
Risk Status
Relative to others in a stated population
Risk State
Relative to self at baseline or selected time period
Available Resources
Internal and social strengths to support safety and treatment planning
Foreseeable Changes
Changes that could quickly increase risk state
PLANNING
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Presenter

Leah Harris, MA

Suicide Attempt Survivors Task Force

of the National Action Alliance for Suicide Prevention

Redefining Risk

- Issues of safety and risk come up particularly around suicide and self-harm, which are often trauma responses.
- Suicide risk increases with ACE score (Felitti et al, 1998).
- Trauma informed approaches emphasize the primacy of healing in mutual relationships.
- Traditional forms of assessment and liability fears interfere with these relationships.
- Dynamics of power and control take away from trauma-informed care and approaches to suicide prevention and intervention.

The Elephant in the Room

"If we don't rethink the notion of risk, the liability issue will continue to drive what we do." - Shery Mead

"Creating safety is not about getting it right all the time; it's about how consistently and forthrightly you handle situations with a client when circumstances provoke feelings of being vulnerable or unsafe. **Honest and compassionate communication that conveys a sense of handling the situation together generates safety.**"

-SAMHSA TIP 57

A Trauma Informed Approach to Suicide Prevention

- The central question of the trauma-informed movement is not “what’s wrong with you?” but “what happened to you?”

- This should be the guiding approach in all assessment and screening.

Responses to My Suicidality

As a trauma survivor with a history of intense suicidal feelings and self-harm, I was never given the space to make sense of these feelings in traditional settings.

Responses:

- Police response – carted away in handcuffs
- Being punished with loss of privileges for self-harming on the ward
- Threatened with interventions I didn't want
- No one asked "what happened to you?"
- Consequently, I learned to hide my suicidal thoughts and feelings and self-harming behaviors.

Safety as a Euphemism for Control

- Safety is one of our deepest human needs; it is a precondition for recovery.
- In many human service settings, people who are suicidal can experience unwanted, traumatic, and humiliating interventions, all in the name of “safety.”
- We need to understand that in this context, safety is a euphemism for “control.”
- Shery Mead talks about “fear-based” vs. “hope-based” responses to suicide.
- Many people in human service fields have been trained not to acknowledge this fear to themselves or the other person, and move directly into “control mode.”

Authenticity

- Though suicidal feelings are common, talking about them is taboo.
- In the traditional provider-patient relationship, sharing about these personal experiences is discouraged.
- In a trauma-informed relationship, the peer practitioner discloses own past or current struggles with suicidal thoughts, when applicable. “I’ve felt that way, too.”
- Peer practitioners also share coping skills (strategies) they have found useful to manage their own suicidal thoughts or feelings.
- Trauma informed approaches facilitate learning and growth for both the support person and person in distress/crisis.

Recommendations from *The Way Forward*

The Way Forward is a July 2014 report authored by the Suicide Attempt Survivor Task Force of the Action Alliance.

- **Recommendation 3.4 – Practice: Clinical professionals should collaborate with a person to understand his or her suicidal experience and specifically address suicide risk.**
- **Recommendation 3.6 – Practice: Informed consent. At the beginning of care, professionals should inform patients about their approach to working through crisis situations.**

  Some attempt survivors have reported being dropped from treatment after a suicidal crisis, at times without a referral to another provider.

Recommendations from *The Way Forward*

- **Recommendation 3.7 – Practice: Behavioral health providers should integrate principles of collaborative assessment and treatment planning into their practices.**

There are at least two models that illustrate ways for assessment to adhere to the Core Value supporting dignity and collaborative care:

- The internationally recognized Aeschi approach; and
- The empirically supported Collaborative Assessment and Management of Suicidality (CAMS) model.

The Aeschi Group

Guiding Principles: http://www.aeschiconference.unibe.ch

- The clinician's task is to reach, together with the patient, a shared understanding of the patient's suicidality.
- The clinician should be aware that most suicidal patients suffer from a state of mental pain or anguish and a total loss of self-respect.
- The interviewer's attitude should be non-judgmental and supportive.
- The interview should start with the patient's self-narrative.
- The ultimate goal must be to engage the patient in a therapeutic relationship.

CAMS Model

- Dr. Jobes, a member of the Aeschi group, developed the CAMS model as a framework for collaborative assessment and treatment for working with suicidal individuals.

- One of the core aspects of the approach is a collaborative assessment of a person's goals or perceived benefits for suicidal thinking.

- The therapist can then help the person consider alternative coping strategies or supports that can help the person achieve those goals or realize those benefits.

Recommendations from *The Way Forward*

- **Recommendation 3.8 – Practice: Behavioral health professionals should complete a comprehensive assessment that goes beyond suicide risk as soon as it is feasible to do so, acknowledging that a person has a life beyond the crisis.**

A comprehensive assessment would also examine several life domains, facilitating a discussion of individual strengths, spirituality, and possible community connections.

Reminding someone that he or she has multiple dimensions of wellness that include strengths could help restore a sense of self-respect or dignity.

Recommendations from *The Way Forward*

- **Recommendation 3.9 – Policy: Protocols for addressing safety and crisis planning should be based on principles of informed and collaborative care.**

Many people have been sent to involuntary, or coerced, inpatient care when they could have benefited from alternatives.

During hospitalization, patients might endure physical and/or psychiatric restraints or solitary confinement. Such practices intensify the crisis, deprive a person of dignity, and substitute potential trauma for treatment while having practically no effect on long-term risk for suicide.

Take Away

From the moment of first contact to discharge and follow up…

Care must be founded on a strong and collaborative therapeutic relationship with mutual respect and trust.

Resources

- **The Way Forward: Pathways to hope, recovery, and wellness with insights from lived experience**
  Suicide Attempt Survivor Task Force (NAASP):
  http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/The-Way-Forward-Final-2014-07-01.pdf

- **Defining Outcomes for Crisis Response** by Shery Mead and Eric Kuno: http://bit.ly/1orvn4e

- **Crisis and Connection** by Shery Mead and David Hilton http://bit.ly/1jtXcRE

Zero Suicide

CONDUCTING A NARRATIVE INTERVIEW: A PATIENT-CENTERED APPROACH

Conducting a Narrative Interview of Suicide-Related Events

- Understand that suicidal thinking and behavior “makes sense” to the patient in the context of his or her history, vulnerability, and circumstances.
- Accept that a patient may be suicidal and empathize with the patient’s strong feelings and desire to reduce pain.
- Understand the function of suicidal behavior or thinking from the patient’s perspective.
- Refrain from trying to help the patient solve his or her problems before understanding the motivations for suicide.

Zero Suicide

ROLE PLAY DEMONSTRATION

TYPE IN THE CHAT

What questions do you have for any of our presenters?

Contact

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Education Development Center
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