Advancing Suicide Prevention and Clinical Management for Diverse Clientele

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Before we start
Please do the following:

1. Fill out your pre-training survey: www.bit.ly/ClinicianPre

2. Read the case description for today: “Zoe”
   (the first page in your folders)

3. What are your struggles or questions about suicide?
   Write 1 (anonymous) question /
   comment on your index card and turn it in
Suicide
A Growing Problem

- Rates have spiked in the past 15 years
- 24% increase in rates from 1999 - 2016
Santa Clara County, 2016 Medical Examiner Data

Suicide rates declining in SCC in recent years.

Overall Suicide Rates

2012 - 2016 Suicides in Santa Clara County: Overview

Source: U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates
Source: U.S. Census Bureau, 2011-2015 American Community Survey 5-Year Estimates
Source: U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates
Source: U.S. Census Bureau, 2009-2013 5-Year American Community Survey
Source: U.S. Census Bureau, 2008-2012 American Community Survey
The outcome of our efforts is hard to measure.

How do know when a life saved was a life saved?
Suicide Can’t Be 100% Predicted, But It Can Be *Prevented*
Liability and Legal Considerations

1. Follow standards of practice
   This includes consultation

2. Common issues in clinical practice
   • Inadequacies in assessment (failure to screen or assess, inappropriate or incomplete assessment)
     • Failure to incorporate available information into assessment
   • Did not disclose or warn others (about suicide risk, to maintain safety)
   • Failure to commit, confine, or negligent release of patient
     • Inadequate discharge or follow-up plan

3. Inadequate documentation
7/1/19: Joint Commission’s Revised National Patient Safety Goal 15.01.0-1

• For hospitals and behavioral health care organizations

• Focuses on:
  • Environmental assessment
  • Screening for suicide
  • Assessment of patients who screen positive for suicide
  • Staff training
  • Follow-up care
### NPSG.15.01.01
Reduce the risk for suicide.

---Rationale for NPSG.15.01.01--
Suicide of an individual served while in a staffed, round-the-clock care setting is a frequently reported type of sentinel event. Identification of individuals at risk for suicide while under the care of or following discharge from a health care organization is an important step in protecting these at-risk individuals.

**Elements of Performance for NPSG.15.01.01**

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<table>
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<tr>
<td>1.</td>
<td>The organization conducts an environmental risk assessment that identifies features in the physical environment that could be used to attempt suicide and takes necessary action to minimize the risk(s) (for example, removal of anchor points, door hinges, and hooks that can be used for hanging). Note: Noninpatient behavioral health care settings and unlocked inpatient units do not need to be ligature resistant. The expectation for these settings is to conduct a risk assessment to identify potential environmental hazards to individuals served, identify individuals who are at high risk for suicide, and take action to safeguard these individuals from the environmental risks (for example, continuous monitoring in a safe location while awaiting transfer to higher level of care and removing objects from the room that can be used for self-harm).</td>
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<td>2.</td>
<td>Screen all individuals served for suicidal ideation using a validated screening tool.</td>
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<td>3.</td>
<td>Use an evidence-based process to conduct a suicide assessment of individuals served who have screened positive for suicidal ideation. The assessment directly asks about suicidal ideation, plan, intent, suicidal or self-harm behaviors, risk factors, and protective factors. Note: EPs 2 and 3 can be satisfied through the use of a single process or instrument that simultaneously screens individuals served for suicidal ideation and assesses the severity of suicidal ideation.</td>
</tr>
<tr>
<td>4.</td>
<td>Document individuals' overall level of risk for suicide and the plan to mitigate the risk for suicide.</td>
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| 5. | Follow written policies and procedures addressing the care of individuals served identified as at risk for suicide. At a minimum, these should include the following:  
- Training and competence assessment of staff who care for individuals served at risk for suicide  
- Guidelines for reassessment  
- Monitoring individuals served who are at high risk for suicide |
| 6. | Follow written policies and procedures for counseling and follow-up care at discharge for individuals served identified as at risk for suicide. |
| 7. | Monitor implementation and effectiveness of policies and procedures for screening, assessment, and management of individuals served at risk for suicide and take action as needed to improve compliance. |

[https://www.jointcommission.org/assets/1/6/NPSG_Chapter_BHC_Jan2020.pdf](https://www.jointcommission.org/assets/1/6/NPSG_Chapter_BHC_Jan2020.pdf)
Key take-homes: A process, a framework, and a model walk into a bar...

- **Our PROCESS** of suicide risk assessment and management - 5 stages or steps that also provide our structure and flow for the day.

- **Our FRAMEWORK** for thorough assessment and conceptualization - the organization of risk and protective factors into static vs. dynamic elements.

- **Our MODEL** of culturally informed suicide risk - factors impacting risk across or within groups that provide content to use with the framework.
Suggested OVERALL Suicide Assessment & Management Process

1. Screening & Re-screening  
   (Inclusive of Direct Suicide Inquiry)
2. Thorough Assessment of Risk & Protective Profile
3. Determine Current Level of Suicide Risk
4. Crisis Response, Safety, or Treatment Plan
5. Suicide Risk Documentation
Suicide Risk Screening I

Measurement of Ideation, Intent, Plans & Means
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   (Inclusive of Direct Suicide Inquiry)
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3. Determine Current Level of Suicide Risk
4. Crisis Response, Safety, or Treatment Plan
5. Suicide Risk Documentation
1. Directly Inquire about Suicide

*Keep in mind: CASE Approach Strategies*

### IDEATION
Frequency, intensity, duration of current ideation
Cultural Variations in experience/expression

**Example questions:**
- Do you think dying would be better than living?
- A lead-in question: How bad is it and how much more can you take?
- Do you have thoughts of suicide?
- Have you have thoughts about ending your life?
- When someone feels very upset, they may have thoughts that life just isn’t worth living. Have you ever had these thoughts?
- Are you wanting to give your life away?
- Have you ever had thoughts you might be better off dead?
- In the last 2 weeks, how many times did you think of killing yourself?
- I appreciate how difficult this problem must be for you at this time. Some of my patients with similar problems/symptoms have told me that they have thought about ending their life. I wonder if you have had similar thoughts?

**Cultural Variations**
- Have you ever wanted to give your life away?
- Have you ever felt your loved ones would be better off without you?
- Have you ever felt no one would care if you weren’t around anymore?
- Have you ever felt you don’t deserve to be alive?
- Have you felt so ashamed that you wanted to disappear?
- Have you ever felt your time on this earth is done?
- Have you felt this world has rejected you and it’s time to leave?
- Have you ever wished someone else would just end your life?

### INTENT
Explicitness

**Example questions**
- How much do you want to die?
- How likely is it that you’d act on your thoughts of wanting to die?
- How serious are you about killing yourself?
- How hopeless do you feel about the future - that things will not get better?
- When you think about suicide, does it comfort you or does it freak you out?

### PLAN, MEANS
Specificity and lethality of plan, Availability of means, Rehearsal, Intersection of impulsivity with access
- Isolation, timing, precautions against discovery, acts to gain help, final acts of preparation, suicide note

**Example questions**
- When did you have these thoughts and do you have a plan to take your life?
- If you were to hurt yourself / attempt suicide, have you thought about how would you do it?
- Have you ever attempted suicide?
- Have you, at any time in your life, ever done anything that anyone could possibly have interpreted as self-destructive or even suicidal?
- Do you think about where you would hurt or kill yourself? Is it a place where if you tried it, there’s a pretty good chance somebody would stop you?
- Do you think about specific times when you would kill yourself?
Strategies for Direct Inquiry: Validity techniques from the CASE approach

Normalization
”Sometimes when people are in a tremendous amount of pain, they find themselves having thoughts of killing themselves”

Shame Attenuation
“With all of your pain, have you been having any thoughts of killing yourself?” (like normalization, but no mention of other people - use client’s own pain as an opener)

Behavioral Incidents
“How many pills did you take?” (ask for specific facts, behavioral details, thoughts)

Gentle Assumption
“What other ways have you thought about killing yourself?” (assume embarrassment, and ask gently)

[It’s hard to] Deny the Specific
“Have you thought of hanging yourself?”

Catch-All Question
“We’ve been talking about different ways you’ve been thinking of killing yourself. Are there any ways you’ve thought about that we haven’t talked about?”

Symptom Amplification
“On the days when your suicidal thoughts are the most intense, how much of the day do you spend thinking about killing yourself...10 hours a day, 14 hours a day, 18 hours a day?” (bypass the tendency to minimize)

Suicide Risk Screening II

Suicide Risk Screening as a Process
What is screening?

• Sensitivity over specificity
  • Increased false positives in the hopes of no false negatives

• For identifying, not for intervening.

• Need to cast a wide-enough net!
Patching holes in your net...

• Example 1
  • I KNOW: I have really never thought about harming myself except very passively during a stressful period more than 10 years ago.
  • YOU ASK: Any recent thoughts about harming yourself?
  • MY ANSWER: ??

• Example 2
  • I KNOW: I constantly think about harming myself but am very aware that I haven’t thought about it for the past three weeks, my longest period ever.
  • YOU ASK: Any recent thoughts about harming yourself?
  • MY ANSWER: ??
Patching holes in your net...

• Example 1
  • I KNOW: I have really never thought about harming myself except very passively during a stressful period more than 10 years ago.
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  • MY ANSWER: ??
Whom do we screen?
When do we screen?

- Initial/intake
- Routinely
- As indicated...
As indicated?

• Rescreen when...
  
  • New or changing info about risk factors
    • Accelerants: hopelessness, psychological pain, recent crises, substance abuse, insomnia, etc
  
  • New diagnostic impressions associated with increased risk
    • Bipolar I, MDD, Schizophrenia, Borderline PD, PTSD, etc.
  
  • Cultural meanings of suicide and life events
    • Info about cultural acceptability of suicide, and of suicide as an acceptable response to certain life events?
Screening *process* must...

- Catch all true positives
- Appropriately funnel...
  - ...imminent cases to emergency intervention.
  - ...non-imminent risk to more complete evaluation.
- Filter out false positives and true negatives
- Plan for re-screening
Suicide risk screening:
A sample screening procedure

**EVERYONE:**
Recent ideation, intent, plans & means via clinical interview AND p&p form

- Not No*
  - Are these current?
    - Not No
      - Are these imminent?
        - Not No
          - Emergency Management Until Stabilization
        - No
          - Thorough & Ongoing Culturally Informed Suicide Risk Assessment + Augmented Tx and Ongoing Management
      - No
        - No
  - No
  - Lifetime ideation intent, plans & means via clinical interview AND p&p form
    - Not No
      - Services as Usual + Repeat Screen Routinely and As Indicated

*Thinking of this as a “yes” inserts a loophole - anyone in the middle between definitive ends
Suicide Risk Screening: Key Points

• Screening is a process, not an item or a question

• Keep your net broad (recent + lifetime, interview + p&b, “Not no”)

• IIPM is only screening.

• Only absolute “no IIPM” patients skip thorough assessment

• You can and should change my examples…
Suicide risk screening: An example alteration you may make

EVERYONE:
Recent ideation, intent, plans & means via clinical interview AND p&p form

Not No*

Lifetime ideation intent, plans & means via clinical interview AND p&p form

Not No

Are these current?

Not No

Are these imminent?

Not No

No

Not No*

Thorough & Ongoing Suicide Risk Assessment + Augmented Tx and Ongoing Management

Not Yes

Emergency Management Until Stabilization

Services as Usual + Repeat Screen Routinely and As Indicated

Not No

*Thinking of this as a “yes” inserts a loophole - anyone in the middle between definitive ends
Suicide risk screening: A more complex version

EVERYONE:
Recent ideation via clinical interview and p&p form

*Not No

No

Lifetime ideation via clinical interview and p&p form

Not No

No

Recent Intent, Plans, Means?

Not No

No

Are these current AND imminent?

Not No

No

Thorough Suicide Risk Assessment to Inform Ongoing Management

Not No

No

Emergency Management Until Stabilization

Repeat Routinely and as indicated

*Not No

No

No

Not No

Not No

*Thinking of this as a “yes” inserts a loophole - anyone in the middle between definitive ends
Suicide risk screening: An “unlimited resources” version

EVERYONE:
Interview and p&p IIPM + Thorough Suicide Risk Factors

Are these current?  Not No

Are these imminent?  Not No

Ongoing Suicide Risk Assessment + Augmented Tx and Ongoing Management

Emergency Management Until Stabilization

Not No

Not No

Not No

*Thinking of this as a “yes” inserts a loophole - anyone in the middle between definitive ends
So what is the role of risk instruments?

• Specific Examples:
  • Columbia Suicide Severity Rating Scale measures (cssrs.Columbia.edu)
  • Ask Suicide-Screening Questions (ASQ) from NIMH
  • Suicide Assessment Five-step Evaluation & Triage (SAFE-T) from SAMHSA
  • Suicide Behavioral Questionnaire Revised
  • Scale for Suicidal Ideation-Worst
  • Adult Suicidal Ideation Q’aire (ASIQ)
  • Firestone Assessments of Self-Destructive Thoughts (FAST) and Suicidal Intent (FASI)
  • Beck Suicide Intent Scale (SIS)

• General Examples
  • Patient Health Questionnaire 9 (PHQ-9) Depression Scale
  • Beck Hopelessness Scale (BHS)

• You will need to evaluate what roles these can play in your screening process (likely incomplete for thorough risk assessment)
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5. Suicide Risk Documentation
Where do I get a THOROUGH list of risk factors?

• American Psychiatric Association (our prior studies)
• Your agency policies
• CARS Model from this afternoon
APA Risk Factors List

- Suicidal ideation
- Previous attempts
- Previous self harm
- Hopelessness
- Reasons for living
- Plans for the future
- Psychiatric history
- Substance use history
- Access to weapons
- Employment status
- Likelihood of exposure to ongoing stressors

- Psych conditions
- Active Substance Use
- Lethality
- Acute stressors
- Impulsivity
- Living situation
- Sexual or physical abuse
- Neglect
- Presence of external supports
- Cultural and religious views about suicide
- Medical history
- Family history
Example 1: UCSF/APA Factors

- Suicidal ideation
- Previous attempts
- Previous self harm
- Hopelessness
- Reasons for living
- Plans for the future
- **Psychiatric history**
- Substance use history
- **Access to weapons**
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- Psych conditions
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- **Acute stressors**
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- Living situation
- Sexual or physical abuse
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- Family history
## Example 2: UCSF/APA Factors

<table>
<thead>
<tr>
<th>Factors</th>
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<tbody>
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<td>- Suicidal ideation</td>
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Advancements
Culture and Diversity Considerations in Suicide
Goals for Today

• Raise awareness about cultural variations and cultural influences on suicide

• Innovations and Gold Standards of Culturally Competent Suicide Assessment and Management
“NOISE” IN EPIDEMIOLOGY RATES

- Culturally specific symptom expression
- Underestimates/Under-reporting
- Classification of cultural group identification
- Classification of death (natural, accidental, suicidal, homicidal)
Cultural Groups at Elevated Risk

• Older Adult Asian American women
• South Korea, China, Japan, India (Kim, Jung-Choi, Jun, & Kawachi, 2010; OECD, 2017; Värnik, 2012)
• Military populations (20 daily suicide deaths) VA Office of Suicide Prevention (2016)
• American Indian/Alaskan Natives (CDC, 2013)
• African American adolescent boys and Latina adolescent girls (CDC, 2009; Eaton et al., 2011)
• Latino/a youth with suicidal ideation and attempts
• Individuals with multiple minority status (Meyer, Dietrich, & Schwartz, 2008)
• Older adults, unemployment, and age discrimination
  • Dramatic increase in suicide rates in adults 55-64 from 1999 to 2010
Cultural Groups at Elevated Risk

- Sexual and gender minority (LGBTQ) populations (Garofalo et al., 1999; Grossman & D’Augelli, 2007; Clements-Nolle, Marx, & Katz, 2006)
  - Lifetime suicide attempt rate consistently shown to be higher in LGB (7-11 x higher) (Haas, 2011)
  - Gender minorities have exceedingly high suicide attempt rate (41% vs. 10-20% LGB and 4.6 overall population) Those who experienced rejection (50 to 78%) (Haas 2014)
  - Little to no U.S. data on “death by suicide” rate GSM
  - Need for future research / efforts
From the 2016 Medical Examiner Data

Recommendations on ethnic subgroup focus:

- High rates for Native Americans and Pacific Islanders.
- For Whites, rate is steady.
Gaps: Training in Culturally Competent Suicide Assessment

Figure 1. *Types of training received by practitioners.*

Chu, Poon, Kwok, Leino, Goldblum, & Bongar (2017)
Why is Cultural Competence Needed in Suicide Prevention?

**Risk prevention / management**
- Directly inquire about suicide ideation, intent, plan
- Access to means, firearms
- Impulsivity
- Risk and protective factors
- Safety plan

**Grace, 33 year old Caucasian female**
- Recent financial troubles
- Feels alone, limited social support
- Reports fatigue, hopelessness, feeling blue

**Grace, 80 year old Chinese female**
- Recent financial troubles
- Feels alone, limited social support
- Reports fatigue, hopelessness, feeling blue

**Risk prevention / management**
- Multi-mode assessment, to account for hidden ideation
- Hanging
- Family conflict, family stressors
- Recent experiences of shame
- Include others in safety plan
Suicide Prevention & Management: A critique

- Checklists, summaries of risk, protection, profile
- Questions to assess for suicide - same
- Little recognition of cultural variation or understanding of context in reporting or assessment
Needed: Cultural Considerations in Suicide Prevention

• Is suicide a mental health phenomenon?

• The majority - ~90% - of suicidal individuals have mental illness (e.g., Mościcki, 1997).
  • Psychiatric symptoms commonly used to flag suicide risk (e.g., Bajaj et al., 2008)
Suicide may actually be a non-mental health phenomenon

Suicide subtype study

• GOAL: classify 191 suicidal Asian Americans into suicide subtypes
  • Latent class analysis (LCA)

• RESULTS:
  • 48% in a “psychiatric” suicide subtype
  • 52% in a “non-psychiatric” sociocultural and health suicide subtype

Known precipitating circumstances for youth suicide, 2003–2015

<table>
<thead>
<tr>
<th>Factor</th>
<th>%</th>
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<tbody>
<tr>
<td>Recent crisis</td>
<td>52.6</td>
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<tr>
<td>Current mental health problem</td>
<td>47.4</td>
</tr>
<tr>
<td>Ever treated for mental health problem</td>
<td>42.8</td>
</tr>
<tr>
<td>Suicide note</td>
<td>42.3</td>
</tr>
<tr>
<td>Suicide thought history</td>
<td>37.1</td>
</tr>
<tr>
<td>Current depressed mood</td>
<td>32.5</td>
</tr>
<tr>
<td>Current treatment for mental illness</td>
<td>30.4</td>
</tr>
<tr>
<td>Suicide intent disclosed</td>
<td>29.4</td>
</tr>
<tr>
<td>Suicide attempt history</td>
<td>29.9</td>
</tr>
</tbody>
</table>

Data Source: Medical examiner reports (2003-2015)
Population: (1) County of residence listed as Santa Clara County, (2) Death occurred in Santa Clara County, (3) Decedent 10 to 24 years of age, (4) Manner of death listed as suicide.
Take Home Points

1. Be Aware: Certain countries, and racial, ethnic, gender, and sexual minority subgroups (elderly, female, adolescents) at elevated risk

2. Don’t use mental illness as a sole screener / warning sign for suicide
Criticisms of diversity and suicidology literature

- Research has largely been:
  - Extensive, variegated, and difficult to synthesize
  - Lacking in a grounding organization
  - Lacking in synthesis
  - Atheoretical
Cultural Synthesis, Improving Suicide Assessment

• Inductive Analysis

• We comprehensively reviewed literature on cultural variations in suicide for extraction of common factors, in four groups:
  • African Americans
  • Asian Americans
  • Latin Americans
  • LGBTQ

Cultural Synthesis, Improving Suicide Assessment

Results

• 95% of the culturally specific suicide risk literature encompassed by 4 factors:

  - Cultural Sanctions
  - Minority Stress
  - Social Discord
  - Idioms of Distress

Chu, Goldblum, Floyd, & Bongar (2010)
The Cultural Theory/Model of Suicide

3 key concepts

#1. Look for Different Signs of Suicide
   *Cultural Idioms of Distress*

#2. Suicide May Be Precipitated By Different Stressors
   *Minority Stress, Social Discord*

#3. Look for the Meaning of Things
   *Cultural Sanctions*
#1. Look for Different Signs of Suicide (Idioms of Distress)
Idioms of Distress

*Definition:*
- The way suicide symptoms are expressed
Method by Race/Ethnicity (5-Year Aggregate, 2012-16)
Idioms of Distress

**Definition:**
- The way suicide symptoms are expressed
- One’s likelihood to express suicidality

Hidden Suicidal Ideation (HSI) (Morrison & Downey, 2000)

Asian Americans with HSI

Cultural Risk Factors

Severity of Suicidal Distress → Hidden Suicidal Ideation
Revisiting Screening from a Cultural Lens
1. Direct Inquire about Suicide

Keep in mind: CASE Approach Strategies

IDEATION

Frequency, intensity, duration of current ideation
Cultural Variations in experience/expression

Example questions:
- Do you think dying would be better than living?
- A lead-in question: How bad is it and how much more can you take?
- Do you have thoughts of suicide?
- Have you ever thought about ending your life?
- When someone feels very upset, they may have thoughts that life just isn't worth living. Have you ever had these thoughts?
- Are you wanting to give your life away?
- Have you ever had thoughts you might be better off dead?
- In the last 2 weeks, how many times did you think about killing yourself?
- I appreciate how difficult this problem must be for you at this time. Some of my patients with similar problems/symptoms have told me that they have thought about ending their life. I wonder if you have had similar thoughts?

Cultural Variations
- Have you ever wanted to give your life away?
- Have you ever felt your loved ones would be better off without you?
- Have you ever felt no one would care if you weren't around anymore?
- Have you ever felt you don't deserve to be alive?
- Have you felt so ashamed that you wanted to disappear?
- Have you ever felt your time on this earth is done?
- Have you felt this world has rejected you and it's time to leave?
- Have you ever wished someone else would just end your life?

INTENT

Explicitness
Example questions
- How much do you want to die?
- How likely is it that you'd act on your thoughts of wanting to die?
- How serious are you about killing yourself?
- How hopeless do you feel about the future—that things will not get better?
- When you think about suicide, does it comfort you or does it freak you out?

PLAN, MEANS

Specificity and lethality of plan, Availability of means, Rehearsal, Intersection of impulsivity with access
Isolation, timing, precautions against discovery, acts to gain help, final acts of preparation, suicide note

Example questions
- When did you have these thoughts and do you have a plan to take your life?
- If you were to hurt yourself / attempt suicide, have you thought about how you would do it?
- Have you ever attempted suicide?
- Have you, at any time in your life, ever done anything that anyone could possibly have interpreted as self-destructive or even suicidal?
- Do you think about where you would hurt or kill yourself? Is it a place where if you tried it, there's a pretty good chance somebody would stop you?
- Do you think about specific times when you would kill yourself?
#2. Suicide May Be Precipitated By Different Stressors

(Social Discord & Minority Stress)
Minority Stress
Components of Minority Stress
(Meyer, 2003)

- **Negative Life Events** due to being a sexual minority
- **Internalized Stigma**: Expectations of rejection and discrimination
- **Outness**: Concealment vs. Disclosure
- **Internalized homophobia, biphobia, and transphobia**: negative beliefs and stereotypes about GSM or self as a GSM.
#3. Look for the Meaning of Things
(Cultural Sanctions)
The Cultural Theory/Model of Suicide

#1. Look for Different Signs of Suicide
   *Cultural Idioms of Distress*

#2. Suicide May Be Precipitated By Different Stressors
   *Minority Stress, Social Discord*

#3. Look for the Meaning of Things
   *Cultural Sanctions*
A Tool for the Culturally Competent Assessment of Suicide: The Cultural Assessment of Risk for Suicide (CARS) Measure

Joyce Chu, Rebecca Floyd, and Hy Diep
Palo Alto University

Seth Pardo
Alliant International University

Peter Goldblum
Palo Alto University

Bruce Bongar
Palo Alto University and Stanford University School of Medicine

A Shortened Screener Version of the Cultural Assessment of Risk for Suicide

Joyce Chu, Brandon Hoedlein, Peter Goldblum, Dorothy Espelage, Jordan Davis, and Bruce Bongar
The Cultural Assessment of Risk for Suicide (CARS) tool

- 39-item self-report questionnaire
- For use across multiple cultural identities

**Validation data**
- Exploratory factor analysis: 8 subscales that map onto 4 theoretical constructs
- Internal consistency of CARS scale = .90
  - of subscale scores: Range from .65-.83
- Discriminates between people with vs. w/o suicide attempts
- Positively correlated with the SIS, suicide item from the BDI, and BHS

### CARS Risk Questionnaire

**Instructions:** Please circle the response that best applies to you.

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Moderately Disagree</th>
<th>Slightly Disagree</th>
<th>Slightly Agree</th>
<th>Moderately Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I have, without anyone’s knowledge, intentionally injured myself in the past.</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
<td>□ 6</td>
</tr>
<tr>
<td>2. There is conflict between myself and members of my family.</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
<td>□ 6</td>
</tr>
<tr>
<td>3. When I get angry at something or someone, it takes me a long time to get over it.</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
<td>□ 6</td>
</tr>
<tr>
<td>4. I have access to a method of suicide other than a gun that I have previously thought to use (like a weapon, a rope, poison, or medication overdose).</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
<td>□ 6</td>
</tr>
<tr>
<td>5. My family, culture, or religion is against the idea of suicide.</td>
<td>□ 6</td>
<td>□ 5</td>
<td>□ 4</td>
<td>□ 3</td>
<td>□ 2</td>
<td>□ 1</td>
</tr>
<tr>
<td>6. I have disappointed my family.</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
<td>□ 6</td>
</tr>
<tr>
<td>7. Suicide would bring shame to my family.</td>
<td>□ 6</td>
<td>□ 5</td>
<td>□ 4</td>
<td>□ 3</td>
<td>□ 2</td>
<td>□ 1</td>
</tr>
<tr>
<td>8. I feel confused or conflicted by my sexual or gender orientation.</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
<td>□ 6</td>
</tr>
<tr>
<td>9. Because of my sexual or gender orientation, no one understands my pain or distress.</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
<td>□ 6</td>
</tr>
<tr>
<td>10. There is something in my life I feel ashamed about.</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
<td>□ 6</td>
</tr>
<tr>
<td>11. There is something in my life / something about me that my family or friends would disapprove of.</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
<td>□ 6</td>
</tr>
<tr>
<td>12. I feel upset because other people have lost respect and confidence in me.</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
<td>□ 6</td>
</tr>
<tr>
<td>13. I consider suicide to be morally wrong.</td>
<td>□ 5</td>
<td>□ 4</td>
<td>□ 3</td>
<td>□ 2</td>
<td>□ 1</td>
<td></td>
</tr>
<tr>
<td>14. I feel connected to, like I am a part of, a community.</td>
<td>□ 5</td>
<td>□ 4</td>
<td>□ 3</td>
<td>□ 2</td>
<td>□ 1</td>
<td></td>
</tr>
<tr>
<td>15. I have, without anyone’s knowledge, thought of suicide in the past.</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
<td>□ 6</td>
</tr>
<tr>
<td>16. I feel uncomfortable when others expect me to know American ways of doing things.</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
<td>□ 6</td>
</tr>
<tr>
<td>17. My family, culture, or religious beliefs about suicide prevent me from considering killing myself.</td>
<td>□ 6</td>
<td>□ 5</td>
<td>□ 4</td>
<td>□ 3</td>
<td>□ 2</td>
<td>□ 1</td>
</tr>
<tr>
<td>18. My family has disappointed me.</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
<td>□ 6</td>
</tr>
</tbody>
</table>
### CARS Screener (CARS-S)

**Instructions:** For each item, please mark an “x” in the box under the label (e.g., Strongly Disagree, Slightly Disagree) that best applies to you. You should **ignore the small numbers** inside of the boxes. Please answer each item as honestly and openly as possible.

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Moderately Disagree</th>
<th>Slightly Disagree</th>
<th>Slightly Agree</th>
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<tbody>
<tr>
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<td>[ ]</td>
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<td>[ ]</td>
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</tr>
<tr>
<td>2. There is a lot of conflict between myself and members of my family.</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
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<td>[ ]</td>
<td>[ ]</td>
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<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
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<td>[ ]</td>
</tr>
<tr>
<td>4. I am accepted and valued by others.</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
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<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>7. Sometimes I feel so tired I do not want to get up/wake up.</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
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<td>[ ]</td>
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<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>11. People treat me unfairly because of my ethnicity, sexual, or gender identity.</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
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</tr>
<tr>
<td>12. Adjusting to America has been difficult for me. (Note: If you were born in America, leave this item blank.)</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>13. Because of my sexual or gender orientation, no one understands my pain or distress. (Note: If you do not identify as LGBTQ, leave this item blank.)</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>14. The decision to hide or reveal my sexual or gender orientation to others causes me great distress. (Note: If you do not identify as LGBTQ, leave this item blank.)</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td></td>
<td>CLASSIC</td>
<td>CULTURAL</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------</td>
<td>--------------------------</td>
<td>-------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression, Hopelessness, Reasons for Living</td>
<td>17%</td>
<td>8%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% variance in attempts</td>
<td>14.1%</td>
<td>8.5%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% correct classification of attempters</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Effects on our Suicide Prevention Efforts?

The Lifeline is **FREE**, confidential, and always available.

**HELP**

a loved one,
a friend,
or yourself deal
with trauma.

Community crisis centers answer Lifeline calls.

**Having Trouble Coping?**

[Suicide Prevention Lifeline](suicidepreventionlifeline.org)
Having Trouble Coping?

After a traumatic event, problems may come and go. It’s important to know when to ask for help. Please call us if you or someone you know is experiencing any of the following problems, especially if a problem is making it hard to get through the day or is getting worse.

- Eating or sleeping too much or too little
- Pulling away from people and things
- Having low or no energy
- Feeling numb or like nothing matters
- Having unexplained aches and pains
- Feeling helpless or hopeless
- Smoking, drinking, or using drugs more than you should
- Feeling unusually confused or forgetful; on edge, angry, or upset; or worried and scared
- Fighting with family and friends
- Unable to get rid of troubling thoughts and memories
- Thinking of hurting or killing yourself or someone else
- Unable to perform daily tasks like taking care of your kids or getting to work or school

Call the Lifeline at 1-800-273-TALK (8255)
(en español, 1-888-628-9454)

With Help Comes Hope
Having Trouble Coping?

After a traumatic event, problems may come and go. It’s important to know when to ask for help. Please call us if you or someone you know is experiencing any of the following problems, especially if a problem is making it hard to get through the day or is getting worse.

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- Feeling unusually confused or forgetful; on edge, angry, or upset; or worried and scared
- Fighting with family and friends
- Unable to get rid of troubling thoughts and memories
- Thinking of hurting or killing yourself or someone else
- Unable to perform daily tasks like taking care of your kids or getting to work or school
- Feeling ashamed about something
- Feeling treated unfairly because of who you are
- Doing careless things that put you in danger
- Feeling too tired to get up
- Feeling isolated from others that understand you
- Thinking others are better off without you

Call the Lifeline at 1-800-273-TALK (8255)  
(en español, 1-888-628-9454)

With Help Comes Hope
Cultural Take Home Points

1. Be Aware: Ethnic and sexual minority subgroups (elderly, female, adolescents) at elevated risk

2. Don’t use mental illness as a sole screener / warning sign for suicide

3. Unique cultural considerations should be incorporated into suicide risk detection, prevention, and management
   a) Look for different signs of suicide
   b) Suicide may be precipitated by different stressors
   c) Look for the meaning of things

Cultural Model / CMMS / CARS: Added Value?

• Assists in detecting cultural risk factors

• Aids in tailoring interventions/treatment planning with cultural minorities

• Individual items provide qualitative information
Zoe: How does the cultural approach affect her suicide management?

Chu, Hoeflein, Goldblum, Bongar, Heyne, Gadinsky, & Skinta (2018)
Case Study
Culture and Suicide Management

Chu, Hoeflein, Goldblum, Bongar, Heyne, Gadinsky, & Skinta (2018)
The FRAMEWORK: Static & Dynamic Factors

Applying a Forensic Risk Conceptualization Model to Enhance Communication and Documentation
Suggested OVERALL Suicide Assessment & Management Process

1. Screening & Re-screening  
   (Inclusive of Direct Suicide Inquiry)
2. Thorough Assessment of Risk & Protective Profile
3. Determine Current Level of Suicide Risk
4. Crisis Response, Safety, or Treatment Plan
5. Suicide Risk Documentation
The FRAMEWORK: What it is NOT

• This is an evidence-based method of conceptualization
  • It is not a validated psychometric measure

• This FRAMEWORK is agnostic of any particular list of risk or protective factors
APA Risk Factors List

- Suicidal ideation
- Previous attempts
- Previous self harm
- Hopelessness
- Reasons for living
- Plans for the future
- Psychiatric history
- Substance use history
- Access to weapons
- Employment status
- Likelihood of exposure to ongoing stressors
- Psych conditions
- Active Substance Use
- Lethality
- Acute stressors
- Impulsivity
- Living situation
- Sexual or physical abuse
- Neglect
- Presence of external supports
- Cultural and religious views about suicide
- Medical history
- Family history
Example 1: UCSF/APA Factors

- Suicidal ideation
- Previous attempts
- Previous self harm
- Hopelessness
- Reasons for living
- Plans for the future
- Psychiatric history
- Substance use history
- Access to weapons
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- Likelihood of exposure to ongoing stressors

- Psych conditions
- Active Substance Use
- Lethality
- Acute stressors
- Impulsivity
- Living situation
- Sexual or physical abuse
- Neglect
- Presence of external supports
- Cultural and religious views about suicide
- Medical history
- Family history
Example 2: UCSF/APA Factors

- Suicidal ideation
- Previous attempts
- Previous self harm
- Hopelessness
- Reasons for living
- Plans for the future
- Psychiatric history
- Substance use history
- Access to weapons
- Employment status
- Likelihood of exposure to ongoing stressors

- Psych conditions
- Active Substance Use
- Lethality
- Acute stressors
- Impulsivity
- Living situation
- Sexual or physical abuse
- Neglect
- Presence of external supports
- Cultural and religious views about suicide
- Medical history
- Family history
Approaches to Violence Risk Assessment

- Clinical Judgment
  - Clinical Interview
    - Face-valid risk factors
    - Client self-report
    - Some collateral support

- Actuarial Measures
  - Clinical Interview
  - Collateral Information (official records)
  - Scoring & weighting of predictive characteristics

- Guided Clinical Judgment
  - Empirically-supported risk factors
  - Standardized “ratings”
  - Clinician ultimately rates the risk
## Approaches to Violence Risk Assessment

<table>
<thead>
<tr>
<th>Approach</th>
<th>Adoption</th>
<th>Accuracy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Judgment</td>
<td>HIGH</td>
<td>LOW</td>
</tr>
<tr>
<td>Actuarial</td>
<td>LOW</td>
<td>HIGH</td>
</tr>
<tr>
<td>Guided Clinical Judgement</td>
<td>HIGH</td>
<td>HIGH</td>
</tr>
</tbody>
</table>
Background of this framework

• From forensic violence risk (specifically the first HCR-20)
  • Static v. dynamic
  • 3-point (yes, maybe, no) ratings

• Research support: Demonstrated to significantly improve documentation of risk factors and thought process in...

  • UCSF Psychiatry and Psychology trainees

  • Palo Alto VA Geriatric-specialist Healthcare Providers
The FRAMEWORK

### Suicide Risk

#### Static
- **Historical**
  - Long-term risk
  - Lower Tx Focus
  - Makes others more concerning

#### Dynamic
- **Clinical**
  - Changing but not quickly
  - Highest Tx Focus

- **Risk Management**
  - Rapid Fluctuation
  - If/then statements
  - Tx Planning
  - Imminence
The FRAMEWORK: Keep in mind...

- Item categorization here is just a suggested starting point.
- Some items could obviously span categories.
- Specific patient endorsement can change meaning and categorization.
The FRAMEWORK: Historical Static Items

- Historical
  - Previous attempts
  - Previous self harm
  - Sexual or physical abuse
  - Neglect
  - Medical history
  - Family history
  - Psychiatric history
  - Substance use history
  - Employment status
The FRAMEWORK: Clinical Dynamic Items

- Clinical
  - Psych conditions
  - Active Substance Use
  - Suicidal ideation
  - Lethality
  - Acute stressors
  - Hopelessness
  - Impulsivity
  - Living situation
The FRAMEWORK: Risk Management Items

• Risk Management
  • Reasons for living
  • Plans for the future
  • Cultural and religious views about suicide
  • Presence of external supports
  • Likelihood of exposure to ongoing stressors
  • Access to weapons
The FRAMEWORK

- **Historical**
  - Previous attempts
  - Previous self harm
  - Sexual or physical abuse
  - Neglect
  - Medical history
  - Family history
  - Psychiatric history
  - Substance use history
  - Employment status

- **Clinical**
  - Psych conditions
  - Active Substance Use
  - Suicidal ideation
  - Lethality
  - Acute stressors
  - Hopelessness
  - Impulsivity
  - Living situation

- **Risk Management**
  - Reasons for living
  - Plans for the future
  - Cultural and religious views about suicide
  - Presence of external supports
  - Likelihood of exposure to ongoing stressors
  - Access to weapons
Example 1: No Framework

- Suicidal ideation
- Previous attempts
- Previous self harm
- Hopelessness
- Reasons for living
- Plans for the future
- Psychiatric history
- Substance use history
- Access to weapons
- Employment status
- Likelihood of exposure to ongoing stressors

- Psych conditions
- Active Substance Use
- Lethality
- Acute stressors
- Impulsivity
- Living situation
- Sexual or physical abuse
- Neglect
- Presence of external supports
- Cultural and religious views about suicide
- Medical history
- Family history
Example 1 with FRAMEWORK

- **Historical**
  - Previous attempts
  - Previous self harm
  - Sexual or physical abuse
  - Neglect
  - Medical history
  - Family history
  - Psychiatric history
  - Substance use history
  - Employment status

- **Clinical**
  - Psych conditions
  - Active Substance Use
  - Suicidal ideation
  - Lethality
  - Acute stressors
  - Hopelessness
  - Impulsivity
  - Living situation

- **Risk Management**
  - Reasons for living
  - Plans for the future
  - Cultural and religious views about suicide
  - Presence of external supports
  - Likelihood of exposure to ongoing stressors
  - Access to weapons
Example 2: No Framework

- Suicidal ideation
- Previous attempts
- Previous self harm
- Hopelessness
- Reasons for living
- Plans for the future
- Psychiatric history
- Substance use history
- Access to weapons
- Employment status
- Likelihood of exposure to ongoing stressors

- Psych conditions
- Active Substance Use
- Lethality
- Acute stressors
- Impulsivity
- Living situation
- Sexual or physical abuse
- Neglect
- Presence of external supports
- Cultural and religious views about suicide
- Medical history
- Family history
Example 2 with FRAMEWORK

- **Historical**
  - Previous attempts
  - Previous self harm
  - Sexual or physical abuse
  - Neglect
  - Medical history
  - Family history
  - Psychiatric history
  - Substance use history
  - Employment status

- **Clinical**
  - Psych conditions
  - Active Substance Use
  - **Suicidal ideation**
  - Lethality
  - Acute stressors
  - Hopelessness
  - Impulsivity
  - Living situation

- **Risk Management**
  - Reasons for living
  - Plans for the future
  - Cultural and religious views about suicide
  - Presence of external supports
  - Likelihood of exposure to ongoing stressors
  - Access to weapons
Practice Vignette

Identifying and Organizing Zoe’s Suicide Risk and Protective Factors
Practice Vignette: ID’ing and Organizing Zoe’s Risk

• Favorite list of risk factors...
• Organized into static vs. dynamic
• “Scoring” on a 3-point scale (I’ll use 0-2)
• Summing of sections just FYI

• As the clinician, YOU ultimately decide level of risk
Sample Documentation

Streamlined Communication of Results and Decisions
Suggested OVERALL Suicide Assessment & Management Process

1. Screening & Re-screening
   (Inclusive of Direct Suicide Inquiry)
2. Thorough Assessment of Risk & Protective Profile
3. Determine Current Level of Suicide Risk
4. Crisis Response, Safety, or Treatment Plan
5. Suicide Risk Documentation
5150 Process

• Emergency Psych hold for imminent risk

• Fantastic, thorough, and local information at: https://www.sccgov.org/sites/bhd-p/Training/5150CIT/Pages/5150.aspx

• An important context in which documentation is relevant.
6. Suicide Risk Documentation

What you did, why you did it: Full details of risk and protective factors, statement of risk level, risk management action plan, recommended follow-up steps. Record of decision-making processes, communications with 3rd parties, all calls/messages, plans for coverage
Suggested OVERALL Suicide Assessment & Management Process

1. Screening & Re-screening
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5. Suicide Risk Documentation
Safety & Treatment Planning
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3. Determine Current Level of Suicide Risk
4. Crisis Response, Safety, or Treatment Plan
5. Suicide Risk Documentation
No suicide contracts

• Little to no empirical support
• Often is not a therapeutic intervention
• Reliance on these contracts may create more liability potential than it will protect against

Bryan et al. (2017); Miller et al. (2017)
5. Safety Planning

THE SAFETY PLAN (Borges et al., 2010; Stanley & Brown, 2009)

- Provider-guided Safety Plans as effective as a short-term intervention (Stanley & Brown, 2009; Bryan et al., 2017; Miller et al., 2017)
- The act of doing a safety plan with someone - can decrease suicidality
- Standard of care
5. Safety Planning

THE SAFETY PLAN
(Borges et al., 2010; Stanley & Brown, 2009)

- 6 Components
  1. Warning Signs
  2. Internal Coping Strategies
  3. People and social settings that provide distraction
  4. People whom I can ask for help
  5. Professionals or agencies I can contact during a crisis
  6. Making the environment safe (reduce access to lethal means)
Means Restriction
Managing Access to Firearms

• Do NOT have people bring a gun to you

• Either do not accept it or call police asap if they do bring to you

• Do NOT recommend that they give a gun to someone else
  • A common recommendation, but illegal in California

• Have them take steps to delay the response or access
  • Store ammo separately
  • Take gun apart
  • Lock it and give someone else the key
### Gun Violence Restraining Orders (GVRO) Types

<table>
<thead>
<tr>
<th></th>
<th>Temporary Emergency</th>
<th>Temp Ex-Parte</th>
<th>One Year After Hearing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Standard For Issuance</strong></td>
<td>Must show there is reasonable cause: (1) the party is and immediate and present danger of causing personal injury to self or another by having guns/ammo AND (2) order is necessary to protect injury because other means have been tried OR are inappropriate under the circumstances.</td>
<td>Must show there is a substantial likelihood: (1) the party poses a significant danger, in the near future, of injury to self/others, AND (2) order is necessary to protect injury because other means have been tried OR are inappropriate under the circumstances.</td>
<td>Must show by clear and convincing evidence: (1) party poses significant danger of injury to self or others, AND less restrictive alternatives were ineffective or inappropriate under the circumstances.</td>
</tr>
<tr>
<td><strong>Who Can Apply?</strong></td>
<td>Law Enforcement Only</td>
<td>Law Enforcement &amp; Family/Housemates</td>
<td>Law Enforcement</td>
</tr>
</tbody>
</table>
| **Process**              | - Apply Orally or in Writing  
- Contact Duty Judge  
- Form EPO-002  
- Once issued, serve & take guns immediately | - Apply in Writing in Family Court  
- Forms: GV-100, CLETS-001, GV-109 | - The hearing is set EITHER by filing Ex Parte OR by operation of law after a temporary emergency order is issued |
| **Duration**             | 21 days (triggers 1 Year hearing, but otherwise expires) | 21 days (pending hearing on 1 Year order) | One Year |
| **Legal Authority**      | PC 18125, et seq. | pc 18150, et seq | PC 18170, et seq |
5. Safety Planning

Technological Tools
5. Safety Planning

Technological Tools
5. Safety Planning: Implementation

- Discuss the reason why the safety plan is important
- The patient generates their own ideas
- Have them write it down themselves - on a card, on the phone, [https://my3app.org/](https://my3app.org/)
- Spend some time having them discuss their reasons for living - it increases the effectiveness of the safety plan
- Talk with them about how they might actually be able to use the plan
Case Practice: Safety Planning with Zoe

Same partners, but switch therapists/clients

Practice creating a safety plan with Zoe

• Practice how to implement the safety plan
• “Zoe” should handwrite on the safety plan card
CARS Implications for Suicide Management: A Case Study

Standard Safety Plan

- **Warning Signs:**
  - Repetitive thoughts about death
  - High emotional dysregulation
- **Internal Coping Strategies:**
  - Listen to upbeat or soothing music
  - Rotate stress balls and focus on them
  - Meditation - either read or listen to audio
  - Watch Netflix show or go for a walk
- **People and Settings that Provide Distraction:**
  - Four people who know true gender identity
  - Dave & Buster’s
  - Take niece to Chuck E. Cheese

- **People Whom I can Ask for Help:**
  - Three Individuals
- **Professionals/Agencies I can Contact During a Crisis:**
  - Mental Health Clinic
  - Suicide Prevention Hotline Number
  - County 24 Hour Crisis Hotline
- **Making the Environment Safe:**
  - If alone, get into immediate social contact
  - Remove dangerous objects and potential means

Chu, Hoeflein, Goldblum, Bongar, Heyne, Gadinsky, & Skinta (in press)
Any cultural components of your safety plans?
Suicide Management Plan

Pre-CARS

WARNING SIGNS

• Repetitive thoughts about death
• High emotional dysregulation

INTERNAL COPING STRATEGIES

• Listen to upbeat or soothing music
• Rotate stress balls and focus on them
• Meditation - either read or listen to audio
• Watch Netflix show or go for a walk

Post-CARS

WARNING SIGNS

• Increase/Activation of Minority Stress
• Internalized transphobia
• Conflict with concealment
• Rejection sensitivity
• Memories of past trans-related negative events
• Feeling Shame, Anger, or Tiredness
• Family Conflict related to Trans expression

INTERNAL COPING STRATEGIES

• Coping with internalized transphobia
• Increase reasons for living
• Decrease immediate activation of minority stress
• Review Reasons for Living Card
  • Trans activism for VA benefits
  • Hope for sex reassignment surgery
  • Hope for marriage as identified gender
  • Not wanting to burden/shame her family
### Suicide Management Plan

#### Pre-CARS

**PEOPLE & SETTINGS THAT PROVIDE DISTRACTION**
- Four people who know true gender identity
- Dave & Buster’s
- Take niece to Chuck E. Cheese

**PEOPLE WHOM I CAN ASK FOR HELP**
- Three individuals

**PROFESSIONALS/AGENCIES I CAN CONTACT DURING A CRISIS**
- Mental health clinic
- Suicide prevention hotline number
- County 24 hour crisis hotline / 911

**MAKING THE ENVIRONMENT SAFE**
- If alone, get into immediate social contact
- Remove dangerous objects & potential means

#### Post-CARS

**PEOPLE & SETTINGS THAT PROVIDE DISTRACTION**
- Four people who know true gender identity (No Changes)

**PEOPLE WHOM I CAN ASK FOR HELP**
- Friends who know true gender identity

**PROFESSIONALS/AGENCIES I CAN CONTACT DURING A CRISIS**
- Trevor Project
- LGBT Veteran Support Group

**MAKING THE ENVIRONMENT SAFE**
- Specify ally status of environment
- Remove alcohol
- Accept or Reduce Family Conflict
5. Treatment: Principles

• Be flexible and expand scope of care (titrate with risk level)
  • Referrals, increase frequency of contact, consider psychiatric referral, involve others, consider hospitalization if necessary, check-ins
• Increase the safety net
• Utilize an evidence-based treatments and principles
5. Treatment: Evidence-Based Brief Interventions

- **Attempted Suicide Short Intervention Program (ASSIP):** For people who had an attempt (e.g., in the hospital post-attempt, 4-7 days of a stay) (Gysin-Maillart, Schwab, Soravia, Megert, & Michel, 2016)

- **The Collaborative Assessment and Management of Suicidality (CAMS)** (Jobes, [http://cms-care.com](http://cms-care.com))

- **The Zero Suicide Model** (Brodsky, Spruch-Feiner, & Stanley, 2018)

- **CBT for Suicide** (Brown & Jager-Hyman, 2014; Beck as well)

- **Other Treatments:** Dialectical Behavior Therapy (DBT), Voice Therapy for self-destructive behavior, CBT and hot cognitions, Emotion-focused therapy, Self-compassion
Therapeutic Alliance

- Therapist as the secure base
  - Therapeutic alliance associated with less attempts long term
- Key element in long-term recovery
- Attend to countertransference; Deal with ruptures
  - Maintain stability, manage unpredictability
  - Suicide deaths associated with more ruptures
<table>
<thead>
<tr>
<th>Collaborative Suicide-Specific Case Conceptualization</th>
<th>Skills Training</th>
<th>Self-management / Safety Planning</th>
<th>Access to Crisis Services</th>
<th>Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide is an ACTION, not an illness</td>
<td>Be explicit about what skills you’re building</td>
<td>See Safety Planning!</td>
<td>Crisis resources, numbers</td>
<td>Follow-up contact decreases suicide deaths</td>
</tr>
<tr>
<td>Understand the suicide story</td>
<td>Postpone suicidal action</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explanatory Model for Suicidal Behavior</td>
<td>Problem solve the suicidal behavior</td>
<td>Many emphasize internal self-management rather than external self-management (<em>Our challenge: cultural adaptation?</em>)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Empathize / Take time to empathize with suicidal wish</td>
<td><strong>Work on:</strong> Cultural meanings/beliefs Emotion regulation Distress tolerance Recovery behaviors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Motivational Interviewing</td>
<td></td>
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</tr>
</tbody>
</table>

**Key Evidence-Based Components of Suicide Treatment Planning**

**THERAPEUTIC ALLIANCE**
Collaborative Suicide-Specific Case Conceptualization

• “I would like to hear the story of how you came to the point of harming yourself”

• “I would like to understand what you were going through during the time of your suicide attempt. Can you walk me through the story?”
5. Treatment: Individual Strategies / Tools

• “What is one thing that if it were to change, you wouldn’t feel suicidal?”
• “You can always kill yourself later. Can you delay it for now?” (In the meantime, let’s try to solve these problems together)
• “Let’s keep you out of the hospital”
• Relapse prevention via guided imagery (from CBT for suicide)
Small Group Discussions

Groups of ~4

Share with each other:

• Your favorite strategies or tools for managing suicide
Brainstorm in groups of ~4

1. Suicide-specific case conceptualization
   • Try to *understand* Zoe’s “suicide story”
   • Brainstorm Zoe’s explanatory model for her suicidal ideation and behaviors. How does she become suicidal?
     • Does this allow you to empathize with her suicidal wish?

2. Suicide-specific case conceptualization
   • Identify main treatment goals and targeted skills
Minority Stress & Family Conflict

Meaning as a Person

Anger, Fatigue, Shame

Serious Suicidal Ideation

Zoe’s suicide-specific case conceptualization

Stressors

Meanings (Sanctions)

Signs (Idioms)
Zoe: Treatment Goals and Skills Acquisition

• **Treatment Goals:**
  • How to mitigate transgender minority stress while preserving Japanese American family traditional norms
  • Enhance meaning as a person, specific to her strengths as a transgender advocate. Support continued participation in Trans Community on-line and support groups

• **Skills Acquisition:**
  • Problem solving around minority stress events
  • Recognition of internalized anger as a suicide warning sign
  • IOD-E as an alternative assessment of suicide symptoms
  • Practice of distress tolerance during interpersonal family and minority stress experiences
  • Cognitive therapy related to her hopelessness

Chu, Hoeflein, Goldblum, Bongar, Heyne, Gadinsky, & Skinta (2017)
Note: Bold Lines indicate the occurrence of cultural risk factors and idioms, and an elevation in ASIQ scores. Dashed lines indicate implementation of CARS-informed interventions and a decrease in ASIQ scores.
1. Be Aware: Ethnic and sexual minority subgroups (elderly, female, adolescents) at elevated risk

2. Don’t use mental illness as a sole screener / warning sign for suicide

3. Unique cultural considerations should be incorporated into risk detection, prevention, & management
   a) Look for different signs of suicide
   b) Suicide may be precipitated by different stressors
   c) Look for the meaning of things

4. The Cultural Model of Suicide and/or the CARS and CMMS can advance culturally-competent suicide management
Useful Resources

- National Action Alliance for Suicide Prevention: Recommended Standard of Care
- Counseling for Suicide: Client Perspective (Paulson & Worth, 2002)
- The Suicidal Patient; Clinical and Legal Standards of Care (Bruce Bongar and Glenn Sullivan, 2013) Suicide Prevention Resource Center (www.sprc.org)
- American Association of Suicidology (www.suicidology.org)
- American Foundation for Suicide Prevention (www.afsp.org)
- IASP Suicide Survivor Organizations (www.iasp.info/resources/Postvention/National Suicide Survivor) Organizations
- National Action Alliance for Suicide Prevention (www.actionallianceforsuicideprevention.org)
- ZERO Suicide in Health and Behavioral Health Care (www.zerosuicide.sprc.org)
- National Suicide Prevention Lifeline (www.suicidepreventionlifeline.org): 1-800-273-TALK
- Crisis Text Line (crisistextline.org): Text Connect to 741741
NPSG.15.01.01
Reduce the risk for suicide.

---Rationale for NPSG.15.01.01---
Suicide of an individual served while in a staffed, round-the-clock care setting is a frequently reported type of sentinel event. Identification of individuals at risk for suicide while under the care of or following discharge from a health care organization is an important step in protecting these at-risk individuals.

Elements of Performance for NPSG.15.01.01

1. The organization conducts an environmental risk assessment that identifies features in the physical environment that could be used to attempt suicide and takes necessary action to minimize the risk(s) (for example, removal of anchor points, door hinges, and hooks that can be used for hanging).
   Note: Nonpatient behavioral health care settings and unlocked inpatient units do not need to be suicidal-resistant. The expectation for these settings is to conduct a risk assessment to identify potential environmental hazards to individuals served, identify individuals who are at high risk for suicide, and take action to safeguard these individuals from the environmental risks (for example, continuous monitoring in a safe location while awaiting transfer to higher level of care and removing objects from the room that can be used for self-harm).

2. Screen all individuals served for suicidal ideation using a validated screening tool.

3. Use an evidence-based process to conduct a suicide assessment of individuals served who have screened positive for suicidal ideation. The assessment directly asks about suicidal ideation, plan, intent, suicidal or self-harm behaviors, risk factors, and protective factors. Note: EPs 2 and 3 can be satisfied through the use of a single process or instrument that simultaneously screens individuals served for suicidal ideation and assesses the severity of suicidal ideation.

4. Document individuals' overall level of risk for suicide and the plan to mitigate the risk for suicide.

5. Follow written policies and procedures addressing the care of individuals served identified as at risk for suicide. At a minimum, these should include the following:
   - Training and competence assessment of staff who care for individuals served at risk for suicide
   - Guidelines for reassessment
   - Monitoring individuals served who are at high risk for suicide

6. Follow written policies and procedures for counseling and follow-up care at discharge for individuals served identified as at risk for suicide.

7. Monitor implementation and effectiveness of policies and procedures for screening, assessment, and management of individuals served at risk for suicide and take action as needed to improve compliance.
Partner Discussion

Discuss with each other:

• How does this work with your patients or clients, in your particular role, in your particular system?
• Next steps for you, or your group or agency?
Reminder to complete evaluation and sign out, particularly for CEUs!
Suicide Prevention 201

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Thank you!