FORENSIC MENTAL HEALTH Association of California

Suicide Risk Assessment Through a Correctional Lens

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Learning Objectives

1. Describe how to conduct a risk assessment with forensic clients in correctional or community settings
2. Differentiate between chronic and acute risk factors for suicide
3. Describe four major components of a suicide risk assessment
4. Identify the eight principles of evidence-based practice in working with forensic clients
5. Differentiate between the variety of special considerations of evaluating risk and completing a treatment plan options

Plan of the day

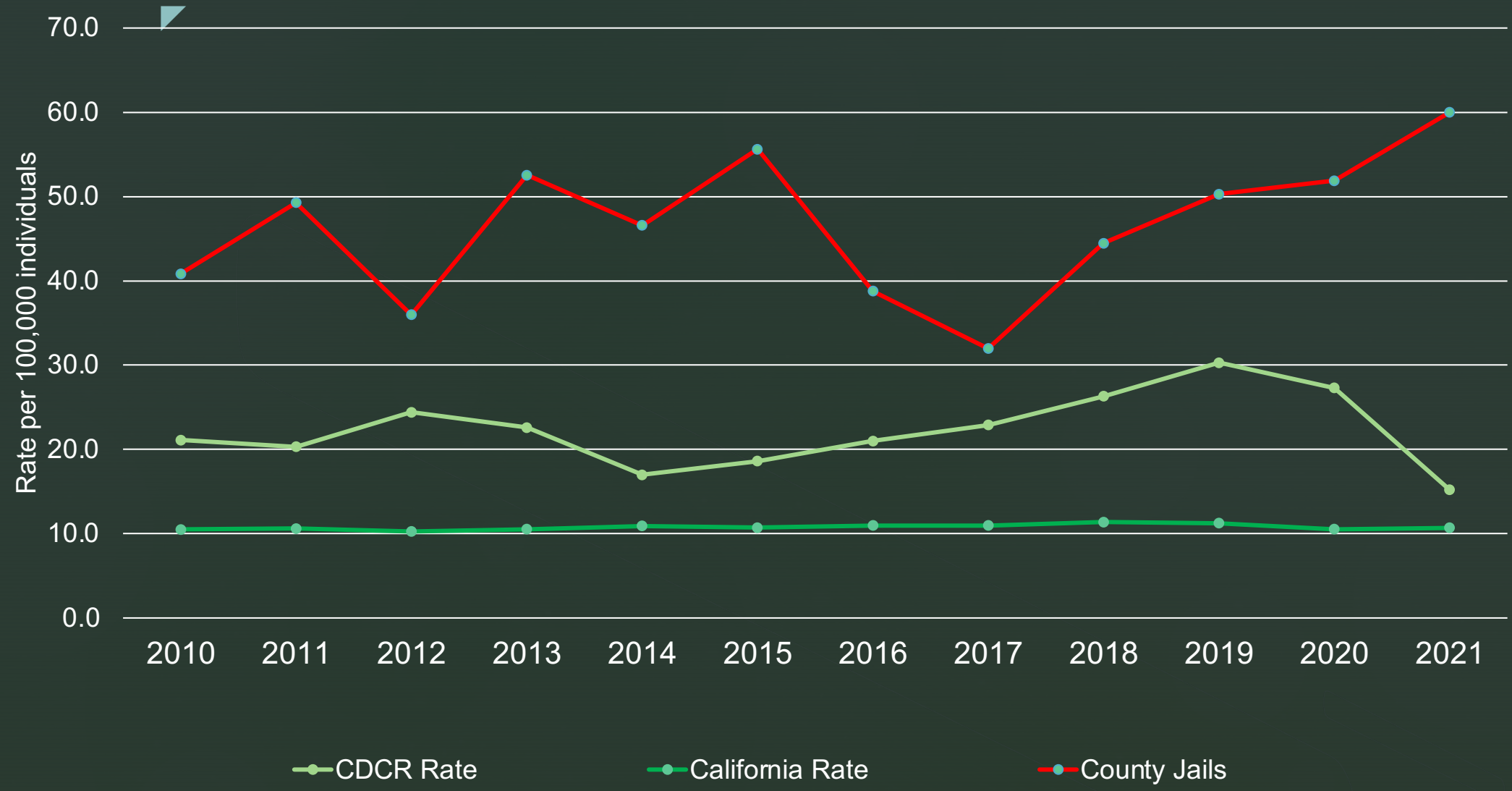
- Six hours CE
- 9:00 AM to 4:15 PM
  - AM and PM break
  - Lunch 12:15 to 1:00 PM

Suicide and Suicide Attempts in the Criminal Justice Populations

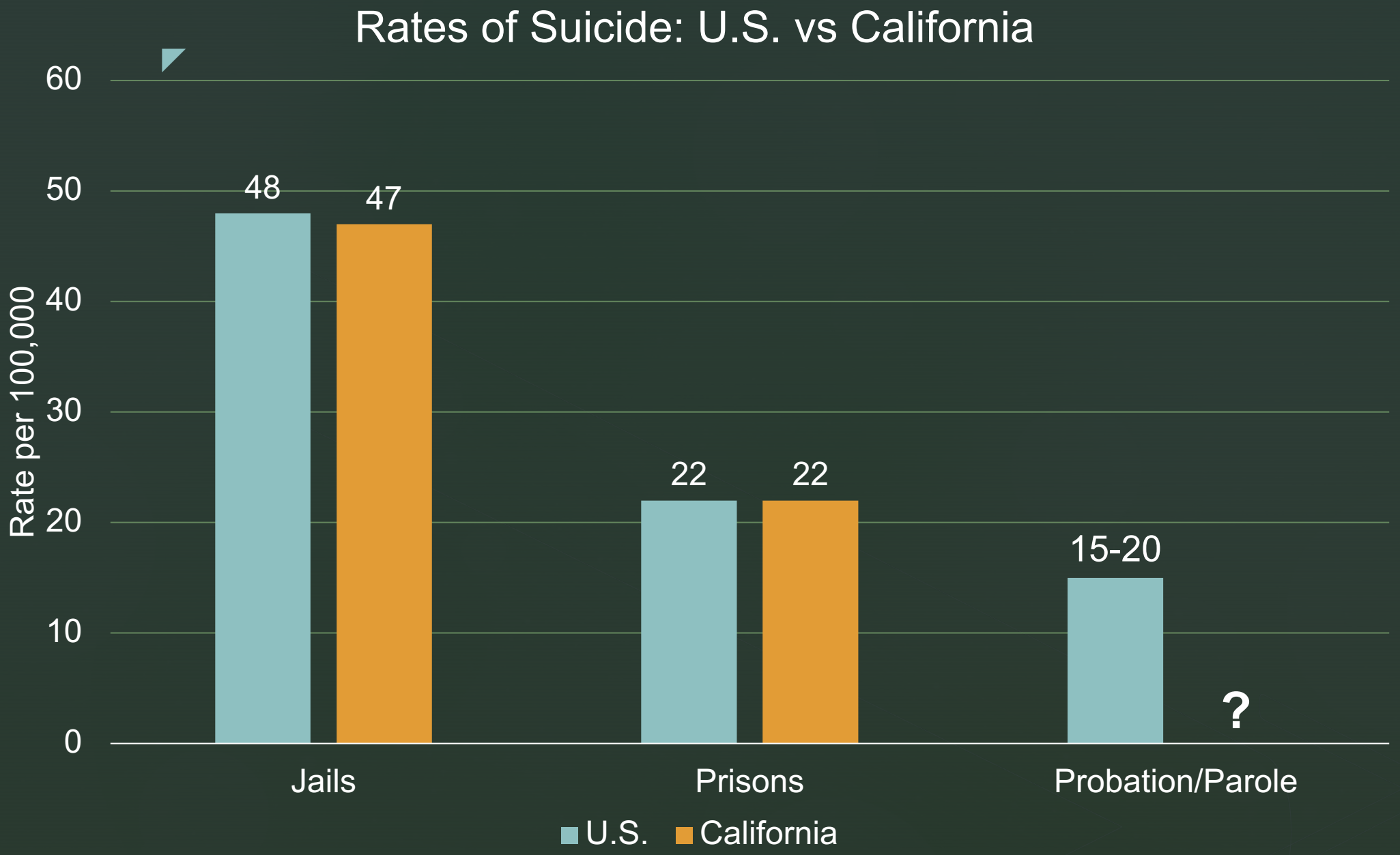
How many people are we talking about?

- State Prisons (end of 2022):
  - 92,051 Males in 33 prisons
  - 3,656 Females in 2 prisons
- County Jails (end of 2022):
  - 52,196 Males
  - 6,089 Females
  - 75% Unsentenced
- Community supervision (end of 2020)
  - 183,334 on probation
  - 110,349 on parole

Annual Suicide Rates: California Community, Jails, & Prisons



Data from U.S. CDC, CDCR, BSCC, and California DOJ


Rates of Suicide: U.S. vs California
Rate per 100,000
60
50
40
30
20
10
0
48
47
22
22
15-20
?
Jails
Prisons
Probation/Parole
U.S.
California

Suicide Attempts In and Out of Custody Settings

- There is systematic on rates of suicide attempts and self-harm in custody
- A survey of U.S. prison systems estimated that less than two percent of inmates self-harmed (Appelbaum et al. 2011)
- CDCR tracks self-harm with and without intent to die
  - In 2021 there were 476 documented suicide attempts, of which 156 (33%) had moderate or severe medical injuries
- There is no good estimate of the number or severity of suicide attempts among individuals housed in California jails

Suicide Ideation

- Good national data for individuals in jails and prison and those on parole/probation is hard to come by
- Good data for California is is non-existent
- Based on educated guesses:
  - Rates of ideation of all three populations is probably much higher than the community in general
  - It is very likely that clinicians in all three will encounter individuals with suicidal ideation
- TAKE AWAY POINT: Most individuals expressing suicidal ideation (whether in the community, in jail or prison, or on probation//parole) DO NOT die of suicide but do need thorough evaluation.

Suicide Mortality after Prison & Jail

- Mortality from drugs and suicide are increased in recently released prisoners
  - Individuals released from Washington State prisons between 1999 and 2003, compared to community members, had significantly higher rates of death from homicide, suicide, drug overdose (Binswanger et al, 2007)
  - Offenders released from jail in New York City 2001-2005 had higher rates than community members and those from the poorest neighborhoods (Lim et al. 2011)
  - Individuals released from North Carolina prisons from 1980-2005 had higher rates of suicide than community residents (Rosen et al. 2008)
  - No comparable data from California.
  - Note: These studies don't differentiate between individuals in supervision and those who are not.

- Characteristics of Suicides by Jail and Prison Residents and by those on Parole/Probation
  - Mostly men
  - Mostly white
  - Mostly middle-aged
  - Mostly substance abusers

Mental Disorders in Prison, Jails, and Community Corrections

- In a study of more than 20,000 adults booked into five U.S. jails, 14.5 percent of men and 31 percent of women (taken together, 17 percent of those entering the facilities) met criteria for SMI.
- In a U.S. Justice Department survey, 16 percent of state inmates were estimated to have a mental illness.
- In U.S. Justice Department and SAMHSA surveys, 9 percent of individuals on probation and 7 percent of individuals on parole were estimated to have a serious mental illness.

Remember:

1. Jail detainees have higher rates of mental disorders than the community in general.
2. These disorders are poorly treated in jail and when these individuals go to prison they bring these disorders with them.
3. Most individuals sentenced to state prison in California leave within a few years.
4. The burden of treatment follows these individuals back to their communities.

Core Competencies

From: Cramer, R.J., Johnson, S.M., McLaughlin, J., Rausch, E.M., & Conroy, M.A. (2013). Suicide risk assessment training for psychology doctoral programs: Core competencies and a framework for training. *Training and Education in Professional Psychology 7*(1), 1-11.

Screening for suicide risk

- A brief set of questions that tell you to be worried or not
  - Can be administered by lay persons or healthcare professionals
  - If positive – requires a referral for a further evaluation
  - Is NOT predictive of suicide attempt
  - Only gives a rough estimate of current risk

Clinical Example: Release from Jail Safety Cells

- Assess hx of self-harm in custody; current ideation
- Are they a recent arrival?
- How desperate are they (agitation/anxiety/anger)?
- Seriousness of charges
- Don’t use a contracts – construct a brief safety plan
- Use warning signs to gauge short-term risk
- Contextual factors – jail/court/family issues
- If no full evaluation maybe you should do one

Suicide Risk Evaluation

- A systematic exploration of current suicidal ideation, history of suicidal ideation and/or behavior, acute and chronic stressors, psychiatric symptoms, and social context
  - Completed by a trained mental health professional
  - Should include contact with collateral informants (teachers, counselors, parents, friends)
  - Used to estimate both acute and chronic risk
  - Should result in a treatment/safety plan

Core components of a suicide risk assessment

- Gathering information from the client
- Gathering data from other sources
- Estimating suicide risk
- Treatment/safety planning
- Documentation

From: Obegi, J.H. (2017) Probable standards of care for suicide risk assessment. *Journal of the American Academy of Psychiatry and the Law 45*, 452-459.

Gathering Data from the Client

Gathering Data from the client

- Systematic review of risk & protective factors
  - Because there are a myriad of risk factors, forms can be handy as memory aids and for documentation purposes
- What are this individual's unique risk & protective risk factors?
- Note warning signs of very short-term risk
  - IS PATH WARM
  - Conduct a mental status exam
  - Suicidal inquiry

What's Up With Risk Factors?

- Any characteristic that precedes an event and increases (or in the case of protective factors decreases) risk of its occurrence
- Risk factors have been the mainstay of risk assessment for decades
- Most risk factors are not good predictors of short-term risk

The problem with risk factors

- Based on group data
- Your client may not be in one of the groups (e.g. think ethnicity or LGBTQ groups)
- They typically do not help with short-term prediction and risk management (with some exceptions)
- So where are we heading?

Risk/Protective Factors vs Warning Signs

	Heart Attack	Suicide
Risk Factors	• Tobacco use • Obesity • High LDL cholesterol • Physical inactivity	• Prior suicide attempt • Mood disorder • Substance abuse • Access to lethal means
Protective Factors	• Exercise • Sound diet • High HDL cholesterol • Stress management	• Connectedness • Good health/mental health care • Positive coping skills
Warning Sign	• Chest pain • Shortness of breath • Cold sweat • Nausea • Lightheadedness	• Threatening to hurt or kill oneself • Hopelessness • Increasing substance use • Dramatic mood changes

WARNING SIGNS

WARNING SIGNS OF VERY SHORT TERM SUICIDE RISK: **IS PATH WARM**

I	Ideation	Active or passive ideas – content?
S	Substances	Substances on board?
P	Purposeless	Psychic pain – reasons for living/dying
A	Anxiety	Anxiety/agitation
T	Trapped	Trapped – ineffective coping
H	Hopelessness	Hopelessness - important, research-based indicator
W	Withdrawn	Withdrawal - alienation
A	Agitation/anger	Anger - self-loathing – acting out
R	Recklessness	Recklessness - Impulsiveness
M	Mood	Labile mood – recent mood changes

Chronic vs Acute Risk Factors

- Chronic Risk Factors
  - Unchanging and unchangeable
  - Impart vulnerability
  - Includes demographics
  - May be context specific (e.g. correctional factors)
- Acute Risk Factors
  - Within the past year (or less)
  - Worsening of chronic syndromes
  - Precipitants, life crises, triggering events
  - May be contextual (e.g. housing changes in prison)

See: Rudd, M. D. (2006). Fluid Vulnerability Theory: A Cognitive Approach to Understanding the Process of Acute and Chronic Suicide Risk. In T. E. Ellis (Ed.), *Cognition and suicide: Theory, research, and therapy* (pp. 355-368). Washington, DC, US: American Psychological Association. http://dx.doi.org/10.1037/11377-016

Protective Factors

- Much less research and understanding of how protective factors work to reduce risk
- “Connectedness” has emerged as the core of protective (or buffering) factors
  - Connected to family
  - Connected to community
  - Connected to self
  - Connected to treatment
- Their effectiveness ebbs as acute risk increases

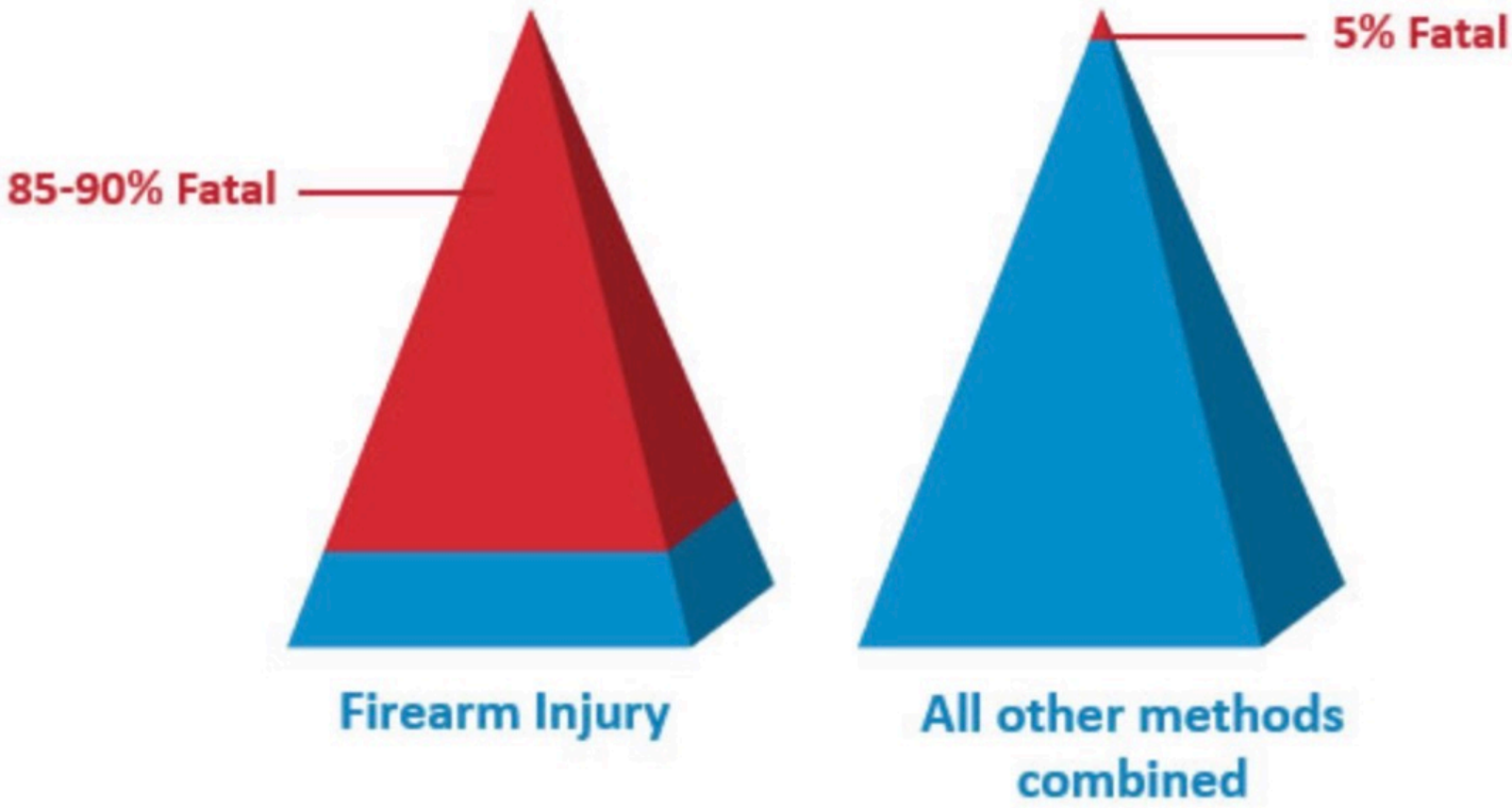
Suicide Inquiry

- Elicit information about:
  - Frequency, Intensity, Controllability, Duration of thoughts
  - Planning (note worst episode for previous attempters)
  - Preparatory behaviors
  - Lethality and intentionality
  - Can augment with measures such as Beck Hopelessness Scale, Reasons for Living scale

C-SSRS Questions about Suicidal Ideation

- How many times have you had these thoughts?
- When you have these thoughts how long do they last?
- Could/can you stop thinking about killing yourself or wanting to die if you want to?
- 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 suicide?
- 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?

Lethality of Suicide Methods



CDC WISQARS: Deaths from death certificate data; nonfatal incidents estimated from national sample of hospital emergency departments

Drivers

- Individual combinations of risk factors and warning signs that “push” the client toward suicidal behavior
- Direct drivers: suicide- specific thoughts, feelings, and behaviors which lead to suicidality for the client
- Indirect drivers: life circumstances which are further contributing to suicidality” such as, “homelessness, depression, substance abuse, posttraumatic stress disorder, isolation

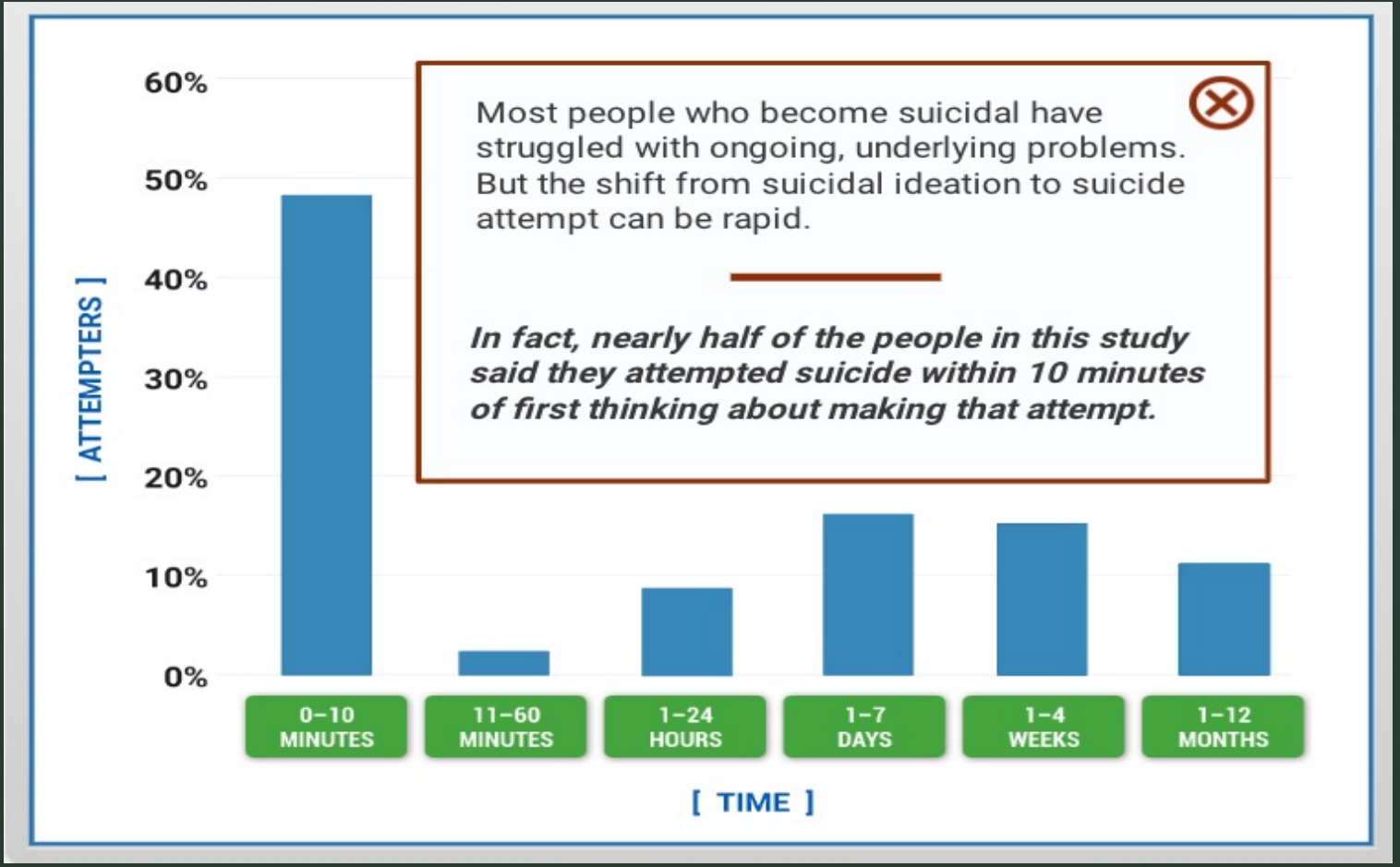
Tucker, R. P., Crowley, K. J., Davidson, C. L., & Gutierrez, P. M. (2015). Risk Factors, Warning Signs, and of Suicide: What Are They, How Do They Differ, and Why Does It Matter? *Suicide and Life-Threatening Behavior*, n/a–n/a. http://doi.org/10.1111/sltb.12161

Impulsivity and the transition to action

- A recent study of ideators in the U.S. Army found that factors predicting a first nonfatal suicide attempt include:
  - Recent onset of ideation
  - Presence and recent onset of a plan
  - Low controllability of suicidal thoughts
  - Extreme risk-taking or “tempting fate” behavior
  - Failure to answer questions about the characteristics of the ideation

Nock, M. K., Millner, A. J., Joiner, T. E., Gutierrez, P. M., Han, G., Hwang, I., et al. (2018). Risk factors for the transition from suicide ideation to suicide attempt: Results from the Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS). *Journal of Abnormal Psychology*, *127*(2), 139–149. http://doi.org/10.1037/abn0000317

Duration of Suicidal Crisis



Deisenhammer, E. A., Ing, C.-M., Strauss, R., Kemmler, G., Hinterhuber, H., & Weiss, E. M. (2009). The duration of the suicidal process: how much time is left for intervention between consideration and accomplishment of a suicide attempt? *The Journal of Clinical Psychiatry*, *70*(1), 19–24.

Mental Status Exam

- Be thorough – take the time
- Can reveal warning signs
- Is there psychosis or other major psychiatric disturbance
- Do they have insight and/or judgment
- Presence of anxiety/agitation

Get a good history

- History of suicidal ideation and behaviors
- Substance abuse
- Violence
- Hx of suicide among family and friends
- Worst episodes of suicidality, if any; get details
- Psychiatric history

Data from Other Sources

- Clinical documentation
- Collaterals
  - Jail/Prison/Probation/Parole Staff
  - Family
  - Custodial/Law Enforcement (forms or in person)
- Other databases– community behavioral health?
- Evaluate the veracity and trustworthiness of sources

Judgment of Risk

Risk Formulation

- No agreed upon method
- No empirical research for any method
- Synthesizing data using both individual and group data for this client
- Task is to classify the risk – typically on a quasi-Likert scale from low to high and possibly extreme risk
- The law expects a clinician to make a judgment of risk based upon the results of the suicide risk assessment
- Risk judgments determine the level of monitoring/intervention required for the individual

Judgment of Risk

- Risk formulation: “[A] concise synthesis of empirically based suicide risk information regarding a client’s immediate distress and resources at a specific time and place.”[1]
- “Ultimately, the goal of [suicide] risk assessment is … prevention, not prediction.”[2]

1. Pisani, A.R., Murrie, D.C. & Silverman, M.M. (2015). Reformulating suicide risk formulation: From prediction to prevention. *Academic Psychiatry* 40(4), 623-629.
2. Hart, S.D. (1998). The role of psychopathy in assessing risk for violence: Conceptual and methodological issues. *Legal and Criminological Psychology 3*, 121-137.

General Risk Considerations

- Chronic risk sets the bar for the client's vulnerability to suicidal behavior across the lifetime
- Acute risk and warning signs offer a glimpse into the near-term risk.
- Chronically vulnerable individuals can move into and out of "zones" of heightened risk depending on the occurrence of precipitants, life events, triggers, etc.
- The greater the number of acute risk factors and warning signs the higher the risk (but they are not additive)
- Protective factors do not (unfortunately) work to reduce risk when acute risk rises

Approaches to Judging Risk

Approach 1

- Derived from:
  - Bryan & Rudd (2006) Advances in the Assessment of Suicide Risk
  - SAMSHA (2009) Suicide Assessment Five-step Evaluation and Triage (SAFE-T)
  - VA Therapeutic Risk Management – Risk Stratification Tool

Chronic Risk Grid

Level	Indicators
High	• Multiple suicide attempts
Med	• One suicide attempt OR • Multiple chronic risk factors
Low	• No history of self-harm behavior OR • No or few chronic risk factors

Courtesy of Joe Obegi, PhD and adapted from Bryan & Rudd (2006); SAMSHA (2009); VA/DOD (2013)

Acute Risk Grid

Level	Indicators	Associated Features
High	• Persistent suicide ideation • **Intent** (explicit or implicit) • Poor control of impulse to self-injure **OR** a recent suicide attempt **OR** unknown risk	• Acute precipitating event(s) • Acute psychiatric symptoms • Multiple warning signs
Med	• Current ideation • **No intent** (explicit or implicit) • Good control of impulse to self-injure	• Some warning signs present • Some protective factors
Low	• Recent of no suicidal ideation • No intent (explicit or implicit) • Absence or good control of impulse to self-harm	• Effective protective factors • Limited risk factors

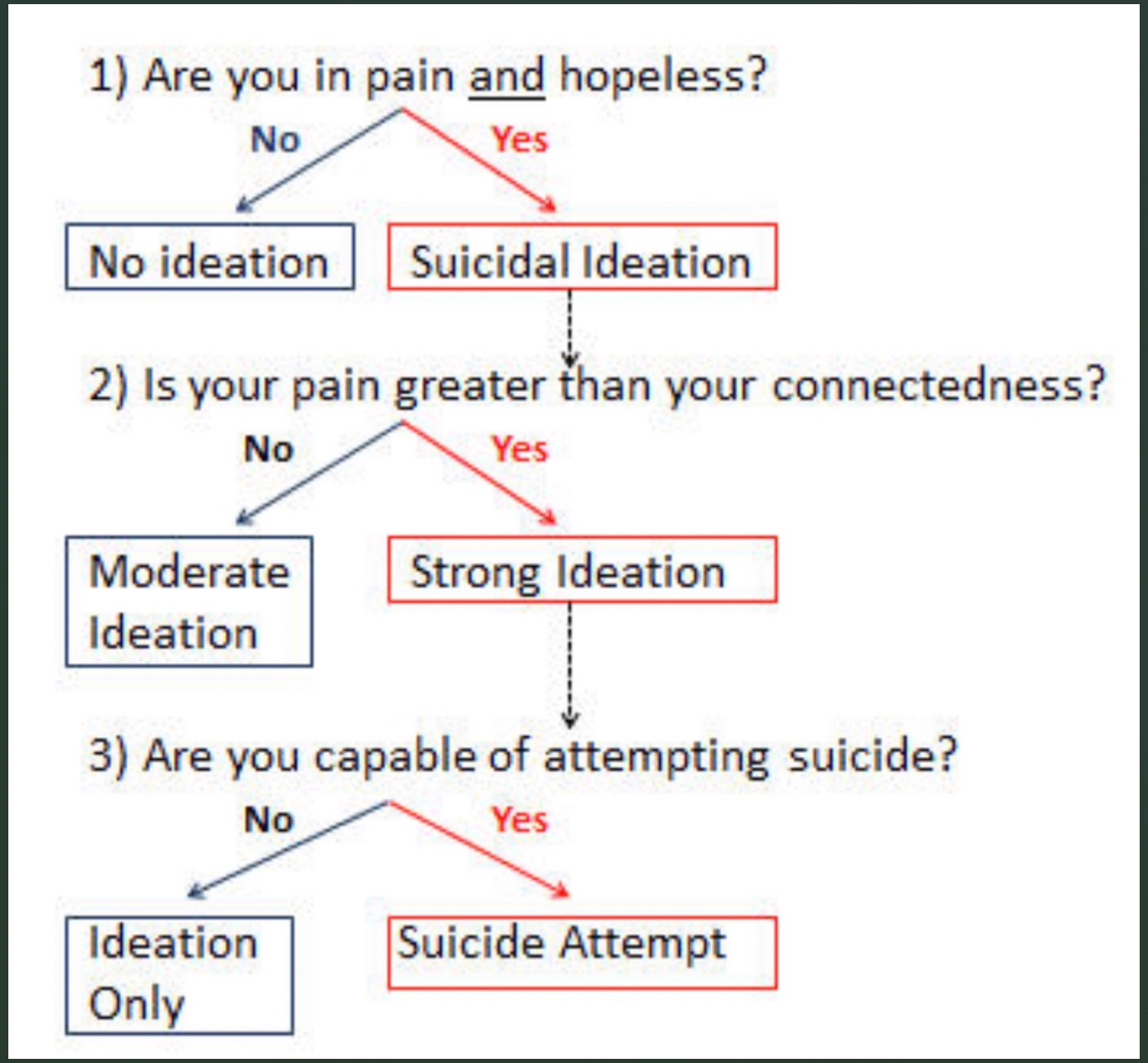
Courtesy of Joe Obegi, PhD and adapted from Bryan & Rudd (2006); SAMSHA (2009); VA/DOD (2013)

Approach 2: 3ST Model

- Ideation to Action Framework
- Core components:
  - Pain
  - Hopelessness
  - Capability
  - Connections

Klonsky, E. D. & May, A. M. The three-step theory (3ST): a new theory of suicide rooted in the “ideation-to-action” framework. *Int J Cogn Ther* **8**, 114 129 (2015).

Three-Steps


1) Are you in pain and hopeless?
No
Yes
No ideation
Suicidal Ideation
2) Is your pain greater than your connectedness?
No
Yes
Moderate Ideation
Strong Ideation
3) Are you capable of attempting suicide?
No
Yes
Ideation Only
Suicide Attempt

3ST: Transition to Action

Suicidal ideation progresses to suicidal action when the person is capable

- High pain tolerance
- History of self-harm
- History of suicide attempts
- Knowledge of or access to lethal means

3ST Risk Levels

- One factor without the others
  - Low to moderate
- Any two factors
  - Medium to high
- All three factors
  - High to extreme
- As in all situations, individual factors and context can alter your judgment of risk

The ideal risk formulation addresses:

- Chronic and acute risk and warning signs (include important negatives, e.g. no history of suicide attempts)
- Protective factors (including current resources)
- If…then statements about possible changes in risk
- Your thinking process about the client's risk
- Veracity of reports and data

REASONABLE
NOT
PERFECT
CLINICIANS

Treatment and Safety Planning

Overall Treatment Goals

- Decrease risk factors
- Increase protective factors
- Focus on suicidality until resolved
- Least restrictive environment

Intervention with Suicidal Jail Detainees

- Assessment of risk is primary focus in the initial stage
  - Complete a thorough evaluation
  - Is there a severe mental illness? (Psychiatric consult)
  - What is the context of the suicidal crisis?
- Interventions are commensurate with level of risk
- Safety first – be conservative

Intervention with Suicidal Jail Detainees II

- Use the least restrictive setting
- Have a good relationship with custody (stick to your guns)
- Does the person need to be hospitalized?
- Higher risk = higher monitoring and frequent reassessments
- Use a problem-solving approach to crises
- Construct a short-term safety plan

Interventions for Suicidal Individuals in Prison

- Assessment of risk is primary focus in the initial stage
  - Complete a thorough evaluation
  - Is there a severe mental illness? Psychiatric consult?
  - What is the context of the suicidal crisis?
- Short-term inpatient care
- High-risk programs
- Follow-up after inpatient stays
- Group treatment can be helpful
- Cognitive-behavioral approaches are best

Treatment Options in the Community

- Assessment of risk is primary focus in the initial stage
  - Is there a severe mental illness? (Psychiatric consult)
  - What is the context of the suicidal crisis?
- Short-term interventions
  - Safety planning
  - Lethal means counseling
  - Use social supports (if available)
  - Cognitive behavioral approach
  - Substances?

Formal treatment for suicidality

- Only a few treatments work
- They target the suicidality
- They require training
- Cognitive behavioral techniques have shown efficacy
  - Collaborative Assessment & Management Suicidality
  - Cognitive Behavioral Therapy for Suicide Attempts
  - Dialectical Behavior Therapy

- Counseling on Access to Lethal Means (CALM)
  - https://www.sprc.org/resources-programs/calm-counseling-access-lethal-means
  - Learn how to:
    - Explain that reducing access to lethal means is evidence-based
    - Explain the connection between reducing access to lethal means can prevent suicide
    - Identify clients who may benefit from this strategy
    - Describe strategies for reducing access to lethal means
    - Advise clients on in-home and off-site storage for firearms and dangerous medications
    - Work with clients and families on a strategy to reduce access to lethal means

Safety Planning

- Used throughout the VA
- Helpful in emergency situations (Eds, Mobile Crisis)
- More difficult in jail and prison
- Takes 30 minutes
- Uses a collaborative approach
- Can increases attendance at follow-up visits

Six Steps to a Safety Plan

1. Develop individualized warning signs
2. Internal coping strategies
3. Social contacts who may distract from the crisis
4. Family members/friends to assist in crisis
5. Professionals and agencies (e.g. crisis line)
6. Safe environment

Consultation

- One of the best things you can do when you encounter a suicidal client
- ”Don’t worry alone”
- Seek out colleagues, treatment teams, other professionals, etc.
- Documentation of consultation is good practice and can be a hedge against liability claims

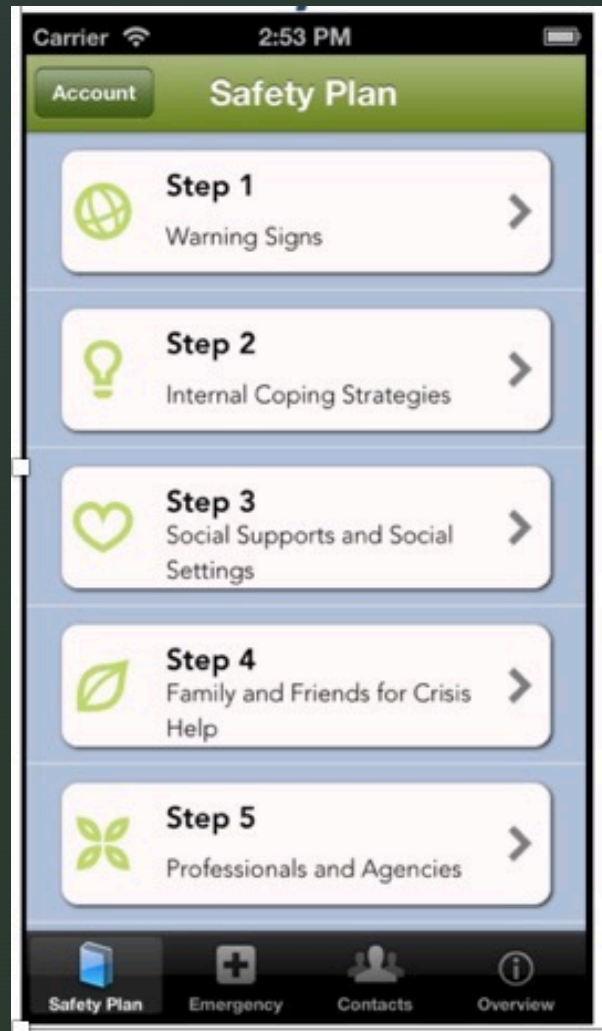
Documentation

- Documentation is VERY important
- Thorough documentation is even MORE important
- Documentation is about communicating your thinking
- Documentation is about communicating to your peers and other professionals
- Document suicide risk assessments each time they occur
- An excellent resource: Appendix A of *The Practical Art of Suicide Assessment: A Guide for Mental Health Professionals and Substance Abuse Counselors* by Sean Shea

Smart Phone Apps

- Numerous smart phone apps to aid clinicians
- Some target clinicians, some clients, and some the family/environment

Safety Planning App



Barbara Stanley, Ph.D.

Gregory K. Brown, Ph.D.

Sponsors: New York State Office of Mental Health and Columbia University

MY3 App

Create your support system.

Add the contact information of the 3 people you feel you would like to talk to when you are having thoughts of suicide.

Build your safety plan.

Customize your safety plan by identifying your personal warning signs, coping strategies, distractions and personal networks. This safety plan will be with you at all times and can help you stay safe when you start thinking about suicide. Learn more about safety planning.

Access Important Resources.

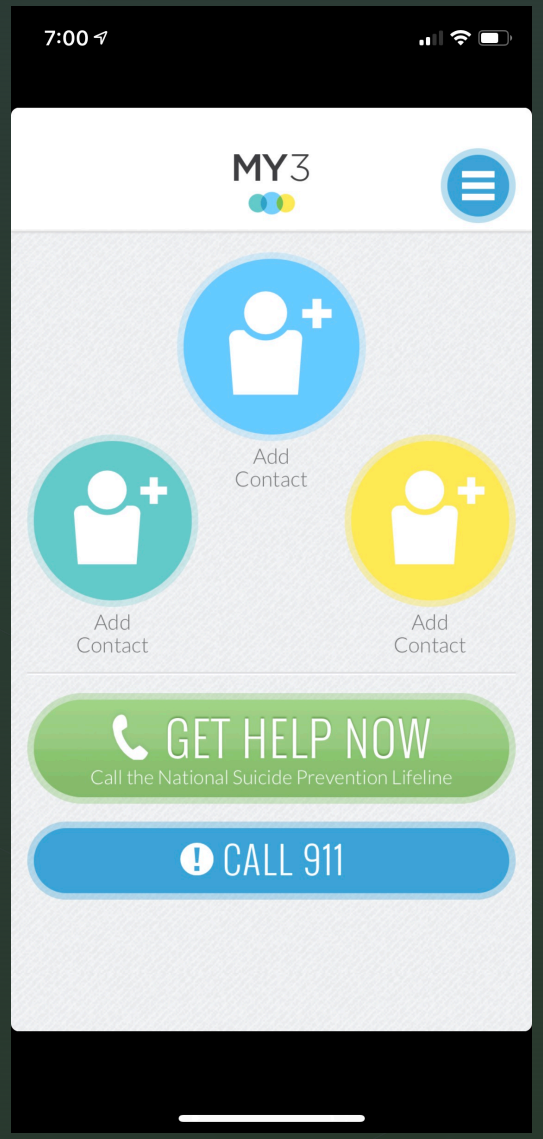
Hold all your resources in the palm of your hand. Whether you're a veteran, want support from your local community, or want to learn more about suicide prevention, pick the resources that best support you.

Get support at times of greatest risk.

When you're having thoughts of suicide and it feels like there's no hope in sight, find support at your fingertips at any time of the day.

Access the National Suicide Prevention Lifeline 24/7.

A trained counselor from a crisis center near you can be reached 24 hours a day, 7 days a week. Anyone can call, whether you're concerned for yourself or someone else. If you need someone to talk to, the National Suicide Prevention Lifeline is always ready for the call.



Virtual Hope Box

Manipulation

- Some suicidal statements and/or behaviors are labeled “manipulation”
- In forensic and correctional settings manipulation is generally seen as “bad” behavior and the language and/or behavior is often dismissed, punished, and/or ignored
- There is no evidence that “manipulative” clients are less at risk of self-injury than those who are so labeled
- A functional approach may be more helpful and lead to a close examination of antecedents and contingencies that in turn may lead to successful interventions to reduce the so-called manipulative behavior

Cultural Issues in risk assessment

- Suicide deaths vary by racial/ethnic groups
  - African-American and Hispanic rates are lower than Caucasian rates
  - Native American rates are very high for the young but then subside
  - Rates vary by age group, gender, and acculturation
- Cultural beliefs and attitudes about suicide vary widely
- Spirituality and religious beliefs can be both a buffer and a risk factor
- Sensitivity to cultural issues can remove barriers, can improve access to resources and generally improve quality of care

Race/Ethnic Suicide Rates by Age Group, California, 2008-2017