

Beyond Screening: Suicide Risk Assessment Across Settings

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Objectives

- Review the components of suicide risk assessment including standardized tools and narrative approaches
- Discuss adaptations of risk assessments across various settings

Suicide Screening



Suicide Risk Screening Tool

NIMH TOOLKIT

Ask Suicide-Screening Questions

Ask the patient:

- In the past few weeks, have you wished you were dead?
- In the past few weeks, have you felt that you or your family would be better off if you were dead?
- In the past week, have you been having thoughts about killing yourself?
- Have you ever tried to kill yourself?

If yes, how? _____

When? _____

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

- Are you having thoughts of killing yourself right now?
If yes, please describe: _____

Columbia Suicide Severity Rating Scale (C-SSRS) — Adult/Adolescent (≥12 years) Quick Screen

Ask each question, then ask whether the patient has had these thoughts or behaviors in the past month if he or she doesn't provide that information.

Questions	Past month	What a positive response indicates
Suicidal Ideation		
Ask questions 1 and 2.		
1. Have you wished you were dead or wished you could go to sleep and not wake up?	Yes No <input type="checkbox"/> <input type="checkbox"/>	Wish to be dead. Subject endorses thoughts about a wish to be dead or not alive anymore, or a wish to fall asleep and not wake up. Example: "I've wished I wasn't alive anymore."
2. Have you actually had any thoughts of killing yourself?	Yes No <input type="checkbox"/> <input type="checkbox"/>	Non-specific active suicidal thoughts. General non-specific thoughts of wanting to end one's life/commit suicide. Example: "I've thought about killing myself."
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3. Have you been thinking about how you might kill yourself?	Yes No <input type="checkbox"/> <input type="checkbox"/>	Active suicidal ideation with any methods (not plan) without intent to act. Person endorses thoughts of suicide and has thought of at least one method. Example: "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."
4. Have you had these thoughts and had some intention of acting on them?	Yes No <input type="checkbox"/> <input type="checkbox"/>	Active suicidal ideation with some intent to act. Active suicidal thoughts of killing oneself, and patient reports having some intent to act on such thoughts. Example: "I have had the thoughts, and I have considered acting on them." Not: "I have the thoughts but I definitely will not do anything about them."
5. Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?	Yes No <input type="checkbox"/> <input type="checkbox"/>	Active suicidal ideation 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. Example: "Next Thursday when I know my husband will be at the office late, I am going to take the sleeping pills I keep in the upstairs medicine cabinet."
Suicidal Behavior		
6. Have you ever done anything, started to do anything, or prepared to do anything to end your life?	Yes No <input type="checkbox"/> <input type="checkbox"/>	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 injury or harm, just the potential for injury or harm. For example, if a person pulls the trigger with gun in mouth but gun is broken so no injury results, this is considered an attempt.
In the past 3 months?	Yes No <input type="checkbox"/> <input type="checkbox"/>	Aborted or self-interrupted attempt. When person takes steps toward making a suicide attempt, but stops him/herself before he/she actually has engaged in any self-destructive behavior.
In the past 4 weeks?	Yes No <input type="checkbox"/> <input type="checkbox"/>	Interrupted attempt. When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act. (If not for that, an actual attempt would have occurred.) Preparatory acts or behavior. Acts or preparation toward imminently making a suicide attempt.
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.		

Patient Health Questionnaire (PHQ-9) (page 1 of 1)

Today's Date: _____ Patient's Name: _____ Date of Birth: _____

Are you currently: on medication for depression? not on medication for depression? not sure? in counseling?

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling/staying asleep, sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed, or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
Total each column				

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?

A. Not difficult at all Somewhat difficult Very difficult Extremely difficult

B. In the past 2 years, have you felt depressed or sad most days, even if you felt okay sometimes?

YES NO

Suicide Screening vs. Suicide Assessment

Screening:

- Procedure used to quickly identify individuals who may be at risk for suicide
- Ideally highly sensitive

Assessment:

- More comprehensive evaluation to evaluate level of risk and decide on treatment course
- Includes standardized tools and a narrative component
- Ideally more specific

The purpose of the assessment is not to *predict* suicide but rather to *plan* effective suicide care.



Suicide Assessment

Goal:

- Understand level of risk leading to specific interventions

Components:

- Assessing suicidal ideation and behaviors
- Understanding risk and protective factors
- Eliciting attitudes about risk, suicide, desire and ability to safety plan

Methods:

- Utilizing both standardized tools and narrative/behavioral approach
- Adapt to current setting

Standardized Tools

- More likely to elicit relevant and consistent information
- Provide consistent documentation / vocabulary
- Extremely valuable for intermittent and early users



Standardized Risk Assessment Tools

- Beck Suicidal Intent, Hopelessness, and Behavior Scales
- Cultural Assessment for Risk of Suicide
- Modular Assessment of Risk for Imminent Suicide (MARIS)
- Suicide Assessment Five-Step Evaluation and Triage (SAFE-T) guide
- Chronological Assessment of Suicide Events (CASE) approach
- Computerized Adaptive Test Suicide Scale
- Columbia Suicide Severity Rating Scale (CSSRS)

Narrative / Behavioral Assessment

- Ability to elicit conversation and context
- Explore level of suicidality and understand attitudes about risk, etc.
- Observe and elicit problem solving, coping skills, and other strengths
- Can be beneficial to use standardized approach



Components to Assessment

- **Assessing suicidal ideation and behaviors**
- Understanding risk and protective factors
- Eliciting attitudes about risk, suicide, desire and ability to safety plan

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.

Questions	What a positive response indicates	Lifetime: time he/she felt most suicidal		Past 1 month	
		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<p>1. <i>Have you thought about being dead or what it would be like to be dead?</i> <i>Have you wished you were dead or wished you could go to sleep and never wake up?</i> <i>Do you ever wish you weren't alive anymore?</i> If yes, describe:</p>	<p>Wish to be dead. Subject endorses thoughts about a wish to be dead or not alive anymore, or a wish to fall asleep and not wake up. Example: "I've wished I wasn't alive anymore."</p>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<p>2. <i>Have you thought about doing something to make yourself not alive anymore?</i> <i>Have you had any thoughts about killing yourself?</i> If yes, describe:</p>	<p>Non-specific active suicidal thoughts. General non-specific thoughts of wanting to end one's life/commit suicide. Example: "I've thought about killing myself."</p>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<p>3. <i>Have you thought about how you would do that or how you would make yourself not alive anymore (kill yourself)? What did you think about?</i> If yes, describe:</p>	<p>Active suicidal ideation with any methods (not plan) without intent to act. Person endorses thoughts of suicide and has thought of a least one method. Example: "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."</p>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<p>4. <i>When you thought about making yourself not alive anymore (or killing yourself), did you think that this was something you might actually do?</i> <i>This is different from (as opposed to) having the thoughts but knowing you wouldn't do anything about it.</i> If yes, describe:</p>	<p>Active suicidal ideation with some intent to act. Active suicidal thoughts of killing oneself, and patient reports having some intent to act on such thoughts. Example: "I have had the thoughts, and I have considered acting on them." Not: "I have the thoughts but I definitely will not do anything about them."</p>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<p>5. <i>Have you ever decided how or when you would make yourself not alive anymore/kill yourself? Have you ever planned out (worked out the details of) how you would do it?</i> <i>What was your plan?</i> <i>When you made this plan (or worked out these details), was any part of you thinking about actually doing it?</i> If yes, describe:</p>	<p>Active suicidal ideation 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. "Next Thursday when my parents are sleeping, I am going to take the sleeping pills in the upstairs medicine cabinet."</p>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Intensity of Ideation

Clinician assessment: Ask about time the patient was feeling the most suicidal. Rate the following features with respect to the most severe type of ideation (i.e., from questions 1–5 above, with a positive response to question 1 being the least severe and 5 being the most severe).

Lifetime—most severe ideation: _____ Description of ideation: _____

Recent—most severe ideation: _____ Description of ideation: _____

Enter # (1–5)

Frequency: How many times have you had these thoughts?

(1) Less than once a week (2) Once a week (3) 2–5 times per week (4) Daily or almost daily (5) Many times each day

Duration: When you have the thoughts, how long do/did they last?

(1) Fleeting — a few seconds or minutes (3) 1–4 hours/a lot of the time (5) More than 8 hours/persistent or continuous
(2) Less than 1 hour/some of the time (4) 4–8 hours/most of the day

Controllability: Could/can you stop thinking about killing yourself or wanting to die if you want to?

(1) Easily able to control thoughts (3) Can control thoughts with some difficulty (5) Unable to control thoughts
(2) Can control thoughts with little difficulty (4) Can control thoughts with a lot of difficulty (0) Does not attempt to control thoughts

Deterrents: Are there things that stopped you from wanting to die or acting on thoughts of killing yourself? (Anyone or anything, such as family, religion, pain of death.)

(1) Deterrents definitely stopped you from attempting suicide (3) Uncertain that deterrents stopped you (5) Deterrents definitely did not stop you
(2) Deterrents probably stopped you (4) Deterrents most likely did not stop you (0) Does not apply

Reasons for Ideation: What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words, you couldn't go on living with this pain or how you were feeling), or was it to get attention, revenge, or a reaction from others? Or both?

(1) Completely to get attention, revenge, or reaction from others (4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling)
(2) Mostly to get attention, revenge, or reaction from others
(3) Equally to get attention, revenge, or reaction from others and to stop/end the pain (0) Does not apply

Lifetime

Past 1 month

Most severe

Most severe

Suicidal Behavior					
Check all that apply, so long as they are separate events; must ask all questions.					
Questions	What a positive response indicates	Lifetime: time he/she felt most suicidal		Past 3 months	
<p><i>Did you ever do anything to try to kill yourself or make yourself not alive anymore? What did you do?</i></p> <p><i>Did you ever hurt yourself on purpose? Why did you do that?</i></p> <p><i>Did you _____ as a way to end your life?</i></p> <p><i>Did you want to die (even a little) when you _____?</i></p> <p><i>Were you trying to make yourself not alive anymore when you _____?</i></p> <p><i>Or did you think it was possible you could die from _____?</i></p> <p><i>Or did you do it purely for other reasons, not at all to end your life or kill yourself (like to make yourself feel better, or get something else to happen)?</i> (Note: This indicates self-injurious behavior without suicidal intent.)</p> <p>If yes, describe:</p>	<p>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 injury or harm, just the potential for injury or harm. For example, if the person the pulls trigger with gun in mouth but gun is broken so no injury results, this is considered an attempt.</p> <p>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.</p>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Clinician assessment: Has the patient engaged in non-suicidal self-injurious behavior?		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Clinician assessment: Has the patient engaged in self-injurious behavior, intent unknown?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p><i>Has there been a time when you started to do something to make yourself not alive anymore (end your life or kill yourself) but someone or something stopped you before you actually did anything? What did you do?</i></p> <p>If yes, describe:</p>	<p>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.)</p> <p>Examples: 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 person is somehow prevented from pulling trigger. (Once the person pulls 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.</p>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
		Total # of interrupted		Total # of interrupted	
<p><i>Has there been a time when you started to do something to make yourself not alive anymore (end your life or kill yourself) but you changed your mind (stopped yourself) before you actually did anything? What did you do?</i></p> <p>If yes, describe:</p>	<p>Aborted or self-interrupted attempt. When person begins to take steps toward making a suicide attempt, but stops him/herself before he/she actually has 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.</p>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
		Total # of aborted or self-interrupted		Total # of aborted or self-interrupted	
<p><i>Have you done anything to get ready to make yourself not alive anymore (to end your life or kill yourself), like giving things away, writing a goodbye note, getting things you need to kill yourself?</i></p> <p>If yes, describe:</p>	<p>Preparatory acts or behavior. Acts or preparation toward imminently making a suicide attempt.</p> <p>Examples: Anything beyond a verbalization or thought, such as assembling a specific method for one's death by suicide (e.g., giving things away, writing a suicide note).</p>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Components to Assessment

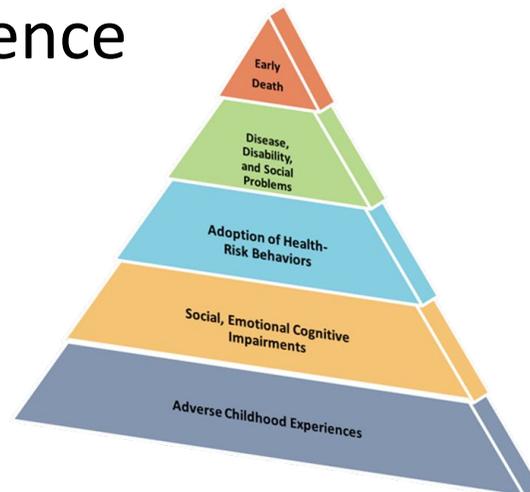
- Assessing suicidal ideation and behaviors
- **Understanding risk and protective factors**
- Eliciting attitudes about risk, suicide, desire and ability to safety plan

Risk Factors

Family history of suicide
Undignosed Mental health
Elderly adults
Substance use
Major physical illnesses
Past suicide attempt
LGBTQ
Local clusters
Hopelessness
Veterans
DCFS
Midlife Men
Relationship Loss
Family Conflict
Court Involvement
Sleep Disturbances
Isolation
Cultural Beliefs
Social Stress
Somatic Complaints
Trauma
Military Bereaved
Parental Mental Health
Financial Loss
Impulsivity/ADHD
Barriers to accessing care
Access to Lethal Means
Aggressive/Disruptive Behaviors

Predisposing Risk Factors

- Psychiatry disorders
- Previous suicide attempt
- Family history of mood disorder and/or suicide
- History of abuse
- Exposure to violence



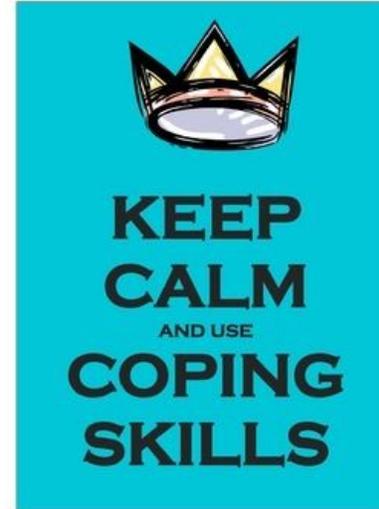
Precipitating Risk Factors

- Access to means
- Alcohol and drug use
- Exposure to suicide
- Social stress and isolation
- Hopelessness



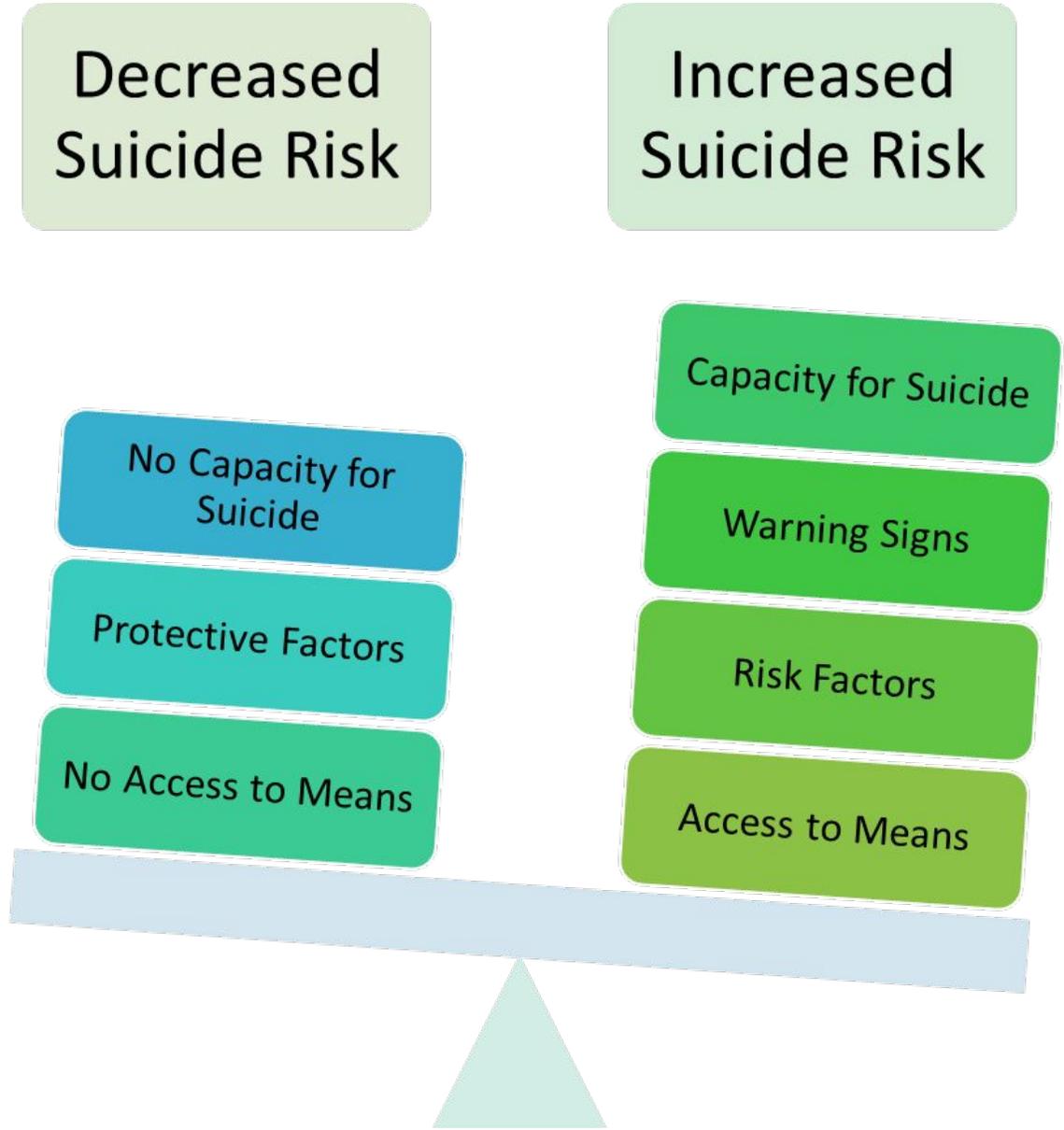
Protective Factors

- Ability to cope
- Coping skills
- Beliefs against suicide
- Sense of responsibility to something else (eg family, pets, etc...)
- Positive therapeutic relationships
- Social supports



Components to Assessment

- Assessing suicidal ideation and behaviors
- Understanding risk and protective factors
- **Eliciting attitudes about risk, suicide, desire and ability to safety plan**



Risk Formulation

- Formulation should be:
 - Anchored in clinical context and client population
 - Fluid in nature
 - Directly lead to intervention strategies
- Formulation does not predict behaviors instead promote communication and collaboration.
- Formulation often gets “stuck” on “do they the meet criteria”?

Risk Assessment Leads to Safety Planning

From:

Categorical Predictions of

1. Low
2. Medium
3. High

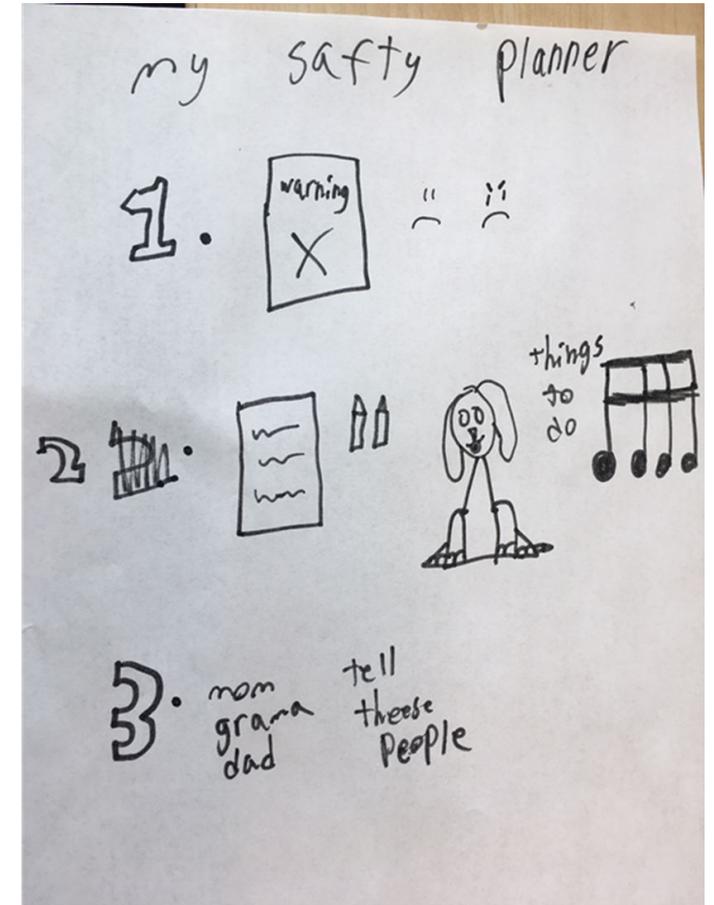
To:

Judgments to directly inform intervention plans

1. risk status (the patient's risk relative to a specified subpopulation)
2. risk state (the patient's risk compared to baseline or other specified time points)
3. available resources from which the patient can draw in crisis, and
4. foreseeable changes that may exacerbate risk

Assessment Leading to Interventions

- Brief CBT strategies
- Safety planning
- Lethal means counseling
- Provide appropriate referral, follow-up, next steps



Adapting to Various Settings

- Goal: to plan effective care (what are next steps?)
- Core components of assessment remain the same
 - Utilizing standardized tools and narrative approach
 - Assessing suicidal ideation and behaviors
 - Understanding risk and protective factors
 - Eliciting ability to safety plan
- Variations based on time, expertise, ability to implement treatment plan

Emergency Room Crisis Evaluation

Mary is a 45 year-old female who arrives in the emergency room after having ingested a handful of pills in an attempt to end her life.



Primary Care Office

John is a 16 year-old male coming to see his pediatrician for a sports physical. He marked a “2” (more than half the days) to question 9 on the PHQ-A.



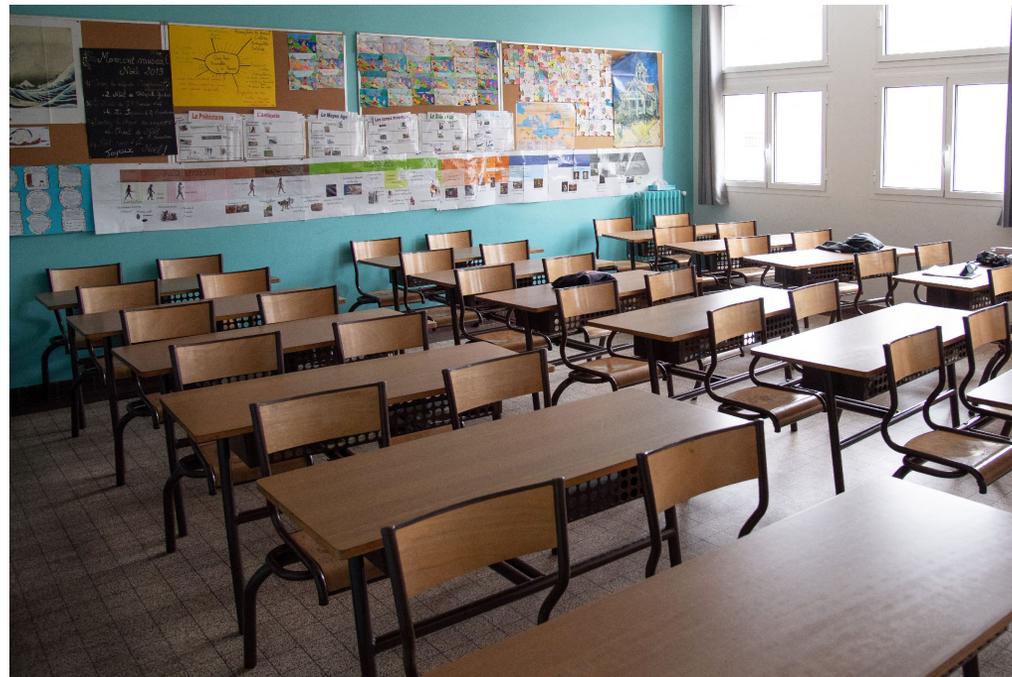
Outpatient Mental Health Clinic

Susan is a 68 year-old female with PTSD presenting for weekly therapy, who reports that she is having increased thoughts of wanting to die on her outcomes questionnaire.



School

Matt is a 13 year-old eighth grader. His friends texted a “tip” on the SAFE UT app that he was talking about killing himself.



TeleVisit

Anne is a 22 year-old college student seeking services due to extreme anxiety. During initial virtual evaluation, she discloses frequent thoughts that she would rather be dead



Questions / Discussion