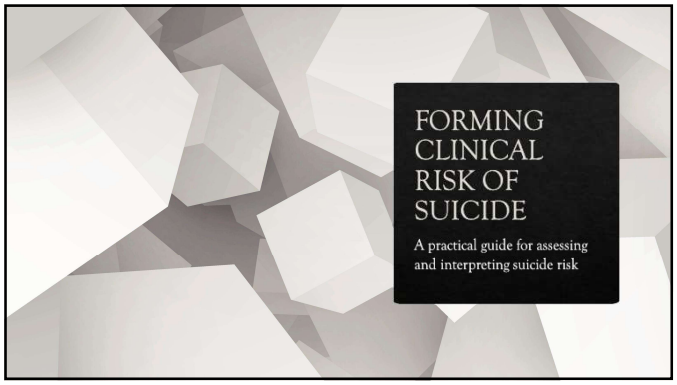

1

OVERVIEW

GOAL: To recognize and develop additional assessment perspectives related to determining the clinical risk of suicide. Using the empathetic recognition of risk factors and informed clinical judgement to assist in making the most appropriate clinical interventions.

Introduction

I. Recent Statistics: A general review of the extent of this terrible problem

II. Generic brief review of screening tools characteristics, their use and their impacts on suicide completion rates and associated factors.

III. The Clinical Interview - Suicide assessment clinical interviewing - approaches, considerations and suggestions based upon the literature and more than 3 decades of clinical experience in multiple settings.

IVa and b. Risk and Protective Factors to evaluate and identify

V. Documentation of the clinical risk assessment.

2

Introduction:

- This presentation is built around a theme I believe was very well-expressed in a quote I found in an online article*:
- "The gold standard for suicide risk assessment is 'get to know your patient.' Don't checklist them. Don't try to fit them in a box. Understand them. Find out what makes their life more stressful and what improves their life. What's missing? What's needed? What's good and needs to be supported?" The quoted clinician goes on to say that he doesn't particularly care what assessment tool is used as "None of them are predictors and none of them can replace the work of getting to know your patient."
- *Pierre, JM. Does suicide risk assessment really prevent suicide? Part 2: Talking suicide with psychiatrist and suicidologist Dr. Tyler Black. *Psychology Today* Posted September 14, 2021.

3

Introduction continued:

- In the article, Dr. Black goes on to state that a "proper suicide risk assessment" includes:
- "A detailed analysis of the risk and protective factors present in the patient
- An interview in which the clinician and the patient can have a dynamic interaction so the clinician can better understand the above
- A synthesis and common understanding ('formulation') of the above
- An approach to reducing risk by reducing established/possible risk factors and bolstering established/possible protective factors"

4

I. Recent Statistics

- 2020 Data from the Centers for Disease Control and Prevention (CDC) revealed:
- 1) 45, 979 deaths by suicide in the United States (1 death every 11 minutes)
- 2) 12.2 million adults reported a serious degree of suicidal ideation
- 3) 3.2 million adults developed suicidal plans
- 4) 1.2 million adults attempted suicide

5

Recent Statistics continued:

- 5) For every completed suicide, there were 4 hospitalizations related to attempts
- 6) For every completed suicide, there were 8 emergency department visits related to suicide
- 7) For every completed suicide, there were 27 self-reported attempts
- 8) For each death by suicide, there were 275 adults who seriously contemplated suicide.
- 9) The suicide rate was 4 times higher among males (22 per 100,000) than females (5.5/100,000). Males make up 49% of the population but are responsible for almost 80% of completed suicides. Males tend to use more lethal means (e.g., firearms). Females attempt suicide more often than males.

10) Per the CDC, Ages 85+ have the highest suicide rate at ~20.9/100,000. Next are those aged 75-84 and 25-34 - both at 18.4/100,000.

6

Recent Statistics continued:

- 11) Suicide rates vary by racial and ethnic groups (Rate per 100,000):
- Non-Hispanic American Indian/Alaska Native 23.9
- Non-Hispanic White 16.9
- Non-Hispanic Native Hawaiian/Other Pacific Islander 12.5
- Non-Hispanic Multiracial 9.6
- Non-Hispanic Black 7.8
- Hispanic 7.5
- Non-Hispanic Asian 6.4

7

Recent Statistics continued:

- According to the National Alliance on Mental Illness (NAMI) from an 8/2022 article available online:
- 46% of people who die by suicide had a known mental health condition
- Substance abuse can worsen suicidal ideation in response to either the associated "highs" or the "lows" – loss of inhibition, impaired judgement, direct mood disruptions, etc.
- 1 in 5 people who die by suicide had alcohol in their systems

8

II. Screening Tools

- Although a variety of screening tools are available for assessing suicidal risk, they are insufficient on their own as "end product" clinical assessment tools. They require an additional accompanying significant and focused clinical interview (when indicated by positive results) to provide needed depth and context for higher level clinical decision-making/interventional actions. Among the scales available are:
- The Columbia-Suicide Severity Rating Scale (C-SSRS) and the VA-associated Comprehensive Suicide Risk Evaluation (CSRE)
- The Assessment of Suicide and Risk Inventory (ASARI)
- Ask Suicide-Screening Questions (ASQ)

9

Screening Tools

This is not at all meant as a dismissal of their value as they were never expected to be sufficient by themselves. The tools are valuable as they can provide a simple and relatively standardized means to raise possible red flags to prompt further investigation for clinical decision-making purposes. This actually holds true, in my experience, not only when the screens trigger as positive but also when they are negative. Probably anyone who has used a screening tool has - at times - after a negative screening result, experienced lingering concerns and/or a desire to know more to feel more secure in their clinical judgment. The next slide conveys the value of suicide screening tools.

10

Screening Tools

There are many examples of the valuable contributions deriving from the use of screening tools for assessment and the enhancement of patient safety. Following the wide dissemination and implementation of the CSSRS screening tool, there have been numerous and consistent data collections/studies indicative of valuable and positive impacts associated with their use. These findings include significantly reducing:

- 1) suicides
- 2) emergency department visits/recidivism rates related to suicidality
- 3) unnecessary involuntary hospitalizations
- 4) false positives in result comparisons of CSSRS to PHQ-9 findings for suicide risk
- 5) healthcare costs in the millions of dollars
- - within non-VA civilian and VA health systems, at state and community levels and throughout the military services.
- From an online article/presentation CSSRS Return-on-Investment Highlights by Dr. Kelly Posner Gerstenhaber at Columbia University for the Columbia Lighthouse Project – Identify Risk, Prevent Suicide

11

Screening Tools

- For additional perspective, MMPIs, GAD-7s, PHQ-9s and laboratory tests are all of limited value without context. As an example, an elevated blood sugar on its own lacks definitive meaning if the interpreter is unaware if the study was a fasting one or not. Another example might be an MMPI not accurately reflecting an individual's baseline personality style or acute presentation if acute stress factors underlying their current emotional or mental states at the time of the testing are not taken into account. E.g., a high score on the "lie" or "hysteria" scales may lack full validity if it is not known to the interpreting clinician that the person is desperate to appear ill enough to be accepted into treatment after chronic and repeated efforts to engage with other providers had failed (for any reason – lack of accessibility, a limited ability to pay for the desired services, being seen as a potentially "difficult" patient, provider scarcity, etc.).

12

Now What?

13

III. The Clinical Interview

1) Identify yourself and your purpose in a courteous and professional manner.
2) Talk openly and directly
3) Discuss confidentiality and under what circumstances it may need to be broken – e.g., if there is imminent risk to self or others with imminent intent to act on homicidal or suicidal thoughts/plans. Reinforce that having suicidal ideations does not necessarily result in an automatic hospitalization.
4) The suicidal client is in crisis – use simple and direct language when asking questions and making suggestions – e.g., "Do you have a plan for how you would kill yourself?"

14

The Clinical Interview

5) Project calm even if you are understandably anxious . The goal of the assessment is the safety of the client and helping them to feel safe/comfortable to communicate openly with you in order to achieve that goal (not CYA).
6) Approach from a "I want to listen to you and understand what you are saying and feeling so that we can together figure out what is the best plan."
7) Identify/reveal your concerns and what triggered them – the patient may find it a relief/reassuring that you picked up on the clues (maybe especially if the patient did not recognize them as concerning). Don't keep it to yourself.

15

The Clinical Interview

- 8) Periodically summarize what the patient has been saying – using their own words if you are able – to reinforce that you are listening and to verify that you are understanding what is being shared. This can help to build trust and to encourage them to continue the dialogue. E.g., "I am hearing you say that you are letting others down and that makes you feel bad – what do those thoughts and feelings mean for you?"
- 9) Acknowledge and validate their emotional distress and associated suicidal ideations/actions. Everyone has different thresholds for stress and their ability to cope with it. Avoid being judgmental. Provide this validation while also identifying that suicide is not supportive of their recovery or well-being.
- 10) It is important to hear what is being said to facilitate your understanding, to strengthen the patient's confidence that you are invested in them and to not prematurely forge ahead with treatment interventions before the assessment portion of the interview is complete. Doing the latter may shut down the patient's disclosure and also lead to missteps. For example: "Why don't we see if your mother can come and stay with you for support?" being suggested before an estranged relationship was disclosed or other relevant psychosocial data was obtained. Stay focused on the suicidal risk assessment until all desired information has been sought.

16

The Clinical Interview

- 11) Avoid being superficial with the person because you feel the risk level is not significant or you are nervous about "digging too deep." Doing so may send signals to the person that you do not care, do not take them seriously or that you are up to the task. As a result, they may not feel safe or valued enough to disclose. They also might perceive that they are "bothering" you and wasting your time.
- 12) Be wary of your own perceptions "Oh, it's just Francis being Francis again…same story, same threats but never any intent." Every assessment must be taken seriously.
- 13) Using any form of humor (because you feel that the risk is minimal and the person is "in on the joke") can be humiliating, insulting and, at a minimum, signal that you do not want the conversation to get serious. The person may take that cue and hide their distress, plans and intent.

17

The Clinical Interview

14) Don't assume that patients know your terminology. They might be hesitant to answer a question out of fear of appearing "ignorant"/"stupid."

15) LISTEN, RESPOND, FOCUS on what is being said/displayed rather than filling out an assessment form. Explore in greater depth (and document) any statements or other data that make you feel uneasy

16) CONTRACTS FOR SAFETY DO NOT WORK.

18

The Clinical Interview

Some clues to watch for during the assessment:

1) Lack of future planning
2) Reporting isolative behaviors
3) Giving things away, settling financial/business/social commitments/affairs, etc.
4) Poor eye contact
5) Inconsistencies in patient's responses within the interview – see #9 on next slide for additional considerations
6) Abrupt mood change to upbeat/elevated mood – for some this is evidence that they have accepted that they will commit suicide and they will feel some emotional "relief" from that acceptance.

19

The Clinical Interview

- 7) Extremes of mood – agitation, rage, intense anxiety, profoundly debilitating sadness.
- 8) Taking dangerous risks – e.g., reports driving extremely fast, increased substance use, carrying weapons, etc.
- 9) Available collateral history – use it to assess consistency in the patient's reporting of symptoms, behaviors and level of intent (not in an "Aha, gotcha!" manner but to help formulate your risk assessment). Keep in mind that collateral sources may have ulterior motives to create or exaggerate the risk of suicidality (legal reasons, desire to see the person "safe" in an institution, to gain/force access to substance use treatment, etc.)

20

The Clinical Interview

Informal scales are only useful in context – e.g., 1-10 (10= worst [clarify this as many will not hear and believe 10 is a "good" score]). The patient says that their self-perceived level of suicidal ideation at the time is 5/10. Sounds bad (and isn't great) but ask the following several questions: What is your usual level off SI/intent? When was the last time you felt the level was lower than 5? What was it when/if you actually ever attempted suicide? Was the level similar before you acted in previous/multiple attempts? Acknowledge your concern about the 5 but ask them if that reflects, in their opinion, a significant imminent risk of suicidal behavior. The point is – what if they perceive their baseline level of SI/intent to be 8/10 or 9/10? What if that day is a good day or seeking help has helped them feel better and the 5/10 score is a relief?

21

The Clinical Interview

Don't scoff at/dismiss risks with borderline or histrionic personality disorder histories – again, "oh, that's just Francis being Francis", "childish"/unrealistic plans, actual children expressing SI (holding their breath may not be a feasible mode of suicide but their intent may be very real and they may work out a way to achieve lack of breathing), histories of dozens of various previous "unsuccessful" attempts (i.e., "they're doing it for attention – they won't do it [even if accurate for the given individual, mistakes/unintended deaths do happen]")
The person may not believe that a given method will be lethal but it actually can be – e.g., some do not think an acetaminophen/Tylenol overdose can be serious/deadly.

22

The Clinical Interview

Problematic assessment Intervention: Don't ask the patient what they would do to commit suicide with the goal to induce them into making statements that can justify an involuntary admission when reported out of context. E.g., patient says – "I am not suicidal." You say "Okay, but if you were…how would you do it?" Patient responds – "I don't know, maybe shoot myself?" You document "Patient with plan to shoot self" and fill out a pink slip for an involuntary admission… Sadly, this happens.

Consequences: I have been the recipient of numerous faulty referrals that stripped patients of their freedom/rights and they were understandably quite angry. Perhaps equally problematic are the numerous resultant threats to never see that provider or return to that referring treatment facility ever again due to the loss of trust. It also initiates the inpatient treatment team's interactions on a sour note. There is little option to do other than maintain the hospitalization while further investigation is pursued. If the person lives in the local area and has limited transportation or coverage options, then dropping out of treatment with the most readily available/accessible provider ramps also increases future risk levels.

23

The Clinical Interview

- Problematic Assessment Intervention: Downgrading or dismissing (consciously or not) patients' responses to assessments of any kind in order to avoid lengthier and time-consuming documentation. The rationale that the patient will "probably be safe this time" is obviously deeply flawed. This can manifest in multiple ways but two common ones that I have observed in my role as a reviewer of clinical documentation are:
- 1) During assessments for potential hospitalization, the provider downplays or explains away the patient's statements, behaviors, previous clinical assessments and collateral history reports that were indicating clear suicidality. This can result from the patient explaining away portions of the referral information or retracting their previous statements/behaviors by identifying them as being the products of false, exaggerated or manipulative testimony by others or him/herself. The potential reasons for doing so are many – avoiding a hospitalization in order to pursue suicide, because the

24

The Clinical Interview

- Continued:
- patient really is/was not suicidal but had other motives for their behaviors or the patient was actually suicidal while in an acute crisis but now feels safe and does not want the consequences of being hospitalized, etc.
- 2) Clinicians may, by words, affect and attitude consciously or subconsciously "steer" a patient to downplay or deny a more intense level of suicidality. This could be from a natural human desire to not want someone be in that much distress - but this is not a helpful approach during a clinical assessment. Such "guidance" could be rationalized by claiming a clinical intent to gauge the severity of the patient's suicidality – "I hear what you are saying but would you REALLY act on those thoughts?" or "Surely, you wouldn't do that and leave your children behind?" These two example questions (of a potentially

25

The Clinical Interview

- Continued:
- infinite number) indicate that the clinician may prefer the answer to be "no." The patient - following the clinician's lead – may influence the nature of the patient's response in order to be a "good patient" and "soothe" the clinician. In addition, the patient may very reasonably feel that their distress and safety are being disregarded by a provider too focused on having a no stress encounter. Obviously, this could result in feelings of anger, rejection, damage to/loss of the therapeutic relationship and increase the risks of disengagement from treatment and suicidal behaviors.
- A better way to ask the same questions generally involves the use of a more open-ended question format:
- "How intense are the thoughts?" and followed by "How likely do you feel that you may act on them?"
- "Is there anything or anyone in your life that helps you want to continue living?"

26

The Clinical Interview

- Gut feelings – don't ignore them and do review for whatever might be contributing to them. If you feel worried for the veteran rather than yourself, then you should err on the side of caution and pursue further investigation and consider possible additional interventions (e.g., invest extra effort to verify access/availability of a support system).
- Seeking supervision or consultation with a supervisor, peer or other individuals/resources for additional assessment is entirely appropriate.

27

Hopefully the information gained thus far will allow you to consider and incorporate the following in your assessment:

28

IVa. Risk Factors:

- The presence of suicidal ideation – active vs. passive and acute vs. chronic
- History of previous attempts to commit suicide or self-harm behaviors – number and interval since most recent attempts (also family history of suicide attempts/completions.
- Desensitization to suicide (loss of associated fears of death and indifference to its potential impacts on others) resulting from others' suicides (friends, fellow soldiers, family, etc.) and/or numerous personal previous attempts
- Plans for self harm
- Intent to act on plans for self-harm
- Access to lethal means (sometimes difficult to reliably assess as access to, for example, motor vehicles, elevated heights, knives, cords, etc. is virtually ubiquitous in addition to possible firearms or supplies of medications/drugs/alcohol) – especially those associated with any noted plans. Question: How far do you go to investigate.
- Mental/emotional status (aggression, hopelessness, anxiety, agitation, shame, impaired judgement [intoxication, dementia, delirium, etc.], disinhibition, pain, command hallucinations) from whatever contributing factor(s)

29

Risk Factors

- Mental Health Diagnoses – e.g., PTSD/trauma history, anxiety, mood, personality and psychotic disorders
- History of psychiatric hospitalizations – timelines (e.g., how recent) and number of hospitalizations
- Problems with ability to access care (mental health and/or medical) and needed/appropriate levels of care
- Mental health treatment history and current/past treatment experiences/relationships
- Medical Diagnoses – cancers, Huntington's Disease, Lou Gehrig's Disease (ALS), HIV/AIDS, multiple sclerosis, chronic pain, traumatic brain injuries
- Feelings of isolation/alienation/lack of a support network. Also, a sense of being a burden to others – "Everyone would be better off without me."
- Psychosocial stressors – relocations away from supportive/familiar environment (scholastic/college, employment, military service), entry into military service, relationship problems/loss, deaths of loved ones, grief arising from any source, loss of job/career, financial hardship, homelessness, criminal and civil legal problems, educational performance stress.
- Military with VA treatment vs non-VA treatment

30

IVb. Protective Factors

- Largely consist of factors that are the "antidotes" to the many risk factors…
- Family, community and organizational (e.g., the military) supports as sources of:
- 1) Obligations to others – e.g., family, friends, co-workers, fellow military personnel and pets
- 2) Opportunities for social interactions to share and vent feelings related to life stressors – in-person or via other means of communication
- 3) Involvement in social organizations and activities – e.g., faith-related activities, community service/volunteering, sports

31

Protective Factors

- Coping Mechanisms:
- 1) Recreational activities such as sports/exercise, hobbies, art, music, reading – serve a distractive purpose and may enhance socialization and emotional/creative expression
- 2) Personal attributes such as the abilities to problem solve as stressors arise and to self-recognize and emotionally self-regulate/react in situationally appropriate manners (e.g., avoid aggressive, hysterical, self-defeating or destructive responses). These attributes help to foster a sense of being resilient, exerting personal control over one's life and having a positive self-image. Being future- and goal-oriented and finding meaning and purpose in one's life.
- 3) Cultural and religious beliefs that promote life and discourage suicide.
- 4) Socio-economic security

32

Protective Factors

- Clinical Care availability/usage
- 1) Ready access to crisis support
- 2) Access via reliable transportation, proximity and/or remote means (e.g., video or phone)
- 3) Actively engaged in counseling
- 4) Psychotropic medications in use when indicated and at appropriate dosages
- 5) Positive therapeutic relationships with the provider(s)
- 6) Access to multiple therapeutic modalities/resources
- 7) Knowledge/understanding of any diagnoses, associated prognoses, course of the illness(es), treatment options/recommendations (to include caregivers, family, guardians, etc. when appropriate)
- - the above promote improved insight, judgement and feeling supported.

33

V. Documentation

If you document thoroughly enough to successfully protect yourself against a hostile lawyer, then you can probably feel confident that you also did a good and thorough job of assessing the patient for their safety. We, sadly, cannot be 100% perfect in predictions.

Some thoughts about documentation:

- Do not skimp on the assessment and its documentation because you believe that you "know" the person and just need to "go through the motions" and document the responses to the basic "routine" questions.
- 1) You might be wrong about how well you really knew and understood the person.
- 2) You may be unaware of new stressors in the person's life that dramatically alter their perceptions. Ask about them and document your awareness of them.
- 3) Doing an in-depth assessment and documenting it may trigger a new perspective on your part with respect to the person's level of risk (or the need to perform additional assessment).
- 4) Others reviewing your documentation may not know the person at all and perceive that you made little effort to be comprehensive/diligent regarding the person's risk level/safety.
- 5) Document what you know and NOT what you hope/conjecture

34

Documentation

6) In my opinion, the actual documentation in the clinical record of the screening tool(s) utilized is needed. Add clarifying narrative if needed if any of the information is ambiguous or there are concerns about its reliability (e.g., due to a lack of records, suspected or confirmed cognitive issues or inconsistencies)
7) Do not try to avoid having to complete the sometimes more extensive assessment tools (e.g., the CSRE after a positive C-SSRS) – ignoring or "spinning" data/clinical clues.
8) Beware of patients recanting/changing the history that resulted in the patient seeing you/others – often done to try to avoid involuntary hospitalization or, at times, your prevention of their suicide.
9) Document all sources of contributing information [Note: discuss episode with allegedly "too much" documentation]
10) Document access to means – drugs/alcohol. guns, knives, ropes, bodies of water, etc.
11) Document rationale(s) for interventions (or the lack thereof)
12) Explore and document all statements or revelations that make you feel uneasy

35

Documentation

- Gathering all of the information from the screening tools, the collateral/referral sources, any previous records (if available) and the direct interview helps to formulate risk assessments into two general categories that are likely familiar to all who perform them – acute vs. chronic risk levels. Documentation should reflect the determined risk levels (and support the recommended intervention). Try to organize your documentation such that any readers (and yourself for that matter) are guided step-by-step to your risk assessment conclusions. Organizing your thoughts in this manner may also help when discussing any recommended interventions with the patient – "I understand what you're saying and why you are making that recommendation.

ACUTE RISK:

- High Acute Risk: Suicidal with plan(s) and intent to die. Cannot be considered to be safe on their own. Intervention generally requires hospitalization.
- Intermediate Acute Risk: Suicidal ideation with plan but can independently maintain safety. The latter may be due to reliable psychosocial support, future thinking and verbalized reasons to live, established outpatient therapeutic relationships, etc. Intervention may take the form of intensive outpatient management.
- Low Acute Risk: Suicidal ideation is without current intent to commit suicide. A suicide plan, if present, is vague, there is a lack of preparatory behaviors, perhaps a lack of access to the means and generally the presence of multiple protective factors. The person can be considered to be independently safe. Intervention may be continued outpatient management or offer of referral to outpatient mental health/emotional support services if not established.

36

Documentation

- CHRONIC RISK:
- High Chronic Risk: Characterized by a history of attempts, chronic contributing mrental and physical health conditions (mood disorders, psychotic spectrum disorders, chronic pain, loss of function, etc.), chronic stressors, few evident coping skills, a limited social support system (if any) or few if any stated reasons for living. Again, everyone is different – I have encountered many patients with incredible stressors of every kind – acute and chronic – that do not consider or attempt suicide despite what seems to me to be overwhelming and hopeless circumstances.
- Intermediate Chronic Risk: Characterized by having a history of chronic conditions/stressors but have better coping mechanisms and crisis management skills.
- Low Chronic Risk: Characterized by a history of coping with/managing life stressors without considering suicide as an option.

37

Summary

- The quote noted earlier in this presentation bears repeating:
- "The gold standard for suicide risk assessment is 'get to know your patient.' Don't checklist them. Don't try to fit them in a box. Understand them. Find out what makes their life more stressful and what improves their life. What's missing? What's needed? What's good and needs to be supported?" The quoted clinician goes on to say that he doesn't particularly care what assessment tool is used as "None of them are predictors and none of them can replace the work of getting to know your patient."

38

The End

Questions?

39