

Suicide Risk Assessment

Goal 4: All children and adults within the public mental health system who are identified as potentially at risk during a suicide screening will receive an evidence-informed suicide risk assessment. This suicide risk assessment should include all of the core components of an effective risk assessment.

Rationale

Behavioral health centers play a critical role in recognizing and intervening with individuals at risk of suicide. In a 2008 study of a crisis hotline (Mishara, Chagnon, Daigle, et al., 2007a), callers were not asked about suicide about half of the time (723 out of 1431 calls). Of the 474 who reported suicidal ideation, 46% were not asked about access to lethal means or means availability. Questions about prior attempts were only asked of 104 callers. Similar findings from other settings suggest that provider behavior may not always mirror best practices in suicide risk assessment (Bongar, Maris, Berman, & Litman, 1998; Coombs, et. al, 1992). Agency policies should identify and support a risk assessment based on the most current research evidence.

Determining the level of risk for an individual at risk of suicide can be one of the most challenging and stressful tasks for mental health providers. While individual safety is the primary goal, individuals deserve to receive treatment in the least restrictive environment possible, so a risk assessment must strive to weigh both the benefits and negative consequences of various intervention approaches. Research and expert consensus does lead to the suggestion of some core best practices in suicide risk assessment.

Engagement in the Risk Assessment

There are a variety of factors that can impact the quality of a suicide risk assessment, including stigma, societal or cultural attitudes, and clinical discomfort. Individuals may be unwilling to disclose information on ideation, intent, plans, or behaviors because they do not want an attempt thwarted or are wary of the potential response of the Research on risk assessments conducted over a national crisis hotline have identified some of the core characteristics of helpful interactions as reported by the person at risk (Mishara, Chagnon, Daigle, et al., 2007b). Approaches that were tied to good outcomes included the demonstration of empathy, respect as well as the use of a supportive approach and collaborative problem-solving. The assessor should approach the interaction as a collaboration, focused on working together to determine what to do next. Providers need to be aware of any direct or indirect communication to the individual that they are uncomfortable with a discussion of suicide, prefer negative responses to questions, or are shocked by the information they share.

The CASE Approach, developed by Shawn Shea, provides a strategy for enhancing the quality of the information gathered from an individual during a suicide risk assessment. Dr. Shea posits that:

$$\textit{Real Suicide Intent} = \textit{Stated Intent} + \textit{Reflected Intent} + \textit{Withheld Intent}$$

Dr. Shea points out that the more strongly the individual's actual intent, the more likely he/she is to withhold his/her true intent. The individual's reflected intent may be the most important component for determining real suicide intent. Reflected intent is "the quality and quantity of the patient's suicidal thoughts, desires, plans, and extent of action taken to complete the plans." (Shea, 2009, p. 3). Shea posits that it is the amount of time spent thinking, planning, preparing and practicing for an attempt may be the strongest indicator of imminent risk of a suicide attempt.

The CASE Approach is a best practice interviewing strategy designed to maximize the likelihood that the assessor is gathering valid information about the stated and reflected intent and to minimize withheld intent. The CASE Approach draws on research to identify strategies to raise the issue of suicidality in a way that minimizes shame and stigma, as well as ways of formulating questions to maximize validity. Training on the CASE Approach can be obtained through the [Training Institute for Suicide Assessment and Clinical Interviewing](#). A resource for guidance on training providers in the CASE Approach can be found at Shea and Barney, 2007 and Shea, Green, Barney, et. al., 2007.

Core Components of a Risk Assessment

A comprehensive risk assessment should include the following information gathered from the individual and his/her natural supports (adapted from SAMHSA SAFE-T and JCAHO B-SAFE):

- Suicide Inquiry - Current and previous suicidal thoughts, plans, behavior, and intent
- Warning signs – characteristics that are temporally related to the acute onset of suicidal behaviors (hours to a few days)
- Risk factors – characteristics that statistically put an individual at increased risk
- Protective factors – characteristics that statistically indicate lower risk
- Determine risk level – develop appropriate treatment plan to address risk in least restrictive environment
- Documentation - document risk level, rationale, treatment plan, and follow-up.

Inquiry Around Suicide

The Texas Department of State Health Services is recommending the use of the **Columbia Suicide Severity Rating Scale (C-SSRS)** to insure a comprehensive, evidence-based assessment of current and previous suicidal thoughts, behaviors, intent, and plan. If the C-SSRS is not used to structure the risk assessment, the assessment should include information on the following, both in the present and past:

- Suicidal thoughts, including intensity, duration, controllability, reasons

- Suicidal behaviors, including interrupted attempts, aborted attempts, and preparatory behaviors
- Any thoughts about methods or specific plan(s) and intent to act on thoughts
- Intention to act on thoughts and intention to act on plan (if present)

Warning Signs

Potential warning signs include:

- Talking about or making plans for suicide
- Expressing hopelessness about the future
- Displaying severe/overwhelming emotional pain or distress
- Feeling intolerably alone
- Feelings of helplessness
- Perception of being a burden to others
- Making arrangements to divest responsibility (e.g., for children, pets, elderly parents)
- Showing worrisome behavioral cues or marked change in behavior, particularly in the presence of other warning signs, including significant:
 - Withdrawal from or changing in social connections/situations
 - Recent increased agitation or irritability
 - Anger or hostility that seems out of character or context
 - Changes in sleep (increased or decreased)

Risks Factors

Risk factors alone do not predict suicidal behavior; however they indicate characteristics that have shown a statistical relationship with an increased risk for suicide. They should be used in combination with warning signs and other elements of the risk assessment.

Potential risk factors include:

- Family history of suicide
- History of previous attempts; previous self-harm behavior
- Access to firearms or other lethal means
- History of mental illness (mood disorders, anxiety, schizophrenia) or
- History of trauma (physical or sexual abuse, victimization by peers)
- Alcohol or substance abuse
- Physical illness, especially new or worsening symptoms and/or chronic pain
- Impulsivity or poor self-control
- Recent losses – personal, physical, financial
- History or current bullying (for youth)
- Frequent/persistent family conflict (for youth)
- Recent discharge from psychiatric hospital

In general, there is consensus that it is the combination of warning signs and potentiating risk factors that increases a person's risk of suicide (Jacobs et al., 1999).

- Barriers to help

Some risk factors are immutable, but the assessor should consider these statistics in the overall assessment of risk. Some demographic characteristics that are related to increased risk are being male, elderly, and widowed, divorced or single marital status, particularly for men. Adolescents and young adults are also at increased risk, as are individuals who are lesbian, gay, or bisexual.

Protective Factors

Protective factors are those that reduce the risk of suicide. Recognizing strengths and resiliency during the risk assessment can foster hope and set the stage for interventions to build upon these protective factors and reduce future risk. Protective factors should not supersede the importance of significant warning signs, however, and should only be one component of the comprehensive risk assessment.

Example protective factors:

- Strong connections to family and community; positive social support
- Adept skills in problem solving and coping
- Optimism for the future
- Sense of responsibility to family; children in the home (except when postpartum psychosis or depression); pregnancy
- Spirituality
- Constructive use of leisure time (enjoyable activities)
- Access to effective physical and behavioral health care; positive therapeutic relationship
- Fear of death and dying; ambivalence towards living/dying

Measures for Suicide-Specific Assessment

Various suicide-specific measures have been developed to assess for suicide risk across populations. Some individuals, especially adolescents, have been found to more openly share information related to suicidal thoughts, behaviors, and risks through self-report instruments, so these tools can be helpful components of the risk assessment. The most common evidence-supported measures are described below.

Columbia Suicide Severity Rating Scale (C-SSRS)

The Columbia Suicide Severity Rating Scale ([C-SSRS](#)) is a tool to measure suicidal ideation and behavior, as well as the intensity of ideation and predicts suicide risk across treatment and research settings (Posner, et al, 2011). It has been widely used and is available at no cost. The [Risk Assessment](#) version includes a checklist of protective and risk factors, to be used in conjunction with information about suicidal ideation and behavior. Training is necessary to administer the measure, but not restricted to mental health professionals.

The Collaborative Assessment and Management of Suicidality (CAMS)

The Collaborative Assessment and Management of Suicidality (CAMS) is a therapeutic framework that can be utilized at the stage of assessment and within the course of clinical treatment (for more information, see Workforce Competency). The Suicide Status Form (SSF) is used during the initial session by both the individual and a clinician to understand the details of the person's suicidality, including risk and protective factors and the person's current sense of safety. The SSF is helpful for outlining the course of intervention and is used to track symptoms throughout treatment (Jobes, 2009).

The Beck Scale for Suicide Ideation (SSI)

The Scale for Suicide Ideation (SSI; Beck, et al., 1979) is a brief 21-item scale that assesses the person's current intensity of attitudes, plans, and behaviors to commit suicide. The SSI examines the duration and frequency of ideation, the sense of control over an attempt, the number of deterrents, and the amount of planning involved into a contemplated attempt (Brown, 2002). This scale is appropriate for both inpatient and outpatient settings, can be conducted through interview or self-report, and requires some interviewer training.

Beck Depression Inventory (BDI)

Both the Beck Depression Inventory (BDI; Beck & Steer, 1988) and the Beck Depression Inventory II (BDI-II; Beck, Steer & Brown, 1996) are moderate cost, self-report scales of depression symptoms with a suicide item that outlines ratings one through four, from passive suicidal ideation to strong intent to commit suicide. Individuals who rate at least a two, or report thoughts of suicide but no intent, were 6.9 times more likely to commit suicide. Research also supports that the measure can be useful to tracking suicidal ideation overtime and for assessment purposes (Brown, 2002).

Beck Hopelessness Scale (BHS)

The Beck Hopelessness Scale (BHS; Beck & Steer, 1988) is another brief, self-report measure that has been shown to predict suicide in both inpatient and outpatient psychiatric clients and is one of the most widely used scales for hopelessness (Brown, 2002). The BHS has 20 true-false questions assessing positive and negative thoughts about the future over the course of the past week. This tool is of medium cost and is available in Spanish.

Documentation

Determining Risk Level

Determining and documenting risk level is a critical component of the risk assessment. No study has identified one specific risk factor or set of risk factors that specifically predicts suicide or suicide behavior; therefore, the determination of risk level will depend on careful consideration of the information gathered in the assessment and the clinical judgment of the assessor. The determination of the best setting of care and course of treatment should

consider not only the level of risk, but also the benefits and potential risks to the individual. While a more restrictive care setting may be necessary to safeguard against potential self-harm, there may also be negative effects from this course of treatment that must be weighed in the decision, such as disruption of employment, disruption of therapeutic alliance, and increased family conflict. When possible, the provider should collaborate with the individual in understanding and weighing different treatment options.

Considerations for Each Risk Level:

Risk Level	Suicidality	Risk/Protective Factors
Urgent/ High	<ul style="list-style-type: none"> • Suicidal thoughts with intent to act in past 30 days (C-SSRS Item 4) • Ideation with plan and intent in past 30 days (C-SSRS Item 5) • Any suicide behavior in past 90 days (C-SSRS Item 6) 	One or more risk factors likely to be present; extra concern for psychiatric diagnoses with severe symptoms, including psychosis; recent discharge from psychiatric inpatient unit; lack of family and/or social support; lack of engagement in care; intent with lethal means
Emergent/ Moderate	<ul style="list-style-type: none"> • Suicidal thoughts with method in past 30 days (but no plan or intent; C-SSRS Item 3) • Suicidal thoughts with intent to act (but no plan) at worst ever (C-SSRS Item 4) • Suicidal thoughts with specific plan and intent at worst ever (C-SSRS Item 5) • Any suicide behavior at worst ever (C-SSRS Item 6) 	Absence or presence of risk and protective factors may play stronger role in overall risk
Low	<ul style="list-style-type: none"> • Wish to be dead in past 30 days (C-SSRS Item 1) • General thoughts of killing self without thoughts of methods (C-SSRS Item 2) 	Modifiable risk factors, strong protective factors; available social support

Information on the potential interventions and monitoring to be considered at each level of risk can be found in the *Pathways to Care* and *Safety Planning* chapters.

Key Resources and References

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Substance Abuse and Mental Health Services Administration (2009). Suicide Assessment Five-Stage Evaluation and Triage (SAFE-T): Pocket Card for Clinicians. Available at <http://store.samhsa.gov/product/Suicide-Assessment-Five-Step-Evaluation-and-Triage-SAFE-T-/SMA09-4432>