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Suicide Prevention in Health Care Systems:
Debunking Myths on the Road to Zero Suicide

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Sponsored by: Minnesota Department of Health

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OBJECTIVES

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- Understand limitations and purposes of assessing and formulating suicide risk
- List and correct generally held false beliefs about the assessment of high or imminent risk
- List and correct generally held false beliefs about scales to assess suicide risk
- Revise thinking about how and why to formulate risk for suicide

2

Suicide Risk Assessment (SRA)
Suicide Risk Formulation (SRF)

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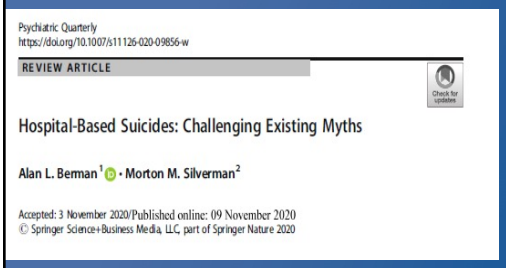

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REVIEW ARTICLE

Hospital-Based Suicides: Challenging Existing Myths

Alan L. Berman[1] · Morton M. Silverman[2]

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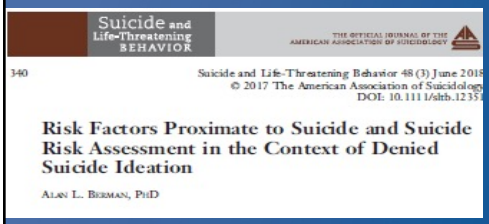

Suicide and Life-Threatening BEHAVIOR

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Suicide and Life-Threatening Behavior 48 (3) June 2018
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Risk Factors Proximate to Suicide and Suicide Risk Assessment in the Context of Denied Suicide Ideation

Alan L. Berman, PhD

Suicide and Life-Threatening BEHAVIOR

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Suicide and Life-Threatening Behavior 44 (4) August 2014
© 2013 The American Association of Suicidology
DOI: 10.1111/sltb.12067

Suicide Risk Assessment and Risk Formulation Part II: Suicide Risk Formulation and the Determination of Levels of Risk

Alan L. Berman, PhD, and Morton M. Silverman, MD

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Assess, Intervene, and Monitor for Suicide Prevention (A-I-M) Clinical Model

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ASSESS → **INTERVENE** & **MONITOR**

Screening with the C-SSRS

Comprehensive Suicide Risk Assessment

Clinical Formulation & Triage

Level of Care Determination
Is the client appropriate for outpatient care?

Risk Level Determination
High – Moderate – Low

AT-RISK PROTOCOL

Entry: *Suicidal ideation with intent or plan or suicidal behavior in the past 90 days* **–OR–** *Clinical judgment*
Exit: *No ideation with intent or plan and no suicidal behavior for 90 days* **–OR–** *clinical judgment*

Take immediate action to ensure safety	**Screen *every* session**
Psychoeducation	**Maintain *weekly* appointments**
Stanley-Brown Safety Plan *(with means restriction and crisis information)*	**Phone contact after missed appointments** to ensure safety and continuity of care
Increase clinical contact	**Session within 72 hours of discharge** from the ED or inpatient unit
Treatment plan that reduces risk factors and enhances protective factors	**Re-screen *at least* quarterly** at treatment plan review or as clinically indicated
Long-term interventions to address symptoms, including suicide-specific treatments if available	
Provide crisis information, including after hours numbers, LIFELINE, & local ED/CPEP	

High Risk: At risk protocol is ***mandatory***
Moderate Risk: At risk protocol is ***strongly suggested***
Low Risk: Treatment as usual, with additional suicide-specific procedures as indicated

Note: Items in white represent procedures for all patients, and items in grey represent enhanced care for at-risk patients.

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Can You Identify the Following?

- 1 lb. beef sirloin, cut into 1/4
- 1 tablespoon flour
- 1/2 teaspoon salt & pepper (or to taste)
- 2 tablespoons butter
- 1 (3 ounce) can mushrooms, sliced, drained
- 1/2 cup onion, thinly sliced, then cut slices in half
- 1/2 teaspoon garlic powder
- 2 tablespoons butter
- 3 tablespoons all-purpose flour
- 1 (10 1/2 ounce) can beef broth
- 1 cup sour cream

5

Suicide Risk Assessment (SRA) Suicide Risk Formulation (SRF)

The relationship between a suicide risk assessment (SRA) and a suicide risk formulation (SRF) is analogous to the relationship between a list of ingredients and a recipe. A recipe informs the cook of what ingredients get mixed with what other ingredients and in what order, at what temperature the mixture gets cooked, and for how long. Unto itself, the list of ingredients fails to inform the individual of how the ingredients in the dish are to be combined and to comprise the desired final dish.

6

Standard of Care

- …generally defined as a duty to exercise that degree of skill and care ordinarily employed by a reasonable and prudent clinician in similar circumstances by members of the same profession, requires that the mental health professional recognizes the possibility that a patient has risk of suicidal behavior and to be foreseeable of that possibility.

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Commonly Held False Belief #1

- Our understanding of people at risk of suicide (hence, risk factors for suicide) is based on studies of people who have died by suicide.

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Commonly Held False Belief #1

- Our understanding of people at risk of suicide (hence, risk factors for suicide) is based on studies of people who have died by suicide.
- Death by suicide is rarely the outcome studied in follow-up research, in contrast to outcomes of repeat SI or suicide attempts. As reported by Franklin (J. Franklin, personal communication, March 25, 2016), "putting this in the context of all prediction cases for all suicide-related outcomes, [deaths by suicide] accounted for about 0.4% of cases."

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Are Studies of Suicide Attempters Reasonable Proxies for Studies of Suicidal Decedents?

Suicide Attempters	Suicide Decedents
More Female	More Male
Younger	Older
Method: Ingestion	Method: Firearm/Hanging
Lesser / Varying Lethality	Lethal
Varying Intent	High Intent
Stronger Assoc'n w/ SI	Lesser Assoc'n w/ SI
More Impulsive	More Planned
More Anxiety	More Psychoses
More Repeat SA	More 1st SA

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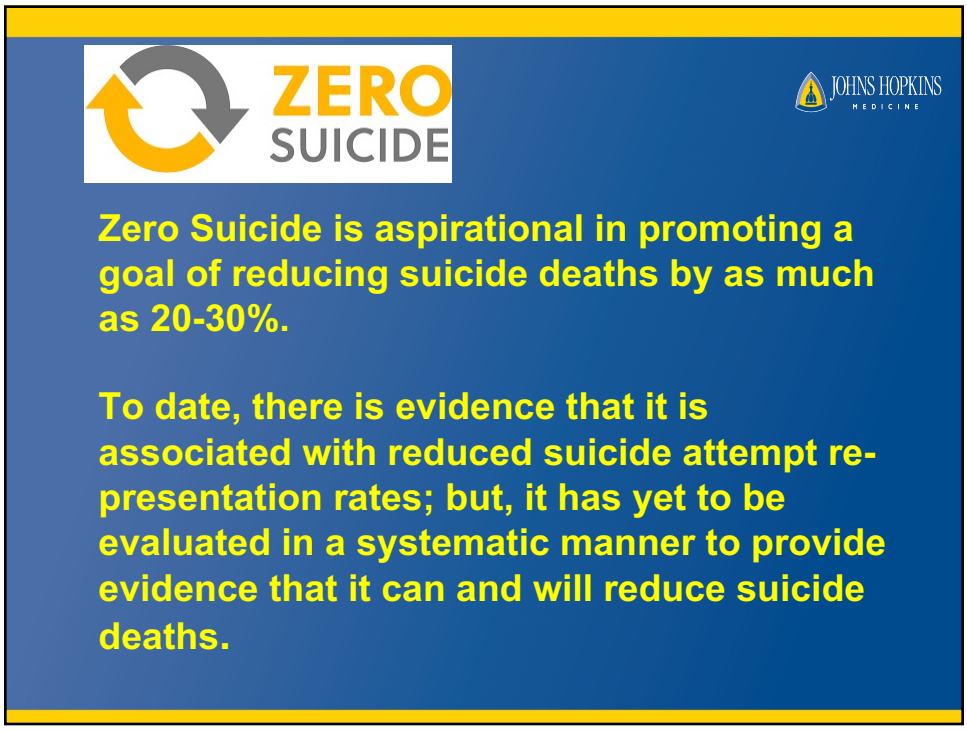
ZERO
SUICIDE
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Zero Suicide is aspirational in promoting a goal of reducing suicide deaths by as much as 20-30%.
To date, there is evidence that it is associated with reduced suicide attempt re-presentation rates; but, it has yet to be evaluated in a systematic manner to provide evidence that it can and will reduce suicide deaths.

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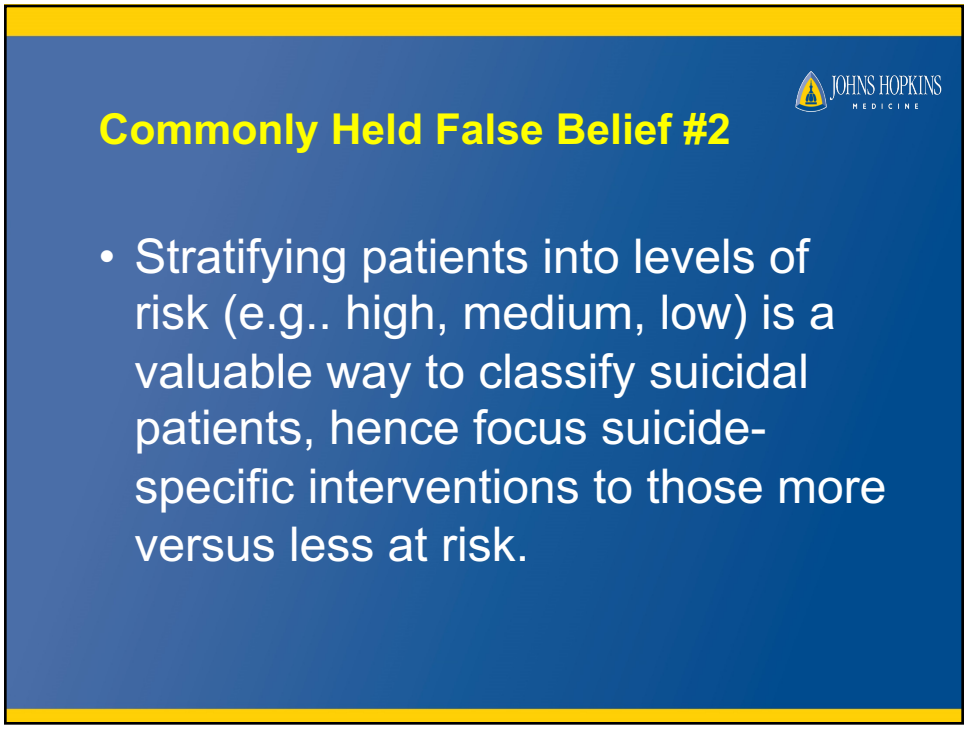
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Commonly Held False Belief #2
• Stratifying patients into levels of risk (e.g.. high, medium, low) is a valuable way to classify suicidal patients, hence focus suicide-specific interventions to those more versus less at risk.

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Commonly Held False Belief #2

- Stratifying patients into levels of risk (e.g.. high, medium, low) is a valuable way to classify suicidal patients, hence focus suicide-specific interventions to those more versus less at risk.

- Models and strategies for making judgments of levels of risk have been proposed, but there is no research that has specifically examined the relative validity of any of these schemas, no less the process and outcome of clinical decision-making that is intended to result from an assignment of a level of risk.
  - Simon (2011)

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Commonly Held False Belief #2

- Stratifying patients into levels of risk (e.g.. high, medium, low) is a valuable way to classify suicidal patients, hence focus suicide-specific interventions to those more versus less at risk.

- Two meta-analyses found that 5% of high risk patients will die by suicide in the long term.
- Almost half of all patients who die by suicide come from lower risk strata, indicating a low sensitivity in high risk status.

  No high risk determination, whether based on a model that integrated multiple risk factors or a suicide risk scale was strongly associated with later death by suicide.

  - Large MM, Ryan CJ, Carter G, Kapur N. Can we usefully stratify patients according to suicide risk? BMJ. 2017 Oct 17;359:j4627. doi: 10.1136/bmj.j4627.

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Commonly Held False Belief #2

Stratifying patients into levels of risk (e.g.. high, medium, low) is a valuable way to classify suicidal patients, hence focus suicide-specific interventions to those more versus less at risk.

- While risk assessments do generate some information about future suicide, suicide risk categorization results in an unacceptably high false positive rate, misses many fatalities, and therefore, is unable to usefully guide prevention strategies. The assessment of suicidal patients should focus on contemporaneous factors and the needs of the patient, rather than probabilistic notions of suicide risk.
  - Large MM. The role of prediction in suicide prevention. Dialogues Clin Neurosci. 2018 Sep;20(3):197-205.

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Commonly Held False Belief #3

The purpose of screening and assessing for suicide risk is to ascertain those patients who are at high risk for death by suicide, hence most likely to die by suicide were no clinical intervention to occur.

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Commonly Held False Belief #3

The purpose of screening and assessing for suicide risk is to ascertain those patients who are at high risk for death by suicide, hence most likely to die by suicide in the immediate future were no clinical intervention to occur.

- Purpose is not predictive of future behavior; Purpose is to ascertain targets for treatment/intervention.
  - (Pisani et al, 2016. Reformulating Suicide Risk Formulation: From Prediction to Prevention)

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Foresee v. Predict

http://freakonomics.com/2008/04/21/how-valid-are-tv-weather-forecasts/

- Four KC TV forecasters and NOAA – 7 months' study
- Excluding days when there clearly was 0% chance of rain, how accurate were predictions of a 50% chance or higher ("more likely than not") of precipitation?
  - At 2 days - all were wrong more than ½ the time
  - At 3 days - correct forecasts averaged about 30%
  - At 7 days - correct forecasts averaged about 10%

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Commonly Held False Belief #3

The purpose of screening and assessing for suicide risk is to ascertain those patients who are at high risk for death by suicide, hence most likely to die by suicide were no clinical intervention to occur.

- **…at last contact, the therapist assessed no suicide risk in 30% and low risk in 54% of patients who then died by suicide.**
  - (Appleby et al., 2012; Appleby, Shaw, & Amos, 1999)

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Commonly Held False Belief #3

The purpose of screening and assessing for suicide risk is to ascertain those patients who are at high risk for death by suicide, hence most likely to die by suicide were no clinical intervention to occur.

…this risk stratification approach is not sufficiently accurate for clinical use. A "high-risk" classification will identify around only half of the future suicides, while the other half of the suicides will occur in the "low-risk" classification and a "high-risk" classification will be incorrect about 95% of the time

Berman AL, Carter G. Technological Advances and the Future of Suicide Prevention: Ethical, Legal, and Empirical Challenges. Suicide Life Threat Behav. 2020 Jun;50(3):643-651. doi: 10.1111/sltb.12610.

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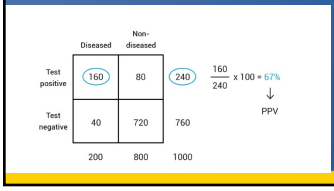
Commonly Held False Belief #3

The purpose of screening and assessing for suicide risk is to ascertain those patients who are at high risk for death by suicide, hence most likely to die by suicide were no clinical intervention to occur.

The positive predictive value of risk categorization among six cohort studies was 0.43% (95% CI 0.014-1.3%, I2 = 95.9%).

Large M, Myles N, Myles H, Corderoy A, Weiser M, Davidson M, Ryan CJ. (2018)



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Commonly Held False Belief #3

The purpose of screening and assessing for suicide risk is to ascertain those patients who are at high risk for death by suicide, hence most likely to die by suicide were no clinical intervention to occur.

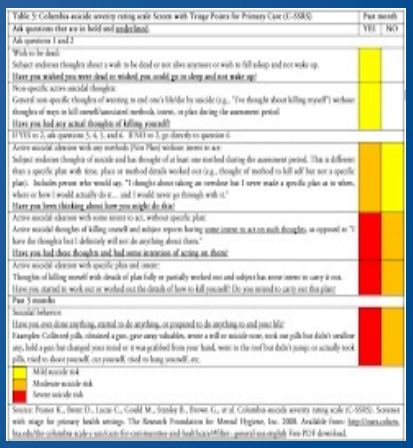
For third-party payers, this is an attractive cost reduction approach. However, we would consider it unethical to restrict service for 95% of a clinical population who will account for half of the suicides, while allocating service to only 5% of a clinical population with essentially the same likelihood of suicide as the whole population.

Berman AL, Carter G. Technological Advances and the Future of Suicide Prevention: Ethical, Legal, and Empirical Challenges. Suicide Life Threat Behav. 2020 Jun;50(3):643-651. doi: 10.1111/sltb.12610.

22

Commonly Held-False Belief #4

Widely used suicide screening scales such as the C-SSRS are validated and reliable scales for predicting patients most at risk of suicide and have clinical value in screening patients most at risk.



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Commonly Held-False Belief #4

Widely used suicide screening scales such as the C-SSRS or the PHQ9 are validated and reliable scales for predicting patients most at risk of suicide and have clinical value in screening patients most at risk.

People who died by suicide were substantially more likely to have screened negative than positive. Of the 11 ED patients who died by suicide within 30 days of discharge, 9 (81%) screened negative on the C-SSRS.

[Simpson et al (in press), Academic Emergency Med].

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Commonly Held-False Belief #4

Widely used suicide screening scales such as the C-SSRS or the PHQ9 are validated and reliable scales for predicting patients most at risk of suicide and have clinical value in screening patients most at risk.

In a 6-month follow-up study, the C-SSRS total score was not better than chance in classifying suicide. The intensity of SI has been shown to predict nonfatal suicide attempts rather than suicides.

(Lindh et al, J Clin Psychiatry, 2019).

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Commonly Held-False Belief #4

Widely used suicide screening scales such as the C-SSRS or the PHQ9 are validated and reliable scales for predicting patients most at risk of suicide and have clinical value in screening patients most at risk.

In a recently published Swedish study of more than 18,000 patients seen for psychiatric assessment, the C-SSRS Screen cut-off score correctly identified seven of the 13 patients who died by suicide in the following 7 days, but the Screen produced 99% false positives, each and every one of whom would compel clinicians to make disposition decisions for hospitalization which, in turn, was not found to be protective.

(Bjureberg et al, Psychological Medicine, 2021)

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Commonly Held-False Belief #5

It is important to ask patients about thoughts of suicide because research has shown that this question is best at ascertaining those patients in clinical care who are most likely to be imminently at risk of dying by suicide.

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A Few Simple Questions to Save A Life: Identify Who Needs Help and Connect Them to Care

Minimum of 2 Questions — Maximum of 6 Questions

COLUMBIA-SUICIDE SEVERITY RATING SCALE
Screen Version - Recent

SUICIDE IDEATION DEFINITIONS AND PROMPTS	Past month YES	NO
Ask questions that are bolded and underlined.		
Ask Questions 1 and 2		
1) Wish to be Dead: *Have you wished you were dead or wished you could go to sleep and not wake up?*		
2) Suicidal Thoughts: *Have you actually had any thoughts of killing yourself?*		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): E.g. *"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."* *Have you been thinking about how you might do this?*		
4) Suicidal Intent (without Specific Plan): As opposed to *"I have the thoughts but I definitely will not do anything about them."* *Have you had these thoughts and had some intention of acting on them?*		
5) Suicide Intent with Specific Plan: *Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*		

6) Suicide Behavior Question: *Have you ever done anything, started to do anything, or prepared to do anything to end your life?* 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. **If YES, ask:** *Was this within the past three months?*	YES	NO

If 2 is Yes, ask 3-6

If 2 is No, go to 6

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Commonly Held-False Belief #5

It is important to ask patients about thoughts of suicide because research has shown that this question is best at ascertaining those patients in clinical care who are most likely to be imminently at risk of dying by suicide.

More than a dozen studies have found that the majority of patients who die by suicide **deny** having suicidal thoughts when last asked prior to their death and/or communicate their risk only in more behavioral (versus verbal) messaging.

(Appleby et al, 1999; Barraclough et al, 1974; Berman, 2018; Busch et al., 2003; Chavan et al, 2008; DeLong & Robins, 1961; Denneson et al., 2010; Hall et al, 1999; Hjelmeland, 1996; Isometsa et al., 1995; McKelve yet al, 1998; Smith et al., 2013).

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Commonly Held-False Belief #5

It is important to ask patients about thoughts of suicide because research has shown that this question is best at ascertaining those patients in clinical care who are most likely to be imminently at risk of dying by suicide

Prior SI was charted more frequently (71%) than current SI immediately prior to death by suicide (27%).

Assess ***the severity of past SI at the worst point in a patient's life*** as a crucial predictor of later suicide (Beck et al, 1999).

Given the frequency with which SI is denied immediately preceding death by suicide, a singular focus on SI as a marker of increased near-term risk or as a necessary gateway to further suicide risk assessment appears misguided.

Berman AL. (2018)

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Commonly Held-False Belief #6

A history of suicide attempt is even better at establishing risk of suicide than is current SI.

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Commonly Held-False Belief #6

A history of suicide attempt is even better at establishing risk of suicide than is current SI.

A history of suicide attempt is, perhaps, our most robust risk factor for later attempt, but

Most individuals who die by suicide do so on their first attempt!

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Commonly Held-False Belief #6

A history of suicide attempt is even better at establishing risk of suicide than is current SI.

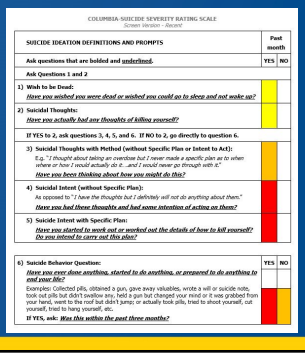
To the extent to which suicidal ideation and behaviors are conceptualized as risk factors, patients with either of these phenomena are more or less equal but at only modestly increased risk of suicide. Patients with suicidal ideation only should not be dismissed as not having suicidal behavior and there is no strong reason why people with suicidal behaviors should receive more restrictive mental health care than those with suicidal ideation only.

Large M, Corderoy A, McHugh C. (2020) Aust N Z J Psychiatry

33

Commonly Held-False Belief #7

A patient expressing active suicide ideation is at greater risk of future suicide than one expressing passive SI.



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Screen Version - Recent

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5) Suicide Intent with Specific Plan: *Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*		

6) Suicide Behavior Question:	YES	NO
Have you ever done anything, started to do anything, or prepared to do anything to end your life? 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.		
If YES, ask: *Was this within the past three months?*		

34

Commonly Held-False Belief #7

A patient expressing active suicide ideation is at greater risk of future suicide than one expressing passive SI.

The scaling of active SI as more predictive of suicide risk than passive SI is questioned by the current data in that nearly equal proportions of active versus passive SI were expressed by decedents who admitted to SI when last asked (Berman, 2018) , and by a number of similar reports (Baca-Garcia et al., **2011**) .

Active SI appears to be no more associated with death by suicide than is passive SI (Simon, **2008**; Silverman & Berman, **2014**; Szanto et al., **1996**).

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Commonly Held-False Belief #8

It is important to assess protective factors against suicide to achieve a balanced assessment of suicide risk.

Table 2 – Risk and protective factors for suicide

Risk factors	Protective factors
• Mental illness • Previous suicide attempt • Serious physical illness/chronic pain • Specific symptoms • Family history of mental illness and suicide • History of childhood trauma • Shame/despair • Aggression/impulsivity • Triggering event • Access to lethal means • Suicide exposure • Inflexible thinking • Genes: stress and mood	• Social support • Connectedness • Strong therapeutic alliance • Access to mental health care • Positive attitude to mental health treatment • Coping skills • Problem solving skills • Cultural/religious beliefs • Biological/psychological resilience

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Commonly Held-False Belief #8

It is important to assess protective factors against suicide to achieve a balanced assessment of suicide risk.

There is no evidence base to support these factors as mitigating or buffering risk for suicide for the individual patient, especially in the near-term assessment of that suicide risk. ***Evidence-based protective factors derive from population-based studies*** *and, applicably, have relevance to public health promotion/primary prevention and are significant in informing treatment/secondary prevention, but they* ***lack evidence to support their often-proposed role in mitigating or buffering risk for suicide on an individual basis****,* ***especially when applied to the assessment of near-term risk of suicide****.*

Berman AL, Silverman MM. Near Term Suicide Risk Assessment: A Commentary on the Clinical Relevance of Protective Factors. Arch Suicide Res. 2020;24(sup2):S370-S380. doi: 10.1080/13811118.2019.1612804.

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Protective Factors Balance Chronic Risk

- Protective Factors Do Not, (note to self, repeat this), ***DO NOT*** Protect if there is Acute Risk.
  - Married folks kill themselves
  - Married folks with children kill themselves
  - Priests and rabbis kill themselves
  - Parents looking forward to their daughter's wedding kill themselves
  - Psychotherapists kill themselves
  - People with easy access to clinical care kill themselves

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UNLESS

- Suicide-related coping, defined as, "knowledge of and perceived self-efficacy in using internal coping strategies and external resources to manage suicidal thoughts with the goal of decreasing imminent risk and averting suicidal crises" (Stanley et al, 2017,, p. 190).
- Examples: engaging in distracting activities, seeking social and professional support, limiting access to lethal means.
- Individuals who reported some ***ability to control their suicidal thoughts*** were less likely to make a first suicide attempt.

(Nock et al., 2018)

Current results show that participants at high-risk for suicide were less likely to experience a suicidal event within 90 days if they endorsed greater ability to use suicide-related coping.

(Interian et al, 2019)

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…or Means Restriction

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Commonly Held-False Belief # 9

Hospitalization, whether voluntary or involuntary, effectively protects patients against suicide during inpatient care and after discharge.

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Commonly Held-False Belief # 9

Hospitalization, whether voluntary or involuntary, effectively protects patients against suicide.

The first week and first month post-discharge following psychiatric hospitalization are periods of extraordinary suicide risk. One-week post-discharge suicide rates were approximately 3000 suicides per 100 000 person years while 1-month rates were approximately 2000 per 100 000 person years. Short-term follow-up of discharged patients should be augmented with greater focus on safe transition from hospital to community care.

Chung D, Hadzi-Pavlovic D, Wang M, Swaraj S, Olfson M, Large M. Meta-analysis of suicide rates in the first week and the first month after psychiatric hospitalisation. BMJ Open. 2019 Mar 23;9(3):e023883. doi: 10.1136/bmjopen-2018-023883.

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Commonly Held-False Belief # 9

Hospitalization, whether voluntary or involuntary, effectively protects patients against suicide.

Knesper et al. (2010) noted that they "could not identify a single randomized trial about the effectiveness of hospitalization in reducing suicide acts after discharge" (p. 41).

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Commonly Held-False Belief #10

- A reasonable criterion for inpatient teams to use to decide to discharge a patient admitted for SI or a suicide attempt is 24 to 48 hours of no reported SI.

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Commonly Held-False Belief #10

- A reasonable criterion for inpatient teams to use to decide to discharge a patient admitted for SI or a suicide attempt is 24 to 48 hours of no reported SI.
- The combined proportion of inpatients in these studies (Isometsä et al, 1995; Busch et al, 2003; Berman, 2018) who denied SI when last asked prior to their deaths by suicide was 73.3% (148/202).
- SI has been shown to be episodic, with quick onset and short duration (Kleiman & Nock, 2019), so it may well be not present today, but present tomorrow.

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Bottom Lines

- Zero Suicide will succeed because clinicians are TRAINED to understand a suicidal patient, based on vulnerability and signs of acute risk; do not rely on either communicated SI or scales to assess that risk; do not overvalue protective factors; and formulate risk for the purpose of designing needed interventions.

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Formulating Risk: SWM, Age 21:

History of depression x 5 months. Sxs of anxiety, including insomnia. Currently depressed mood, anhedonia, social anxiety, dramatic mood swings. No SI. Recent increase in ETOH, binge drinking.

Two year hx of Adderall abuse; during abuse, increased aggression, ideas of reference, delusions and hallucinations -- felt he was "an evil presence," lost relationships. Went cold turkey x 2 months; Feels intense guilt; increased hopelessness, fears he will not be forgiven for abusing friends. Increased mood swings, symptoms of paranoia. Has family hx of depression and schizophrenia.

Level of Risk	Chronic Risk	Acute Risk
Low		
Moderate	•Comorbid Dxs: brief substance induced psychotic disorder; MDD •Family Hx Depr/Schiz	• Anxiety •Insomnia •Dramatic mood swings •Guilt/paranoia •Increased ETOH •anhedonia
High		

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Questions:
drlannyberman@gmail.com

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