



# *Recognizing and Addressing Suicidal Ideation & Behavior in Individuals with a First Episode of Psychosis (FEP)*

Part 1: June 28, 2016





# **Suicide risk among people with psychosis: Focus on first episode**

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**American Foundation for Suicide Prevention**

# What is suicidal behavior?

- **Thoughts about death and dying**
- **Wish to die**
- **Wanting to kill yourself**
- **Thoughts about ways to kill yourself**
- **Making preparations to kill yourself**
- **Starting to kill yourself and stopping or being interrupted at the last minute**
- **Making an attempt to kill yourself**
- **Dying by suicide**

# People say: Is it really a problem for people with psychosis?

- **“Not that many people die”**
  - *Of 42,773 suicides per year approximately 15% have psychosis*
- **“Of course they want to die”**
  - *If I were psychotic I would want to kill myself*
- **“There’s nothing we can do anyway”**

# Individuals with psychosis are at risk for suicidal behavior

- **15% of people who die by suicide are psychotic at the time of death**
- **4-10% of people with schizophrenia die by suicide.**
- **20-40% attempt suicide.**  
*50+% of attempters make repeat attempts.*  
*Suicide attempts are serious in their own right*

*They can result in permanent damage and/or disability*

# Suicide does not come out of the blue

- **Risk Factors**
- **Warning Signs**

**Prevention is more than possible**

# Suicidal behavior is preventable

- **Access to care**
- **Identification of individuals at risk**
- **Use of targeted interventions**
- **Continuity of care**

# Understanding suicide and psychosis

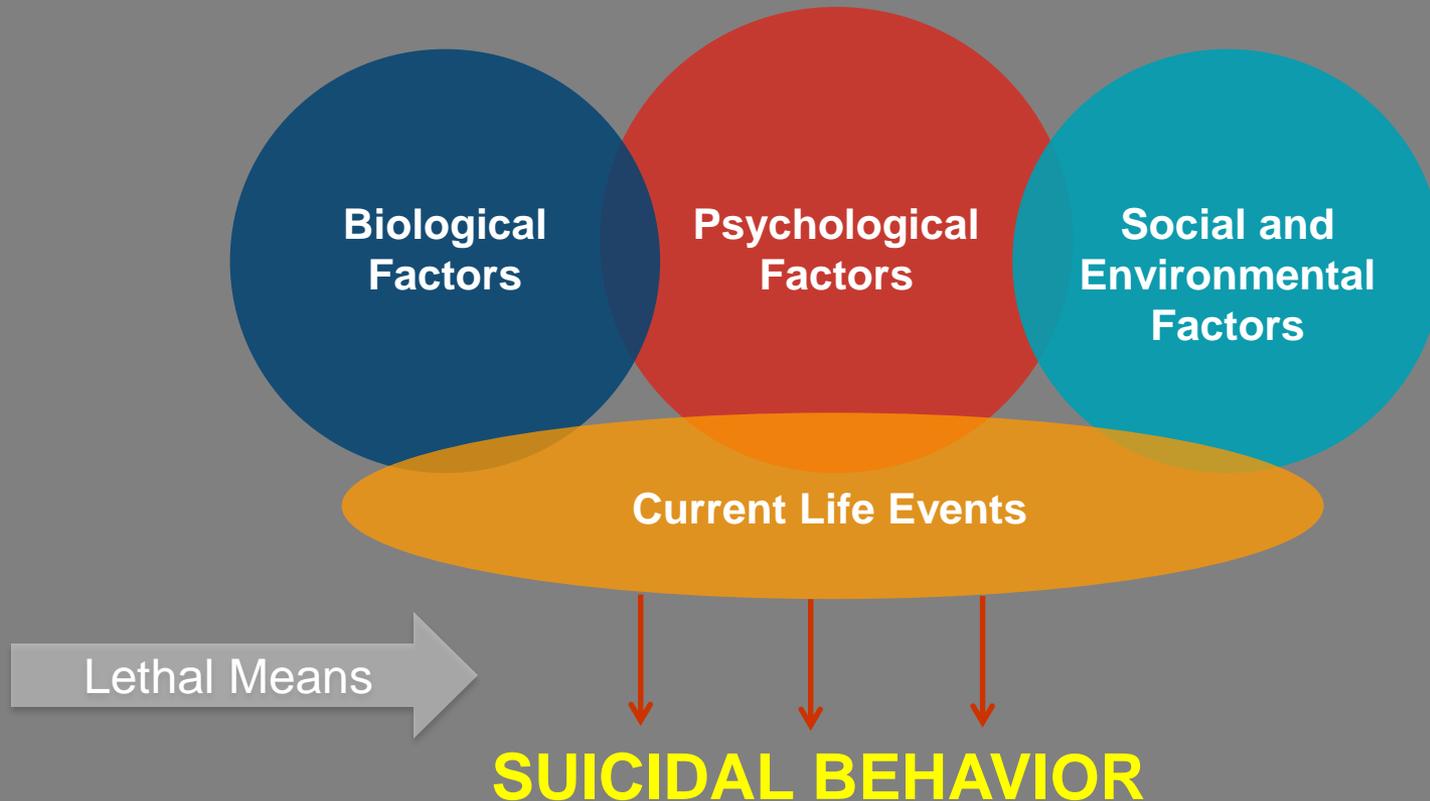
- **Lack of research on prodromal, first-episode or longer-term psychosis and suicide**
- **Looks like risk factors and warning signs are similar for prodromal, first-episode and longer-term psychotic disorders**

# What happens right before suicidal behavior?

- **While most people who make attempts or complete suicide have discussed their suicidal thoughts, most do not tell anyone right before they act.**

**So how do we know when someone is at short-term risk?**

# Interacting Risk and Protective Factors



# Contributors to suicidal ideation and behavior

## Diathesis/Threshold Variables

- Aggression/ Impulsivity
- Hopelessness
- Premorbid Social Adjustment
- Family History
- Childhood Abuse/Trauma
- Head Injury
- Genetics
- Low Serotonergic Fx
- Chronic Illness
- Chronic Substance Abuse
- Early Loss

## Stress/ Trigger Variables

- Acute Psychiatric Episode (e.g., MDE, Psychosis)
- Acute Medical Illness
- Stressful Life Event
- Acute Substance Use

## Protective Factors

- Social connection with others
- Problem solving skills
- Reason for living
- Positive attitude toward mental health care
- Family support and acceptance

# Demographic characteristics: Age

- **Suicidal behavior persists throughout the lifespan**
  - *Population high risk period is 45-59 yrs*
- **The period of greatest risk is during the first 1 year after onset of psychosis**
  - *Rate of suicide in first year has dropped recently in several countries*

# Gender and suicidal behavior

- **More males than females complete suicide**
  - *Females with psychosis are at higher risk for suicide than females in the general population or other high risk groups*
  - *Males and females with make attempts at the same rate*

# Marital Status

**Single individuals with psychosis die by suicide more than those in relationships**

*Many individuals with psychosis are single  
(70+%)*

# Employment

**The risk is greater when the individual is unemployed or not engaged with a regular activity**

*Most individuals with psychosis are unemployed*

# Risk Factors

- **Previous suicidal behavior**

*The best predictor of behavior is past behavior.*

- **Over 50% of individuals with schizophrenia who die by suicide have made a previous attempt**

# Suicide Attempt Behavior

- *50+% make more than one attempt*
- *Most attempts of moderate to extreme lethality*
- *Methods included overdose, stabbing, running into traffic, jumping, hanging*

# Psychotic Symptoms are a risk factor

- **No evidence that suicidal behavior occurs frequently in response to psychotic behavior**
  - *But: Suicidal behavior frequently occurs because people are bothered by psychotic behavior.*
- **About 20% with command hallucinations will act on them**
  - *Behavioral interventions have been effective*
- **Greatest risk is after the “post-psychotic” period or hospitalization**
- **Many have made suicide attempts before onset of psychosis**

# Depression is a risk factor

- ✓ Depressed mood
  - ✓ Depressive episode
  - ✓ Hopelessness
- 
- The rate of Major Depression the same for attempters and nonattempters (~55%)
  - Risk for suicidal behavior is increased during a depressive episode
  - Hopelessness is key in first-episode

# Social functioning is important

## Social functioning before illness

- Individuals with poor social functioning may be at greater risk due to lack of problem solving skills, impulsiveness and aggression, poor social skills, social isolation.
- Individuals with better social functioning may be at greater risk because of feelings of demoralization & hopelessness

## Loss of social support is a risk factor

- Especially family, therapist
- Not being able to return home after hospitalization

# Demoralization Syndrome

- **Presupposes**
  - *Good premorbid functioning*
  - *Insight*
  - *Hopelessness*
- **Problems**
  - *Many with good premorbid functioning do better*
  - *Many with poor premorbid functioning die by suicide*
  - *Insight is not a stable characteristic*
  - *Type of insight/awareness is important*

# Other factors related to suicidal behavior

- **Substance use and abuse**
  - *Especially when comorbid*
- **Neurotransmitters**
  - *Serotonin, dopamine, glutamate...*
- **Genetics**
  - *Stress sensitivity and resilience*
- **Family history of mental illness or suicide**
- **Cognitive inflexibility & ineffective decision making**

# Experience

**In a suicidal moment people with  
psychotic disorders are likely to be  
experiencing**

*active psychotic symptoms*

**&**

*feelings of depression & stress*

**&**

**Can talk about it**

# Potential Protective Factors

- Positive attitude towards mental health treatment
- Feeling connected with others
- Effective problem solving skills
- Accepting and supportive social environment
- Reasons for living
- Limited access to lethal means

# Warning Signs: Talk

- *Killing themselves*
- *Having no reason to live*
- *Being a burden to others*
- *Feeling trapped*
- *Unbearable pain*
- ***Hopelessness***



# Warning Signs: Behavior

- *Increased use of alcohol or drugs.*
- *Acting recklessly.*
- *Isolating and withdrawing from activities*
- *Change in sleep, appetite, energy level*
- *Visiting or calling people to say goodbye.*
- *Giving away prized possessions.*
- *Aggression or agitation*
- *Discomfort due to psychosis*

# Mood

- *Depression, despair*
- *Loss of interest*
- *Rage*
- *Irritability*
- *Humiliation*
- *Anxiety*

- Early identification of psychosis reduces suicidal behavior and/or interferes with its development
- Suicidal behavior is intermittent and getting through high risk periods will help to prevent suicidal behavior.
- Suicide risk for people with psychosis tends to be longer-term and needs to be monitored regularly.
- Pharmacological and social treatments for psychosis and depressed mood in are likely to reduce suicidal behavior.

# Preventing Suicidal Behavior

- **Antipsychotic medications and lithium can reduce suicidal behavior**
  - *Effectiveness depends on:*
    - **DUP: Duration of untreated psychosis**
    - **Non-adherence**
    - **Management of side-effects**

# Preventing Suicidal Behavior

- **Interventions to enhance treatment engagement**
- **Development of alternative behaviors**
- **Close monitoring**
- **Reduce alienation and increase connectedness**
- **Community education about symptoms of psychosis increases identification and referral of individuals at risk for suicidal behavior**

# The Joint Commission Sentinel Event Alert

## 56 February 24, 2016

“Many communities and health care organizations presently do not have adequate suicide prevention resources, leading to the low detection and treatment rate of those at risk. As a result, providers who do identify patients at risk for suicide often must interrupt their workflow and disrupt their schedule for the day to find treatment and assure safety for these patients.”

# The Joint Commission suggestions

- Review personal & family medical history for suicide risk factors
- Screen all patients for suicidal ideation
- Review screening questionnaires before the patient leaves the appointment or is discharged.
- Take action, using assessment results to inform the level of safety measures needed.

# Assessment

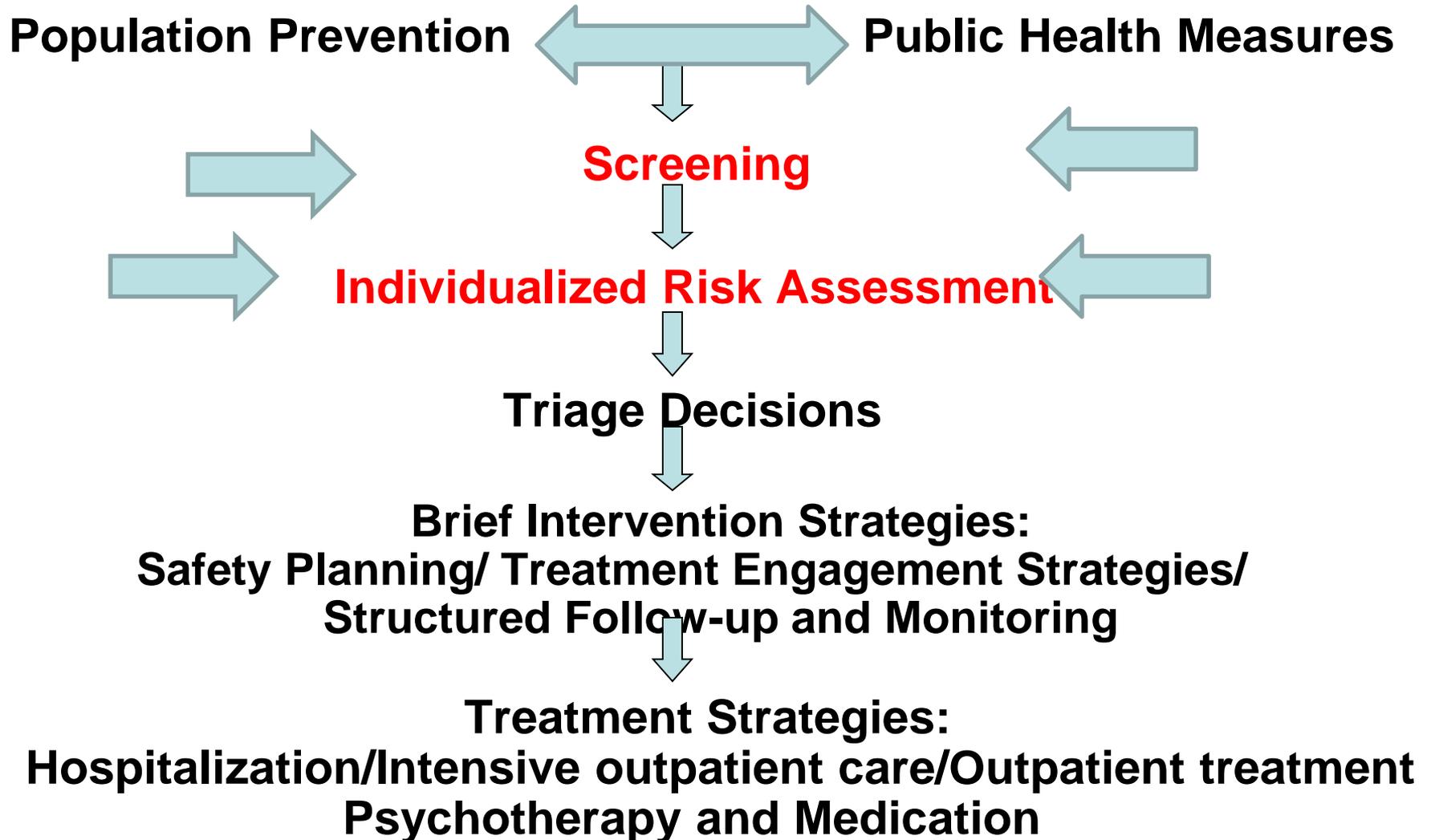
- **There are many measures of risk**
- **Many measures to ask about past and current suicidal ideation and behavior**
  - *Choice of measure depends on population of interest, setting, staffing, timing, goals ...*



# **Suicide Screening & Risk Assessment in Context**

**Barbara Stanley, Ph.D.**  
**Columbia University Medical Center**

# Points of Intervention to Prevent Suicide



# Screening for Suicide Risk: Who, What, When?

- **Who---Everyone**
- **What---Consists of inquiring about:**
  - *Suicidal ideation*
  - *Suicidal behavior*
  - *Other factors that raise concern---e.g. dramatic change in clinical condition or life circumstances; persistent, unrelenting hopelessness; comments or behaviors that indicate suicide risk despite denial of suicidal ideation*
- **When---At a minimum---on admission; change in clinical condition or life circumstances; following a change in level of care, e.g. hospitalization, ED visit; routinely at predetermined times**
  - *During periods of elevated risk, frequency should be increased*

# What happens with a positive screen?

- *Conduct a risk assessment*
- *Identify those at risk-----Necessary but insufficient to prevent suicide*
- *Inform a triage decision and appropriate level of care or follow-up action to be taken*

# Categories of Risk Factors

- 1. Suicide-specific characteristics**
- 2. Demographic risk factors**
- 3. Psychiatric diagnosis and symptoms**
- 4. Family and social factors**
- 5. Precipitants**
- 6. Treatment history difficulties**
- 7. Access to means**

*Source: American Foundation for Suicide Prevention*

# SAFE-T

## Suicide Assessment Five-step Evaluation and Triage

**1**

### IDENTIFY RISK FACTORS

Note those that can be modified to reduce risk

**2**

### IDENTIFY PROTECTIVE FACTORS

Note those that can be enhanced

**3**

### CONDUCT SUICIDE INQUIRY

Suicidal thoughts, plans, behavior, and intent

**4**

### DETERMINE RISK LEVEL/INTERVENTION

Determine risk. Choose appropriate intervention to address and reduce risk

**5**

### DOCUMENT

Assessment of risk, rationale, intervention, and follow-up



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Substance Abuse and Mental Health Services Administration  
[www.samhsa.gov](http://www.samhsa.gov)

*Suicide assessments should be conducted at first contact, with any subsequent suicidal behavior, increased ideation, or pertinent clinical change; for inpatients, prior to increasing privileges and at discharge.*

## 1. RISK FACTORS

- ✓ Suicidal behavior: history of prior suicide attempts, aborted suicide attempts or self-injurious behavior
- ✓ Current/past psychiatric disorders: especially mood disorders, psychotic disorders, alcohol/substance abuse, ADHD, TBI, PTSD, Cluster B personality disorders, conduct disorders (antisocial behavior, aggression, impulsivity).  
*Co-morbidity and recent onset of illness increase risk*
- ✓ Key symptoms: anhedonia, impulsivity, hopelessness, anxiety/panic, insomnia, command hallucinations
- ✓ Family history: of suicide, attempts or Axis 1 psychiatric disorders requiring hospitalization
- ✓ Precipitants/Stressors/Interpersonal: triggering events leading to humiliation, shame or despair (e.g., loss of relationship, financial or health status—real or anticipated). Ongoing medical illness (esp. CNS disorders, pain). Intoxication. Family turmoil/chaos. History of physical or sexual abuse. Social isolation.
- ✓ Change in treatment: discharge from psychiatric hospital, provider or treatment change
- ✓ Access to firearms

## 2. PROTECTIVE FACTORS *Protective factors, even if present, may not counteract significant acute risk*

- ✓ Internal: ability to cope with stress, religious beliefs, frustration tolerance
- ✓ External: responsibility to children or beloved pets, positive therapeutic relationships, social supports

## 3. SUICIDE INQUIRY *Specific questioning about thoughts, plans, behaviors, intent*

- ✓ Ideation: frequency, intensity, duration--in last 48 hours, past month and worst ever
- ✓ Plan: timing, location, lethality, availability, preparatory acts
- ✓ Behaviors: past attempts, aborted attempts, rehearsals (tying noose, loading gun), vs. non-suicidal self injurious actions
- ✓ Intent: extent to which the patient (1) expects to carry out the plan and (2) believes the plan/act to be lethal vs. self-injurious; Explore ambivalence: reasons to die vs. reasons to live

*\* For Youths: ask parent/guardian about evidence of suicidal thoughts, plans, or behaviors, and changes in mood, behaviors or disposition*

*\* Homicide Inquiry: when indicated, esp. in character disordered or paranoid males dealing with loss or humiliation. Inquire in four areas listed above.*

## 4. RISK LEVEL/INTERVENTION

- ✓ Assessment of risk level is based on clinical judgment, after completing steps 1-3
- ✓ Reassess as patient or environmental circumstances change

RISK LEVEL	RISK / PROTECTIVE FACTOR	SUICIDALITY	POSSIBLE INTERVENTIONS
<b>High</b>	Psychiatric disorders with severe symptoms, or acute precipitating event; protective factors not relevant	Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal	Admission generally indicated unless a significant change reduces risk. Suicide precautions
<b>Moderate</b>	Multiple risk factors, few protective factors	Suicidal ideation with plan, but no intent or behavior	Admission may be necessary depending on risk factors. Develop crisis plan. Give emergency/crisis numbers
<b>Low</b>	Modifiable risk factors, strong protective factors	Thoughts of death, no plan, intent or behavior	Outpatient referral, symptom reduction. Give emergency/crisis numbers

(This chart is intended to represent a range of risk levels and interventions, not actual determinations.)

## 5. DOCUMENT Risk level and rationale; treatment plan to address/reduce current risk (e.g., setting, medication, psychotherapy, E.C.T., contact with significant others, consultation); firearm instructions, if relevant; follow up plan. For youths, treatment plan should include roles for parent/guardian.

# Key Points in Conducting a Risk Assessment

- **Not based on any one risk factor (or set of risk factors)**
- **Risk and protective factors are assessed together to provide an overall picture**
- **Identifies factors that are modifiable with intervention**
- **Identifies and distinguishes between Acute/Proximal risk factors and warning signs from the ongoing, Chronic/Distal risk factors**
- **Guides treatment decisions**
- **In an ongoing care situation, risk assessment is not a single event; it must be evaluated over time; risk fluctuates**
- **Risk assessment supports, does not replace, clinician decision-making**

# Types of Risk Factors

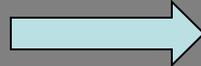
## Proximal vs. Distal vs. Warning Signs

- **Distal (chronic, background) risk factors**
  - *Ongoing general characteristics or factors that are known to be associated with an elevated longer term risk for suicide; they exist in the individual's background*
  - *Example: Suicide attempt 10 years ago*
- **Proximal (acute) risk factors**
  - *Recent events or exacerbations of ongoing characteristics that can indicate imminent risk*
  - *Example: Suicide attempt within the last 3 months*
- **Warning Signs (most acute risk factors)**
  - *Individualized behaviors that are directly related to those that precede a spike in suicide risk in a particular individual, according to individual's history; time frames varies from individual to individual from minutes to days*
  - *Example: Active, escalating suicidal ideation that is similar to the type of ideation present directly preceding a previous suicide attempt*

# Suicide Screening Scales Listed on SAMHSA Website

- The [Columbia-Suicide Severity Rating Scale \(C-SSRS\)](#)
- [Suicide Behaviors Questionnaire \(SBQ-R\)](#) assesses suicide-related thoughts and behavior. The SBQ-R has 4 items, each tapping a different dimension of suicidality:
  - *Item 1 taps into lifetime suicide ideation and/or suicide attempt.*
  - *Item 2 assesses the frequency of suicidal ideation over the past twelve months.*
  - *Item 3 assesses the threat of suicide attempt.*
  - *Item 4 evaluates self-reported likelihood of suicidal behavior in the future.*

	Past Month	
	YES	NO
<b>Ask questions that are bold and underlined</b>		
<b>Ask Questions 1 and 2</b>		
<b>1) Wish to be Dead:</b> Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.  <b><u>Have you wished you were dead or wished you could go to sleep and not wake up?</u></b>		
<b>2) Suicidal Thoughts:</b> 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."  <b><u>Have you actually had any thoughts of killing yourself?</u></b>		
<b>If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6</b>		
<b>3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act):</b> 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."  <b><u>Have you been thinking about how you might kill yourself?</u></b>		
<b>4) Suicidal Intent (without Specific Plan):</b> Active suicidal thoughts of killing oneself and patient reports having <u>some intent to act on such thoughts</u> , as opposed to "I have the thoughts but I definitely will not do anything about them."  <b><u>Have you had these thoughts and had some intention of acting on them?</u></b>		
<b>5) Suicide Intent with Specific Plan:</b> Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out.  <b><u>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?</u></b>		
	<b>Past 3 Months</b>	
	<b>YES</b>	<b>NO</b>
<b>6) Suicide Behavior</b>  <b><u>Have you done anything, started to do anything, or prepared to do anything to end your life?</u></b>  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.		



# Same Screening Questions

\*If 1 and 2 are no, ideation section is done

# This is the C-SSRS Screener

\*Minimum of 3 Questions

# Overview of the Columbia-Suicide Severity Rating Scale (C-SSRS): Screening version

- Suicidal ideation, of increasing severity (from a wish to die to an active thought of killing oneself with plan and intent) 1-5 rating

Two screen questions for ideation



- *Have you wished you were dead or wished you could go to sleep and not wake up?*
- *Have you actually had any thoughts of killing yourself?*

*If answer is “No” to both, no more questions on ideation*

- Suicidal behaviors assessed in one additional question
  - *All items include definitions for each term and standardized questions for each category are included to guide the interviewer for facilitating improved identification*

# C-SSRS Format and Administration

## *...How many questions should I ask?*

- **Semi-structured interview/flexible format**
- **Questions are provided as helpful tools – it is not required to ask any or all questions – just enough to get the appropriate answer**
- **Most important: gather enough clinical information to determine whether to call something *suicidal or not***

# Example....

**Clinician: “Have you made a suicide attempt?”**

**Individual: “Yes, I took *50 pills because I definitely wanted to die.*”**

**You have enough information to classify as an actual attempt, no need to ask additional questions**

# Multiple Sources: *Don't have to rely solely on individual's report*

- **Most of time person will give you relevant info, but when indicated....**
- **Allows for utilization of *multiple sources of information***
  - *Any source of information that gets you the most clinically meaningful response (subject, family members/caregivers, records)*

*Source: American Foundation for Suicide Prevention*

# This is the Full C-SSRS Ideation Page

<b>SUICIDAL IDEATION</b>		Lifetime: Time He/She Felt Most Suicidal	Past 1 month
<p>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.</p>			
<p><b>1. Wish to be Dead</b> Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. <i>Have you wished you were dead or wished you could go to sleep and not wake up?</i></p> <p>If yes, describe:</p>		Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>
<p><b>2. Non-Specific Active Suicidal Thoughts</b> 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. <i>Have you actually had any thoughts of killing yourself?</i></p> <p>If yes, describe:</p>		Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>
<p><b>3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act</b> 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." <i>Have you been thinking about how you might do this?</i></p> <p>If yes, describe:</p>		Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>
<p><b>4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan</b> 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." <i>Have you had these thoughts and had some intention of acting on them?</i></p> <p>If yes, describe:</p>		Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>
<p><b>5. Active Suicidal Ideation with Specific Plan and Intent</b> Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out. <i>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</i></p> <p>If yes, describe:</p>		Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>
<b>INTENSITY OF IDEATION</b>			
<p>The following features should be rated with respect to the most severe type of ideation (i.e., 1-5 from above, with 1 being the least severe and 5 being the most severe). Ask about time he/she was feeling the most suicidal.</p>			
<p>Lifetime - Most Severe Ideation: _____ Type # (1-5) Description of Ideation</p> <p>Recent - Most Severe Ideation: _____ Type # (1-5) Description of Ideation</p>		Most Severe	Most Severe
<p><b>Frequency</b> <i>How many times have you had these thoughts?</i> (1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day</p>		---	---
<p><b>Duration</b> <i>When you have the thoughts how long do they last?</i> (1) Fleeting - few seconds or minutes (4) 4-8 hours/most of day (2) Less than 1 hour/some of the time (5) More than 8 hours/persistent or continuous (3) 1-4 hours/a lot of time</p>		---	---
<p><b>Controllability</b> <i>Could/can you stop thinking about killing yourself or wanting to die if you want to?</i> (1) Easily able to control thoughts (4) Can control thoughts with a lot of difficulty (2) Can control thoughts with little difficulty (5) Unable to control thoughts (3) Can control thoughts with some difficulty (6) Does not attempt to control thoughts</p>		---	---
<p><b>Deterrents</b> <i>Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of committing suicide?</i> (1) Deterrents definitely stopped you from attempting suicide (4) Deterrents most likely did not stop you (2) Deterrents probably stopped you (5) Deterrents definitely did not stop you (3) Uncertain that deterrents stopped you (6) Does not apply</p>		---	---
<p><b>Reasons for Ideation</b> <i>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?</i> (1) Completely to get attention, revenge or a 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) (2) Mostly to get attention, revenge or a reaction from others (5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (3) Equally to get attention, revenge or a reaction from others and to end/stop the pain (6) Does not apply</p>		---	---

# Suicidal Ideation

## 1. Wish to die

- *Have you wished you were dead or wished you could go to sleep and not wake up?*

## 2. Active Thoughts of Killing Oneself

- *Have you actually had any thoughts of killing yourself?*

**\*\*\* If “NO” to both these questions Suicidal Ideation Section is finished.\*\*\***

**\*\*\* If “YES” to ‘Active thoughts’ ask the following three questions.\*\*\***

## 3. Associated Thoughts of Methods

- *Have you been thinking about how you might do this?*

## 4. Some Intent

- *Have you had these thoughts and had some intention of acting on them?*

## 5. Plan and Intent

- *Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*

**\*Auditory hallucinations qualify as ideation\***

# Intensity of Ideation

- **Once types of ideation are determined, few follow-up questions about most severe thought**
  - *Frequency*
  - *Duration*
  - *Controllability*
  - *Deterrents*
  - *Reasons for ideation (stop the pain or make someone angry—stop the pain is worse)*
- **Gives you a 2-25 score that will help inform clinical judgment about risk**

# C-SSRS: Lifetime / Recent

<b>SUICIDAL IDEATION</b>		Lifetime: Time He/She Felt Most Suicidal		Past 1 month	
<p><i>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.</i></p>					
<p><b>1. Wish to be Dead</b>                      Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.  <i>Have you wished you were dead or wished you could go to sleep and not wake up?</i></p> <p>If yes, describe:</p>		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<p><b>2. Non-Specific Active Suicidal Thoughts</b>                      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.  <i>Have you actually had any thoughts of killing yourself?</i></p> <p>If yes, describe:</p>		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>

<b>SUICIDAL BEHAVIOR</b>	Lifetime		Past 3 months		Yes	No	Yes	No
<i>(Check all that apply, so long as these are separate events; must ask about all types)</i>	Yes	No	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p><b>Actual Attempt:</b>                      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. <i>There does not have to be any injury or harm</i>, 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.  <i>Have you made a suicide attempt?</i>  <i>Have you done anything to harm yourself?</i>  <i>Have you done anything dangerous where you could have died?</i>                      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:</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
	Total # of Attempts		Total # of Attempts					
					Yes	No	Yes	No
	<input type="checkbox"/>							
<b>Has subject engaged in Non-Suicidal Self-Injurious Behavior?</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

# Monitoring is Critical...

- **Need to determine how often to ask.**
- **Every visit?**

<b>SUICIDAL IDEATION</b>		Since Last Visit
<p><i>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.</i></p>		
<p><b>1. Wish to be Dead</b>            Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.  <i>Have you wished you were dead or wished you could go to sleep and not wake up?</i></p> <p>If yes, describe:</p>	<p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/></p>	
<p><b>2. Non-Specific Active Suicidal Thoughts</b>            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.  <i>Have you actually had any thoughts of killing yourself?</i></p> <p>If yes, describe:</p>	<p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/></p>	
<p><b>3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act</b>            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".  <i>Have you been thinking about how you might do this?</i></p> <p>If yes, describe:</p>	<p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/></p>	
<p><b>4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan</b>            Active suicidal thoughts of killing oneself and subject reports having <u>some intent to act on such thoughts</u>, as opposed to "I have the thoughts but I definitely will not do anything about them".  <i>Have you had these thoughts and had some intention of acting on them?</i></p> <p>If yes, describe:</p>	<p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/></p>	
<p><b>5. Active Suicidal Ideation with Specific Plan and Intent</b>            Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out.  <i>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</i></p> <p>If yes, describe:</p>	<p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/></p>	

# Clinical Monitoring Guidance

- **For Intensity of Ideation, risk is greater when:**
  - *Thoughts are more frequent*
  - *Thoughts are of longer duration*
  - *Thoughts are less controllable*
  - *Fewer deterrents to acting on thoughts*
  - *Stopping the pain is the reason*

# Clinical Monitoring Guidance: Threshold for Next Steps

<b>SUICIDAL IDEATION</b>	
<p>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.</p>	
<p><b>1. Wish to be Dead</b> Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. <i>Have you wished you were dead or wished you could go to sleep and not wake up?</i></p> <p>If yes, describe:</p>	<p>Lifetime: Time He/She Felt Most Suicidal</p> <p>Yes    No <input type="checkbox"/>   <input type="checkbox"/></p>
<p><b>2. Non-Specific Active Suicidal Thoughts</b> 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. <i>Have you actually had any thoughts of killing yourself?</i></p> <p>If yes, describe:</p>	<p>Yes    No <input type="checkbox"/>   <input type="checkbox"/></p>
<p><b>3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act</b> 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". <i>Have you been thinking about how you might do this?</i></p> <p>If yes, describe:</p>	<p>Yes    No <input type="checkbox"/>   <input type="checkbox"/></p>
<p><b>4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan</b> Active suicidal thoughts of killing oneself and subject reports having <u>some intent to act on such thoughts</u>, as opposed to "I have the thoughts but I definitely will not do anything about them". <i>Have you had these thoughts and had some intention of acting on them?</i></p> <p>If yes, describe:</p>	<p>Yes    No <input type="checkbox"/>   <input type="checkbox"/></p>
<p><b>5. Active Suicidal Ideation with Specific Plan and Intent</b> Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out. <i>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</i></p> <p>If yes, describe:</p>	<p>Yes    No <input type="checkbox"/>   <input type="checkbox"/></p>

Indicates  
Need  
for  
Next Step

# Full C-SSRS Suicidal Behavior Sub-scale

<b>SUICIDAL BEHAVIOR</b> <i>(Check all that apply, so long as these are separate events; must ask about all types)</i>	<b>Lifetime</b>		<b>Past 3 months</b>	
<p><b>Actual Attempt:</b> 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 <b>ANY</b> intent/desire to die associated with the act, then it can be considered an actual suicide attempt. <b>There does not have to be any injury or harm</b>, 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.</p> <p><b>Have you made a suicide attempt?</b> <b>Have you done anything to harm yourself?</b> <b>Have you done anything dangerous where you could have died?</b> <i>What did you do?</i> <i>Did you _____ as a way to end your life?</i> <i>Did you want to die (even a little) when you _____?</i> <i>Were you trying to end your life when you _____?</i> <i>Or Did you think it was possible you could have died from _____?</i> <i>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)</i> If yes, describe:</p>	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
<p><b>Has subject engaged in Non-Suicidal Self-Injurious Behavior?</b></p>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<p><b>Interrupted Attempt:</b> 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. <b>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?</b> If yes, describe:</p>	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
<p><b>Aborted or Self-Interrupted Attempt:</b> 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. <b>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?</b> If yes, describe:</p>	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
<p><b>Preparatory Acts or Behavior:</b> 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). <b>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)?</b> If yes, describe:</p>	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
	Total # of Attempts		Total # of Attempts	
	_____		_____	
	Total # of Interrupted		Total # of Interrupted	
	_____		_____	
	Total # of aborted or self-interrupted		Total # of aborted or self-interrupted	
	_____		_____	
	Total # of preparatory acts		Total # of preparatory acts	
	_____		_____	

# Suicide Attempt Definition

A self-injurious **act** committed with at least **some** intent to die, **as a result of** the act

- 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%
- Intent and behavior **must** be linked

# Inferring Intent

- **Intent can sometimes be inferred clinically from the behavior or circumstances**
  - *e.g., if someone denies intent to die, but they thought that what they did could be lethal, intent can be inferred*
  - *“Clinically impressive” circumstances; highly lethal act where no other intent but suicide can be inferred (e.g., gunshot to head, jumping from window of a high floor/story, setting self on fire, or taking 200 pills)*

# Suicide Attempt

- A suicide attempt begins with the first pill swallowed or scratch with a knife
- Questions:
  - *Have you made a suicide attempt?*
  - *Have you done anything to harm yourself?*
  - *Have you done anything dangerous where you could have died?*

# As Opposed To *Non-suicidal Self-injurious Behavior*

- Engaging in behavior **PURELY (100%)** for reasons other than to end one's life:
  - *Either to affect:*
    - **Internal state (e.g. feel better, relieve pain)**
    - and/or -
    - **External circumstances (e.g. get attention, make someone angry)**

# Suicidal Behavior

## SUICIDAL BEHAVIOR

(Check all that apply, so long as these are separate events; must ask about all types)

### 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:

Has subject engaged in Non-Suicidal Self-Injurious Behavior?

Since Last Visit

Yes No

Total # of Attempts  
 \_\_\_\_\_

Yes No

May help to infer intent

Important: Shows you did the appropriate assessment and decided it should not be called suicidal

# Other Suicidal Behaviors....

## *Interrupted Attempt*

- **When person starts to take steps to end their life but someone or something stops them**
- **Examples**
  - *Bottle of pills or gun in hand but someone grabs it*
  - *On ledge poised to jump*
- **Question:**
  - *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?*

# *Aborted Attempt*

- **When person begins to take steps towards making a suicide attempt, *but stops themselves* before they actually have engaged in any self-destructive behavior**
- **Examples:**
  - *Man plans to drive his car off the road at high speed at a chosen destination. On the way to the destination, he changes his mind and returns home*
  - *Man walks up to the roof to jump, but changes his mind and turns around*
  - *She has gun in her hand, but then puts it down*
- **Question:**
  - *Has there been a time when you started to do something to end your life but you stopped yourself before you actually did anything?*

# Preparatory Acts or Behavior

- **Definition:**
  - *Any other behavior (beyond saying something) with suicidal intent*
- **Examples**
  - *Collecting or buying pills*
  - *Purchasing a gun*
  - *Writing a will or a suicide note*
- **Question:**
  - *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, writing a suicide note)?*

# Suicidal Behavior Administration

- **Select (check) all that apply**
- **Only select if discrete behaviors**
  - *For example, if writing a suicide note is part of an actual attempt, do not give a separate rating of Preparatory Behavior (**ONLY MARK A SUICIDE ATTEMPT**)*
- **Every potential event should be described**

# Lethality

(Compilation of Beck Medical Lethality Rating Scale)

## *What actually happened in terms of medical damage?*

### **Actual Lethality/Medical Damage:**

0. No physical damage or very minor physical damage (e.g. surface scratches).
1. Minor physical damage (e.g. lethargic speech; first-degree burns; mild bleeding; sprains).
2. Moderate physical damage; medical attention needed (e.g. ~~conscious but~~ sleepy, somewhat responsive; second-degree burns; bleeding of major vessel).
3. Moderately severe physical damage; *medical* hospitalization and likely intensive care required (e.g. comatose with reflexes intact; third-degree burns less than 20% of body; extensive blood loss but can recover; major fractures).
4. Severe physical damage; *medical* hospitalization with intensive care required (e.g. comatose without reflexes; third-degree burns over 20% of body; extensive blood loss with unstable vital signs; major damage to a vital area).
5. Death 

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# Why Potential Lethality?

Likely lethality of attempt if no medical damage. Examples of why this is important are cases in which there was no actual medical damage but the potential for very serious lethality

- Laying on tracks with an oncoming train but pulling away before run over
- Put gun in mouth and pulled trigger but it failed to fire – Both 2

## **Potential Lethality: Only Answer if Actual Lethality=0**

Likely lethality of actual attempt if no medical damage (the following examples, while having no actual medical damage, had potential for very serious lethality: put gun in mouth and pulled the trigger but gun fails to fire so no medical damage; laying on train tracks with oncoming train but pulled away before run over).

0 = Behavior not likely to result in injury

1 = Behavior likely to result in injury but not likely to cause death

2 = Behavior likely to result in death despite available medical care

# Optimal Time Frame to Assess

- **Lifetime**

- *For Ideation: Most suicidal time most clinically meaningful – even if 20 years ago, much more predictive than current*
- *For Behavior: Lifetime behavior highly predictive (e.g. history of suicide attempt #1 risk factor for suicide)*

- **Recent**

- *For Ideation: During the past month*
- *For Behavior: During the past 3 months*



# Integrating the C-SSRS into FEP Clinical Practice

**Tara Niendam, Ph.D.**

**Assistant Professor in Psychiatry**

**Director of Operations, EDAPT & SacEDAPT Clinics**

**University of California, Davis**

# UCD Early Psychosis Treatment & Research Programs

- **2004 – Cameron Carter, MD. established an early psychosis research program and outpatient clinic (EDAPT) at UCD**
  - *First episode psychosis and clinical high risk, ages 12-40*
  - *More info: <http://earlypsychosis.ucdavis.edu>*
- **Began using C-SSRS initially as a research tool at UCD in 2009**
  - *Recognized its utility for assessing suicidal ideation and behavior*
- **Integrated it into our EDAPT clinic in 2010**
  - *Improve clarity in communication between clinicians for purposes of treatment planning and risk management*
  - *Evaluate the impact of our care on suicide risk*

# UCD-Affiliated Early Psychosis Programs

- **Expanded our clinic in 2011 – Sacramento County EDAPT Clinic (SacEDAPT)**
  - *First episode psychosis and clinical high risk, ages 12-30*
  - *More info: <http://earlypsychosis.ucdavis.edu>*
- **Supported implementation of EP care in Napa (2014) and Solano (2015) in collaboration with Aldea Child and Family Services**
  - *First episode psychosis and clinical high risk, ages 12-40*
  - *More info: <http://http://www.aldeainc.org/services/behavioral-health/early-diagnosis-preventative-treatment>*
- **At all clinics, the C-SSRS is completed at:**
  - *Intake*
  - *Every 6 months thereafter (as part of outcomes evaluation)*
  - *Whenever clinically indicated*

# Integrating the C-SSRS

- **Provide training for all new clinicians**
  - *2-3 hours long. Reviews rationale, how to score, LOTS of practice vignettes*
- **Clearly document findings in medical record**
- **Review as part of supervision**
  - *At each assessment point*
  - *If there is a report of suicide risk*
- **Examine data as part of outcomes evaluation**

# Clinicians' Reactions

- **Before the training – they are nervous...**
  - *What if this causes them to become distressed – or suicidal?*
    - **Asking about suicidality DOES NOT cause distress or suicidality (Gould et al., JAMA, 2005)**
  - *Does this decrease client's hope for a positive outcome or recovery?*
    - **Crisis planning is important part of treatment and recovery process**
  - *What do I do if they endorse suicidality?*
    - **Provide training in safety planning, lots of supervision and support**

# Clinicians' Reactions

- **After the training – they are excited!**
  - *Recognize the importance of the importance of suicide risk AND feel empowered to do something*
  - *Feel like they have a tool to use to gather the data they need for clinical decision making*
    - **Know the questions they need to ask – and how to report what they find with clear terms (“thorough”)**
    - **Supervisors really like it!**
    - **Have taken it to other clinical sites OR incorporated into their everyday practice**
  - *Ask A LOT of questions about how to manage suicide risk → need more training!*

# Ongoing Feedback

- **It adds time to the assessment**
  - *2 minutes... up to 20 minutes (for HIGH risk cases)*
  - *Need to determine WHERE to place it in the interview flow to minimize burden while also ensuring it gets completed*
- **“Not enough space to write”**
  - *Have created a word version with more space for clinician’s comments*
- **Sometimes, they forget to complete it (or parts of it)**
  - *Have to make it part of standard assessment protocol*
  - *Often forget to respond to ALL of the behavior items (stop at the top)*
  - *Need clerical support to check it immediately and ask it to be completed*

# Ongoing Feedback

- **Challenges of self-report**
  - *Individual may minimize (e.g. to avoid hospitalization)*  
→ *Need to talk to collaterals, look at records*
- **Helped us to be more clear about suicidal ideation/behavior vs NSSI → Realized NSSI is more prevalent than we once thought...**
  - *Not an ideal tool for “high action” clients with lots of SI, SA or NSSI → does not assess for protective factors or supports, identify ways to keep people OUT of the hospital*
  - *Need additional tools and training for how to respond when risk is high*

# Summary

- **Standardized suicide risk assessment is an essential component of FEP care**
- **C-SSRS represents a valuable tool in an FEP clinical setting**
  - *Gives clinical team a concrete tool – increases confidence in ability to manage risk situations*
  - *Improve clarity in communication between clinicians for purposes of treatment planning and risk management*
  - *Provides data on the impact of our care on suicide risk*
- **Need additional training on how to manage the risks you identify.**



# Clinical Vignettes

**Yael Holoshitz, MD**

**Psychiatrist at OnTrackNY/WHCS**

# Vignette #1: ID and History of Presenting Illness

- **C is a 25 year old single man, living alone in an apartment, supported by his parents. He recently completed college and is an aspiring playwright**
- **C presented to a first episode psychosis program after a psychotic episode, requiring inpatient hospitalization, characterized by: grandiose delusions, change in sleep, inability to care for himself, and aggressive behavior towards his mother, whom he thought was “possessed”**

# Presentation on Intake

- **Currently C is taking Zyprexa. He finds that this has helped his symptoms, but he has multiple side effects and feels that his creativity is “blunted”**
- **He feels anxious and concerned about his future. He is also not sure why/how he became psychotic, and is particularly worried about the experience that the episode “came out of nowhere.”**
- **On initial interview, he is very focused on “getting off the meds,” and wants to know exactly what his trajectory will be, including whether he can or should pursue a graduate degree. He is worried that “my brain is deteriorating”**

# Psychiatric History

- **No psychiatric hospitalizations prior to this episode**
- **C states “I’ ve always been a little moody... I guess I was an irritable kid”**
- **Describes difficulty “taking things in stride”**
- **States that one way he got into writing was that it helped him cope with overwhelming emotions, as a young child**

# Social History

- **C describes an ongoing contentious relationship with his family, especially his mother. He would like to detach from them, but he is financially dependent on his parents currently**
- **C has “experimented” with various drugs of abuse, including marijuana and hallucinogenic drugs. Denies current substance use**
- **He did well in school, graduated with Honor’ s from college, and since graduation has been attempting to write a play**

# History of Suicide Attempts

- **When asked if he had ever attempted suicide, C said, “nah, not really.”**
- **When probed further, and asked what he means by “not really,” he says that when he was in college he once took a knife to his wrist and held it there. He then “chickened out”**
- **He did not report this to anyone**

# Current Suicidal Ideation

- **C initially says, “I would never do that” but with completion of a structured suicide assessment, he reveals that he has frequent wishes to be dead, with intermittent thoughts of suicide**
- **States he would “jump in front of a subway” but denies intent, denies specific plan, and denies preparatory behavior**
- **In speaking about this, C becomes tearful and expresses fear about his future**

# Putting it together

- **Ongoing (chronic) Risk Factors**: male, single, psychotic disorder, past suicide attempt
- **Acute risk factors**: fear about his “brain deterioration,” sense of loss about his future prospects, hopelessness, depression, contentious relationship with his family, current suicidal ideation with no real plan or intent
- **Protective factors**: writing as a way of coping (historically), adherent to medications and currently engaged in treatment, recovery goals
- Determined to be **moderate risk** for suicide

# Take home points

- **Psychiatric history revealed crucial information about his premorbid functioning and past ways of coping**
- **If clinician had not questioned C further when he said, “not really” to the suicide attempt, clinician would have missed a crucial piece of information**
- **Structured assessment revealed the quality and quantity of his suicidal thoughts**
- **C felt that doing this was helpful and he felt relieved to talk about this. C and his clinician came up with a treatment plan that involved the SPI and ongoing monitoring**

# Vignette #2: ID and History of Presenting Illness

- **J is a 19 year old single young man, unemployed, recently dropped out of college, and living with his parents**
- **He comes to the First Episode Treatment program after two back-to-back hospitalizations for severe disorganization and paranoia**

# Presentation on Intake

- **J was discharged on Risperdal but states he only takes it half of the time because he “forgets.” His family does not remind him**
- **On initial presentation J continues to be somewhat thought disordered, vague, and not clear about why he is in the treatment. He appears somewhat internally preoccupied, and laughs to himself at multiple points in the interview**
- **When asked what the medication does for him he says, “I need it so that I can sleep.”**

# Psychiatric History

- **J unable to give most of his psychiatric history**
- **As per J' s family, prior to this episode he was, “happy, easy-going,” and had no history of outpatient or inpatient psychiatry**

# Social History

- **J completed high school, was an average student**
- **Subsequent to this, J has been working with his father, who is a super of a building**
- **He would like to become an electrician, and his family says he has a knack for this**
- **Denies all substance use, past or present**
- **States he is very religious and very connected to his religious community**

# History of Suicide Attempts

- **When asked about suicide attempts, J says, “nah, why would I ever do that!”**
- **However, on structured assessment, J reveals that prior to his hospitalization, he wrapped a belt around his neck**
- **He denies that he wanted to die, but does state, “I knew it could kill me, and that would have been ok. I just figured it was in god’s hands...At the end of the day it wasn’t up to me”**
- **In discussing this, J continues to seem somewhat disorganized vague and says, “it was really no big deal. It was what I was supposed to do...”**

# Current Suicidal Ideation

- **J denies current wish to be dead, denies ideation, intent or plan**
- **Denies preparatory behaviors**
- **Denies non-suicidal self-injury**
- **When asked about whether he has ideation to wrap the belt around his neck again, he says, “not unless I have to!”**
- **He also states that he is morally opposed to suicide, because of his religious beliefs**

# Putting it together

- **Ongoing (chronic) Risk Factors**: male, single, psychotic disorder, past suicide attempt in the setting of disorganization and delusional thinking
- **Acute risk factors**: disorganized, intermittently adherent to medications
- **Protective factors**: religion, supportive family, no current suicidal ideation
- Determined to be **moderate risk** for suicide

# Take home points

- **J' s case is very different from C' s– suicide attempt presented in a very different context**
- **Would be easy to brush off the incident of wrapping the belt around his neck, but J does indicate at least some knowledge that this would be lethal, and some intent to “leave it in god’ s hands...”**
- **J’ s clinician very aware of importance of targeting ongoing psychotic symptoms and thought disorganization**
- **Given degree of thought disorganization, J’ s family was incorporated into psychoeducation about suicide risk and psychosis, and safety planning moving forward**



# **Suicide and Early Psychosis: Resources for Providers**

**Richard McKeon, Ph.D.**

Chief, Suicide Prevention Branch, SAMHSA

# Resources and Tools

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The screenshot shows the homepage of [www.ZeroSuicide.com](http://www.ZeroSuicide.com). The website has a dark blue header with the Zero Suicide logo and navigation links: HOME, ABOUT, TECHNICAL ASSISTANCE, and RESOURCES. Below the header is a search bar and three main navigation buttons: Toolkit, Champions, and Get Involved. The main content area is a grid of colorful tiles. The top row features 'WHAT IS ZERO SUICIDE?' (teal) and 'ZERO SUICIDE TOOLKIT' (green). The second row has 'FOR CHAMPIONS' (purple) and 'MAKING HEALTH CARE SUICIDE SAFE' (grey with a video player). The third row includes 'GET INVOLVED' (teal), a photo of two women, and 'NEWS AND EVENTS' (red). The bottom row shows a photo of a man and woman, 'ZERO SUICIDE ACADEMY' (yellow), and 'GET TECHNICAL ASSISTANCE' (purple). The footer contains logos for UHS Universal Health Services, Inc., SPRC, Action Alliance, and the Suicide Prevention Hotline (1-800-273-TALK).

# The Elements of Zero Suicide in a Health Care Organization



Continuous  
Quality  
Improvement

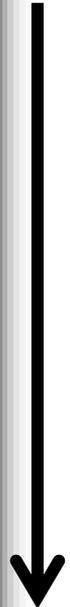
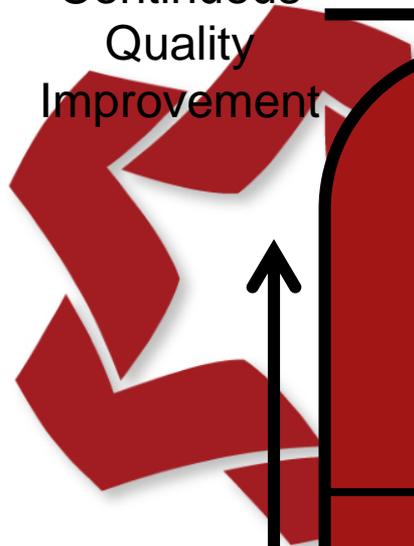
Create a leadership-driven,  
safety-oriented culture

## Pathway to Care

- Identify and assess risk
  - Screen
  - Assess
- Evidence-based care
  - Safety Plan
  - Restrict Lethal Means
  - Treat Suicidality and MI
- Continuous support as needed

*Electronic Health Record*

Develop a competent, confident,  
and caring workforce



# A System-Wide Approach Saved Lives: Henry Ford Health System

98



# Resource: Suicide Care Training Options

99

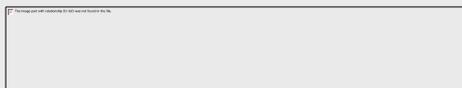
**ZERO**Suicide  
IN HEALTH AND BEHAVIORAL HEALTH CARE

[www.zerosuicide.com](http://www.zerosuicide.com)

## SUICIDE CARE TRAINING OPTIONS

### SUICIDE RISK DETECTION AND REFERRAL (PAGE 1 OF 2)

TRAINING NAME (Organization) Website	LENGTH & FORMAT	PROGRAM HIGHLIGHTS
Applied Suicide Intervention Skills Training (ASIST) (LivingWorks) <a href="http://www.livingworks.net/programs/asist">www.livingworks.net/programs/asist</a>	2 days (14 hours) In person	<ul style="list-style-type: none"><li>• Workshop emphasizes teaching suicide first aid to help a person at risk stay safe and seek further help as needed</li><li>• Standardized, customizable, and delivered by two trainers</li></ul>
Connect Suicide Prevention/Intervention Training (National Alliance on Mental Illness: New Hampshire) <a href="http://www.theconnectprogram.org">www.theconnectprogram.org</a>	1- to 4-hour options In person	<ul style="list-style-type: none"><li>• Training uses the socio-ecological model</li><li>• Examines suicide prevention and intervention in the context of the individual, family, community, tribe (if applicable), and society</li></ul>



# Resource: Zero Suicide Work Force Survey

100

**ZERO**Suicide  
IN HEALTH AND BEHAVIORAL HEALTH CARE

[www.zerosuicide.com](http://www.zerosuicide.com)

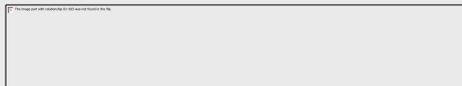
## ZERO SUICIDE WORKFORCE SURVEY QUESTIONS

**The Zero Suicide Workforce Survey is the ideal tool to use to assess staff knowledge, practices, and confidence. To administer the Zero Suicide Workforce Survey in your organization, submit a request through the Zero Suicide toolkit in the train section.**

<ORGANIZATION NAME> is making a commitment to improve care for our clients who are at risk for suicide. This survey is part of an overall organizational mission to adopt a system-wide approach to caring for individuals who are suicidal. The results of this survey will be used to help us determine the training needs of our staff.

All responses are anonymous. Please answer items honestly so that we can best serve both our staff and clients. Please be thoughtful about your answers even if you do not work directly with suicidal clients. We believe that suicide prevention is a shared responsibility among everyone in our organization. Unless otherwise indicated, please mark only one answer. It is anticipated that this survey will take you 5-15 minutes to complete. By answering this survey, you give your consent to participate; however, you may terminate your participation at any time.

We thank you in advance for your participation and for your dedication to this important issue!



# Resource: Using the C-SSRS

101

Assessment of Suicidal Risk Using C-SSRS Exit

Menu

## Suicide Risk Identification and Triage Using the Columbia Suicide Severity Rating Scale

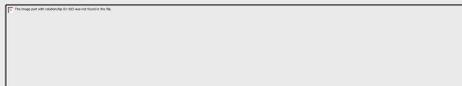


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Forms   Text Version   Resources   Play   Replay   Audio   Page 1 of 25   Next

Access at: [www.zerosuicide.com](http://www.zerosuicide.com)

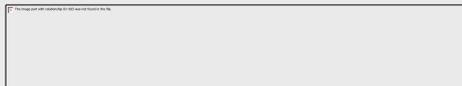


# Resource: Safety Planning Intervention

102

The screenshot shows a video player interface for a presentation titled "Safety Planning Intervention for Suicidal Individuals". The interface includes a title bar with "Safety Planning Intervention for Suicide Prevention" and an "Exit" button. Below the title bar is a "Menu" button. The main content area features the text "Welcome to the Safety Planning Intervention for Suicidal Individuals" above a video player. The video player shows a man in a light green shirt speaking. To the left of the video is a circular logo for "Suicide Prevention" with the text "We think you can help." To the right is the logo for the "New York State Office of Mental Health" and the "Center for Practice Innovations" at "Columbia Psychiatry, New York State Psychiatric Institute", with the tagline "Building best practices with you." Below the video player is a copyright notice: "© 2013 Research Foundation for Mental Hygiene, Inc." At the bottom of the interface is a navigation bar with buttons for "Text Version", "Resources", "Play", "Replay", "Audio", and "Page 1 of 27 Next".

Access at: [www.zerosuicide.com](http://www.zerosuicide.com)

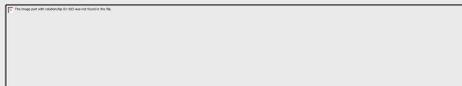


# Resource: Counseling on Access to Lethal Means

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The screenshot shows a web-based learning interface. At the top, the title 'Counseling on Access to Lethal Means' is displayed. Below the title is the logo for the Suicide Prevention Resource Center (SPRC). A navigation menu on the left includes options like 'Lifeline Contact Information', 'Welcome', 'Produced By', 'What This Course Covers', 'Before You Begin', 'Module 1: Introduction to Means Restriction', and 'Module 2: Counseling on Access to Lethal Means'. The main content area features a collage of images depicting people in various emotional states, such as a man being comforted, a woman in a hoodie, a man in a white shirt, a woman on a couch, and a man in a plaid shirt. At the bottom of the main area, the text 'Counseling on Access to Lethal Means Online Learning' is visible, along with logos for HICRC (Harvard Injury Control Research Center) and SPRC. A video player control bar at the bottom indicates 'SLIDE 2 OF 64', 'PAUSED', and a timer of '00:03 / 00:06'.

Access at: [www.zerosuicide.com](http://www.zerosuicide.com)



# Resource: Structured Follow-up and Monitoring

104

Structured Follow-up and Monitoring Exit

Menu

## Welcome to Structured Follow-Up and Monitoring for Suicidal Individuals



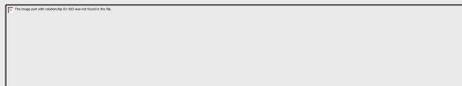
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New York State Psychiatric Institute  
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[Text Version](#) [Resources](#) [Play](#) [Replay](#) [Audio](#) Page 1 of 27 [Next](#)

Access at: [www.zerosuicide.com](http://www.zerosuicide.com)



# SAMHSA funded training resources

- **Suicide Prevention Resource Center, [www.sprc.org](http://www.sprc.org) Assessing and Managing Suicide Risk (AMSR)**
- **SAFE-T Card and SuicideSafe app walks clinicians through a suicide risk assessment**
- **Treatment Improvement Protocol 50-Suicide and Substance Abuse**

# National Suicide Prevention Lifeline

- **Joint Commission recommends giving those with suicidal ideation the Lifeline number -1-800-273-TALK (8255)**
- **Link to Veterans Crisis Line**
- **160+ local crisis centers**
- **Local Lifeline crisis centers are a vital partner for suicide prevention-talk to them, support them, partner with them**



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**Branch Chief, Suicide Prevention, SAMHSA**  
**240-276-1873**  
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# What's Next?

- **Part 2: Addressing Suicidal Ideation and Behavior in Individuals with a First Episode of Psychosis**
  - Wednesday, September 7 at 2:00pm Eastern

# Discussion

# Thank you!

Please contact NRI or NASMHPD with any comments, questions, or suggestions for the second webinar:

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