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Suicide Risk Assessment and Treatment Options

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DESCRIPTION OF SUICIDE RELATED TERMS

Definitions

Completed *suicide* is death under circumstances and evidence of intention to take one's own life (Suicide Prevention Resource Center; SPRC, 2018). *Suicide attempt* is trying to take one's own life with a nonfatal outcome and which may or may not result in injuries. *Suicidal ideation* includes thinking about, considering, or planning for suicide (e.g., means to kill oneself, when to kill oneself, where to kill oneself; CDC, 2012). Suicide ideation ranges from passive thoughts (e.g., "I wish I wasn't around") to clear, active thoughts of suicide (e.g., "I will jump in front of a car tomorrow on the freeway"). *Suicidal behavior* is suicide, suicide attempts, suicidal ideation, and planning/preparation done with the intent of attempting or dying by suicide (SPRC, 2018). *Suicide risk/lethality* is defined on multiple levels, depending on the severity or level of risk to which a person experiences suicidal ideation or behavior (e.g., no risk, low risk, moderate risk, high risk; Paladino & Barrio Minton, 2008).

Resource:
Other helpful topics and terms can be found at: https://www.sprc.org/about-suicide/topics-terms

Prevalence

In 2016, there were 44,965 suicides in the United States. From 1999 through 2016, the age-adjusted suicide rate in the United States increased nearly 28%, from 10.5 to 13.4 per 100,000 population, with a greater increased pace after 2006. There was a rise in suicide rates from 1999 through 2016 for both males and females and for all ages (10–74 years). The percent increase in suicide rates for females was greatest for those aged 10–14 years, and for males, those aged 45–64 years. The rate of suicide is highest in middle age and for white men. White males accounted for seven of ten suicides in 2013. It is important to know that firearms account for over 50% of all suicides (CDC, 2016).

Suicide is the tenth leading cause of death for Americans 18 to 65 years of age, with suicide being the third leading cause of death in ages 10-24 years and second leading cause for those 25-34 years of age (CDC, 2014). Many suicide attempts, however, go unreported or untreated and surveys suggest that at least one million people in the United States each year engage in intentionally inflicted self-harm (CDC, 2016). Rates of attempted suicide vary considerably among demographic groups; for example, females attempt suicide three times more often than males, while males are four times more likely than females to die by suicide. The ratio of suicide attempts to suicide deaths in youth is estimated to be about 25:1, compared to about 4:1 in adults over the age of 65 years.

IDENTIFICATION/ASSESSMENT STRATEGIES

Counselors typically use a suicide risk assessment (SRA) to determine whether an individual is at risk of suicidal behavior. The purpose of the SRA is to identify risk and protective factors that assist clinician's formulation of risk. The suicide risk formulation assigns a level of suicide risk that ideally

informs decisions about triage and treatment (Silverman & Berman, 2014). The SPRC (2018) identified three common steps to a suicide risk assessment that provide a foundation for treatment planning: (1) gather complete information about past, recent, and present suicidal ideation and behavior; (2) gather information about the patient's context and history; and (3) synthesize information gathered into determination of risk rooted in the context of the client's situation. Overall, by completing an SRA, clinicians aim to increase safety, reduce risk, and promote wellness. Suicide assessment should always be done within the context of a clinical interview; however, risk assessment can be strengthened by using assessment tools in combination (Sommers-Flanagan & Shaw, 2017). All resources identified below were recognized by one of the following organizations: American Foundation for Suicide Prevention (AFSP), Suicide Prevention Resource Center (SPRC), or Substance Abuse and Mental Health Services Administration (SAMHSA).

The Columbia-Suicide Severity Rating Scale (C-SSRS)

The C-SSRS (Posner et al., 2011) is a screening tool administered via interview and the client is asked a range of "yes or no" questions. After completion, the C-SSRS provides guidance on potential next steps for the individual (e.g., hospitalization, counseling, referrals). The C-SSRS was designed to distinguish the domains of suicidal ideation and suicidal behavior; four constructs are measured. The first is the severity of ideation (referred to as the Severity Subscale), rated on a 5-point ordinal scale in which 1 = wish to be dead, 2 = nonspecific active suicidal thoughts, 3 = suicidal thoughts with methods, 4 = suicidal intent, and 5 = suicidal intent with plan. The second (Intensity of Ideation Subscale) is comprised of five items, each rated on a 5-point ordinal scale: frequency, duration, controllability, deterrents, and reason for ideation. The third (Behavior Subscale; rated on a nominal scale) includes actual, aborted, and interrupted attempts; preparatory behavior; and non-suicidal self-injurious behavior. The fourth subscale (Lethality Subscale) assesses actual attempts; lethality is rated on a 6-point ordinal scale, and if actual lethality is zero, potential lethality of attempts is rated on a 3-point ordinal scale. The items for assessing severity of ideation (e.g., a specific plan or method) and intensity (e.g., frequency, duration) of ideation were based on factors predicting attempts and suicide identified in previous studies. The C-SSRS was originally developed for adolescents with depression but has since been developed to be used with anyone who may be having suicidal ideation/behavior. Information gathered by the C-SSRS helps to: identify whether someone is at risk for suicide; assess the severity and immediacy of that risk; and gauge the level of support that the person needs. The C-SSRS has been translated into 45 languages. The scale and the training on how to use it are available free of charge for use in community and healthcare settings. Mental health training is not required to administer the C-SSRS; materials are available to the public domain. More information about the C-SSRS can be found at: http://cssrs.columbia.edu/

Resource:
http://cssrs.columbia.edu/wp-content/uploads/C-SSRS_Pediatric-SLC_11.14.16.pdf

Patient Health Questionnaire-9 (PHQ-9)

The PHQ-9 is a brief, basic screening tool used to identify at-risk patients. This tool is used extensively in primary care. The PHQ-9 contains nine items, and item 9 asks, "Over the past two weeks, have you been bothered by … thoughts that you would be better off dead or of hurting yourself in some way." While the wording of item 9 is indirect and does not directly ask about suicidal thoughts and behaviors, it is a tool that can lead to further assessment. If a client responds yes to Item 9, the clinician should follow up with specific, direct questions about suicidal thoughts and plans (e.g., Are you having thoughts of killing yourself?). If a client is having suicidal thoughts or has attempted suicide, a complete SRA should be done immediately.

Resource:
http://www.phqscreeners.com/sites/g/files/g10016261/f/201412/PHQ-9_English.pdf

SAFE-T (Suicide Assessment Five-Step Evaluation and Triage)
The SAFE-T assists clinicians in conducting a suicide assessment using a 5-step evaluation and triage plan to identify risk factors and protective factors, conduct a suicide inquiry, determine risk level and potential interventions, and document a treatment plan. Professionals who use the SAFE-T card should be better able to: (a) conduct a comprehensive suicide assessment and triage, estimate suicide risk and develop treatment plans and interventions responsive to the risk level of patients; (b) identify individuals at risk for suicide; and (c) protect and plan the care of individuals at-risk for suicide. The SAFE-T was developed in collaboration with the Suicide Prevention Resource Center and Screening for Mental Health Inc.

Resource:
http://www.integration.samhsa.gov/images/res/SAFE_T.pdf

Suicide Status Form
The Suicide Status Form (SSF; Jobes, 2016) helps the clinician and client to understand the details of a person's suicidality, including risk and protective factors and current sense of safety. The SSF is used from the initial session and throughout treatment. The SSF helps to outline the course of intervention and to track symptoms throughout treatment (Jobes, 2016). Counselors may administer the SSFs as part of the course of care in CAMS (Collaborative Assessment and Management of Suicidality; Jobes, 2012) discussed in detail in the intervention section below.

Resource:
http://cams-care.com/

INTERVENTION STRATEGIES

Clinicians can choose from multiple evidence-based therapies or approaches when working with clients who are suicidal. Regardless of approach, work with suicidal clients should have a person-centered foundation, be collaborative in nature, and address the ambivalence experienced by the client experiencing suicidal thoughts.

Attachment-Based Family Therapy (ABFT)
Attachment-based family therapy (ABFT) is a 16-week treatment for youths aged 12–24 years who have experienced depression, suicidal thoughts, suicide attempts, or trauma. ABFT treatment consists of the following five tasks: 1) relational reframe, 2) adolescent alliance, 3) parent alliance, 4) attachment, and 5) autonomy. ABFT is effective for reducing suicidal thoughts and behaviors (Diamond et al., 2010). Based on one study and two measures, the average effect size for suicidal thoughts and behaviors was .88 (95% CI: .41, 1.35). By posttest, patients in the intervention group were more likely to self-report suicidal ideation in the normative range, compared with the control group. Similarly, intervention patients were more likely to report no suicide ideation in the previous week to their clinician compared with the control group.

Resource:
https://www.nrepp.samhsa.gov/ProgramProfile.aspx?id=208

Cognitive Behavioral Therapy for Suicide Prevention (CBT-SP)
Cognitive behavioral therapy for suicide prevention is rooted in principles of cognitive behavior therapy (CBT), dialectical behavioral therapy (DBT). and targeted therapies for suicidal, depressed adolescents and adults. CBT-SP focuses on: cognitive restructuring strategies, such as identifying and evaluating automatic thoughts from cognitive therapy; emotion regulation strategies, such as action urges and choices, emotions thermometer, index cue cards, mindfulness, opposite action, and distress tolerance skills from DBT; and other CBT strategies, such as behavioral activation and problem-solving strategies (Stanley et al., 2009). Two studies tested the efficacy of CBT-SP: (a) one study with adults found reductions in attempts

and symptoms; and (b) a second study demonstrated the feasibility of using a similar intervention with adolescents (Brown, Ten Have, & Henriques, 2005; Stanley et al., 2009).

Resource:
http://zerosuicide.sprc.org/toolkit/treat/interventions-suicide-risk

Complicated Grief Treatment

Complicated grief treatment (CGT) targets adults experiencing complicated grief (CG), also known as prolonged grief disorder, traumatic grief, or persistent complex bereavement disorder. CGT is a semi structured, manualized treatment administered by a licensed therapist. The intervention includes seven core procedures: 1) psychoeducation about CG and CGT; 2) self-assessment and self-regulation; 3) aspirational goals work; 4) rebuilding connections; 5) revisiting the story of the death; 6) revisiting the world changed by the loss; and 7) addressing memories and continuing bonds. This program is promising for reducing suicidal thoughts and behaviors. Based on one study and one measure, the effect size for suicidal thoughts and behaviors is .66 (95% CI: .10, 1.22). Statistically significant group differences also were found for rates of suicidal ideation at the 20-week posttest (6.7% for PLA with CGT versus 19.0% for PLA alone).

Resource:
https://www.nrepp.samhsa.gov/ProgramProfile.aspx?id=185

Problem Solving Therapy

Problem-solving therapy (PST) is a brief, psychosocial treatment for patients experiencing depression and distress related to inefficient problem-solving skills. The PST model educates clients on problem identification, efficient problem solving, and managing associated depressive symptoms. PST is divided into three phases: Introduction/Education, Training, and Prevention. PST has been adapted for use with a variety of patient populations, including those in primary care and those who are homebound, medically ill, or elderly. PST is effective for reducing suicidality: in two studies and two measures the average effect size for reduced suicidality is .75 (95% CI: .26, 1.00). One study of Turkish high school and university students who participated in the intervention reported a statistically significant decrease in suicide risk (Eskin, Ertekin, & Demir, 2008) compared with students in the control group. In another study (Stewart, Quinn, Plever, & Emmerson, 2009), suicidal adults who participated in the intervention reported a statistically significant decrease in suicidal ideation from pretest to posttest, compared with the control group.

Resource:
https://www.nrepp.samhsa.gov/ProgramProfile.aspx?id=108

The Collaborative Assessment and Management of Suicidality (CAMS) Approach

CAMS is a flexible therapeutic framework for assessment and treatment of a client's suicidal risk (Jobes, 2012) that can be used across theoretical orientations and disciplines for a wide range of individuals. The CAMS approach integrates psychodynamic, cognitive, behavioral, humanistic, existential, and interpersonal theories into a structured clinical framework that emphasizes the clinician and patient working together to better understand the role of suicidality in the client's world. Every session of CAMS requires the client's input about what is and is not working. CAMS is guided by a multi-purpose clinical tool called the "Suicide Status Form" (SSF; previously discussed above). This form is a multipurpose clinical assessment, treatment planning, tracking, and outcome tool. Typically, CAMS is focused on outpatient care, but can be modified for inpatient use. CAMS can be used in a range of clinical settings (e.g., college counseling center, outpatient counseling facility, inpatient psychiatric care). There are multiple published open trials/correlational investigations on the effectiveness of CAMS (and the embedded use of the Suicide Status Form) in a variety of clinical settings with varying samples of suicidal patients (Andreasson et al., 2016; Comtois et al., 2011; Jobes et al., 2017; Wenche et al., 2016).

Resource: http://cams-care.com/

Non-demand "Caring Contacts."
After an individual is discharged from an emergency department following a self-harm incident, follow-up procedures can reduce future suicidal behaviors (Luxton, June, & Comtois, 2013). These follow-ups can be considered "non-demand" because they may not be considered official treatment, but they may provide the added assistance an individual may need. Extending contact may keep patients engaged, provide a follow-up with an individual who may be difficult to engage in person, or simply extend the connection between the provider and individual after treatment has concluded. Follow-ups, or "caring contacts," may consist of simply a telephone call, combining telephone calls with in-person meetings, or sending some form of written communication (e.g., postcard, letter, email) to the individual after leaving the emergency department.

Resource:
http://zerosuicide.sprc.org/toolkit/treat/interventions-suicide-risk

Safety Planning Intervention (SPI)
The SPI (Stanley & Brown, 2012) is comprised of a prioritized list of coping skills and resources that clients can use as a way to mitigate feelings during a suicidal crisis. SPI is a collaborative method; both clinician and client are involved in creating the individualized safety plan. Basic components of the SPI include: (a) recognizing warning signs of a future suicidal crisis; (b) using internal coping strategies' (c) reaching out to social contacts/settings as a means of distraction for suicidal ideation; (d) using positive family members or friends to help resolve the crisis; (e) contacting mental health professionals; and (f) restricting access to lethal means.

Resource:
http://www.suicidesafetyplan.com/About_Safety_Planning.html

TRAININGS

Applied Suicide Intervention Skills Training (ASIST)
ASIST is a two-day workshop that provides interactive training for individuals interested in learning about suicide. The main objective of this training is to help professionals and non-professionals, recognize someone who may be thinking about suicide and give them the tools they need to create safety plans or healthy alternatives to their harmful thoughts. Through presentations, learning aids, group discussions, hands-on practice, and many other methods, an individual can learn practical methods for aiding a person who may be suffering from self-harming thoughts or behaviors. Upon completion of the training, an individual can identify attitude patterns that put persons at risk, determine effective aspects of safety plans, individualize treatment, and understand the importance of integrating suicide prevention into all treatment, including the community level.

Resource:
https://www.livingworks.net/programs/asist/

Counseling on Access to Lethal Means (CALM)
CALM is an online interactive training that helps individuals learn how to discuss access to lethal means with an individual who may be having self-harming thoughts or behaviors. Upon completion an individual will have more knowledge in understanding the different aspects of lethal means, fitting lethal means into suicide prevention counseling, discussing lethal means with individuals whom it may apply to, and communicating with individuals who may need to reduce their access to lethal means. CALM is available to anyone who wishes to take the course but is tailored to mental health and medical professionals, specifically those who provide counseling services to people at risk for suicide. The course can be completed in approximately two hours and provides plenty of resources. CALM is free of charge after registration.

Resource:
https://training.sprc.org/enrol/index.php?id=3

HELPFUL ONLINE RESOURCES

The American Foundation for Suicide Prevention: https://afsp.org/
American Association for Suicidology: http://www.suicidology.org/
National Action Alliance for Suicide Prevention: http://actionallianceforsuicideprevention.org/
National Suicide Prevention Lifeline: https://suicidepreventionlifeline.org/
The Suicide Prevention Resource Center: http://www.sprc.org/
Substance Abuse and Mental Health Services Administration (SAMHSA) National Registry of Evidence-based Programs and Practices (NREPP): https://www.samhsa.gov/nrepp

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