Suicide Risk Assessment: Research, Refinement and Innovation within California's Prisons

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Presentation Overview

1. The challenges for clinicians making suicide risk assessment in correctional settings
2. The DSH Suicide Risk Assessment Study: Phase I measures and the development of the Chronic-Acute-Idiosyncratic structured professional judgment measure
3. The DSH Suicide Risk Assessment Study: Phase II measures
4. Applications within correctional inpatient Suicide Risk Assessment

Challenges for Clinicians Making Risk Assessments in Correctional Settings

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California Prisons

- 33 institutions plus out-of-state facilities and others
- 2013 average daily population of 132,000 (126,000 male)
- Lifers comprise >25,000 inmates
- Average of 30 suicides per year over last ten years
- 50-70% of suicides are in the mental health system at death
- 35-45% occur in segregated housing
- 27% of inmates are treated in the mental health system
- 1200+ mental health staff

What's the Problem?

- Rates of suicide are high (not only in California)
  - Jail rates have been over 40 per 100K for > ten years
  - Prison rates are 16 per 100K and seem to be rising
- High suicide rates attract attention – often in the form of litigation
- BUT…
  - Throwing money at it doesn't seem to help
  - The problem may be more profound than simply improving detection and treatment

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Prison/jail inmates carry more risk than non-inmates

- As a group, inmates have:
  - Higher prevalence of psychiatric disorders
  - Higher rates of substance abuse disorders
  - Higher rates of violence
  - Higher rates of social dysfunction
  - Higher rates of childhood adversity
  - Higher medical morbidity (especially >50)

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Prison inmates have higher chronic suicide risk

- Chronic risk - enduring vulnerabilities that either:
  - Do not change over time (demographics, historical incidents)
  - Or whose meaning slowly evolves and can be affected with long-term care (childhood maltreatment, chronic psychiatric disorders)
- Inmates often have what Maris called "suicidal careers"
- Self-harm behavior and suicidal thoughts are a "go to" coping strategy for some

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Unique Risk Factors Among Prison/Jail Inmates

- Fazel (2008) meta-analyzed 34 studies (12 from U.S.)
  - Single celling
  - Commitment offense murder or violent crime
  - Long sentences, especially life
  - Marriage
  - Pre-adjudication status

CDCR Risk Factors

- Ten years of data comprising almost 300 suicides
- Prominent commonalities among these deaths include:
  - Segregated housing (especially short term)
  - Recent negative staff interactions
  - First prison term
  - New to prison
  - Receipt of "bad news"
  - Concerns for personal safety
  - Recent disciplinary violations

Risk Evaluation in Prison is Very, Very Difficult for Clinicians

- A federal court expert has opined that 60-80% of suicide risk evaluations and treatment were inadequate
- Clinicians come with varied backgrounds
- Few have formal training in suicide risk evaluations – particularly with correctional populations
- Inmates use suicidal language and self-harm behavior for a variety of ends
- Some inmates commit suicide for non-mental health reasons
- The culture of prison is not very compassionate

Suicide Autopsies as System Improvement Tools

- Part of CDCR's CQI process
- Psych autopsies are required for every suicide and look at:
  - Was the emergency response appropriate and timely?
  - Were mental health needs met?
  - Were custodial policies followed?
  - Was medical care appropriate?
  - Why now?
- Root Cause Analysis now being applied to these sentinel events

Problems Identified by Autopsies

- Poor continuity of care
- Poor differential diagnosis skills
- Poor documentation
- Poor ability to synthesize data
- Inconsistent judgments of risk
- Poor safety planning

Improvements Over Time

- Better documentation
- Better (and more frequent) training
- Improvements in continuity of care
- Better coordination between medical, mental health, and custodial staff
- Public health approach instituted

The DSH Suicide Risk Assessment Study

Phase 1 and the Development of the Chronic-Acute-Idiosyncratic Professional Judgment Measure

The Purpose of the Study

- Suicide risk assessment procedures in correctional and forensic hospital settings largely were not created through empirical processes
  - Differing methods for suicide assessment by state or agency, often 'borrowing' forms that were not validated to begin with
- Two screening measures were shown to have good sensitivity and specificity with inmate samples– The Suicide Concerns for Offenders in Prison Environment (SCOPE) and the Suicide Potential Scale (Perry, Marandos, Coulton, and Johnson, 2010)
  - However, studies evaluating processes and measures after screening are largely absent

DSH/CDCR Research Collaboration

- Explore *reliability, validity, generalizability, and clinical utility* of commonly used suicide risk measures
- Generate normative comparison groups
- Determine empirically how to effectively assess for suicide potential in correctional populations
- Develop and evaluate a structured professional judgment suicide risk assessment process

Structured Professional Judgment

- A clinician makes a determination of risk using a structured process in which the decision is closely guided by a review of key risk factors identified in the literature
- Incorporates the benefits of an actuarial approach by providing an evidence base for evaluation of risk factors
- Incorporates the benefits of a clinical approach by allowing for flexibility and case-specific considerations

Structured Professional Judgment

- Structured Professional Judgment tools show promising ability to assess future risk and guide individual treatment planning (Webster, Nichols, Martin, Desmarais, & Brink, 2006)
  - HCR-20
  - S.T.A.R.T.
  - SAVRY

Research Setting

The Dept of State Hospitals-Vacaville Psychiatric Program is a 440 bed inpatient psychiatric facility

CA Dept of Corrections And Rehabilitation refers approximately 1200-1400 patients per year

Approximately 84% of acute admissions for suicidal ideation/attempts

Research Procedure

- Participation based upon recency of admission
- 60 minute structured interview, comprehensive record review, and administration of instruments
- Several steps taken to ensure valid, cooperative and truthful participation
- Dependent variables
  - Step 1: Number of prior attempts
  - Step 2: Number of future attempts based on CDCR inmate tracking databases and DSH-V Serious Incident Reports
  - Step 3: Death reviews from 2008-2012 (N =129)

Measures (Phase 1)

- **Beck Scale for Suicidal Ideation (BSS)**
  - 21 items: suicidal desire, attitudes, plans and behaviors
- **Beck Hopelessness Scale (BHS)**
  - 20 items reflecting hopelessness and pessimism about the future
- **Adult Suicidal Ideation Questionnaire (ASIQ)**
  - 25 items measuring the frequency of suicidal ideation within the past month
- **Reasons for Attempting Suicide Questionnaire – Internal Perturbation (RASQ-Int)**
  - 6 items of internally-motivated reasons for suicide attempts (psychache/internal anguish)

Measures (Phase 1)

- **RASQ – Extrapunitive/Manipulative (RASQ–Extra)**
  - 8 items of externally-motivated reasons for suicide attempts
    - Hypothesized to be uncorrelated w/ suicidal intent
- **Suicide Risk Assessment Checklist (SRAC)**
  - Numerous checklist items categorized as Static, Slowly-Changing, Acute, and Protective (present/not present format)
    - Exploratory research question, non-validated measure

Participants

- **N =** 545
- **Average Age:** 38
- **Ethnicity:** 33% African American, 34% Caucasian, 21% Latino, 1% Asian, 10% Other/Biracial
- **Average Education level:** 11 years
- **Average SES:** 77% were either Unskilled Laborers or Machine Operators
- **Average Length of Incarceration:** 6 years
- **Relationship Status:** 84% single

Suicide History Findings

- 87% engaged in at least one suicide attempt, with a mean of 4.3 attempts
- Most common methods – cutting (49%), hanging (49%) and overdose (45%)
- 58% reported engaging in self-injurious behavior (without intent to die)
- 66% psychiatrically hospitalized prior to being incarcerated
  - Most typically for suicidal behavior

Suicide History Findings

- Ethnicity
  - 4 for African Americans, 4.3 for Caucasians, 4.7 for Latinos, 3 for Asians, and 4.6 for the Other/Biracial group
  - No significant differences among groups
- Age
  - Uncorrelated with amount of prior suicide attempts
- Presence of Axis I and Axis Disorders
  - Uncorrelated with amount of prior suicide attempts

Mental Health Findings

- Axis I Mental Illness – 100%
  - Major Depressive Disorder or Depressive Disorder NOS (30%)
  - Schizophrenia or Psychotic Disorder NOS (25%)
  - Schizoaffective Disorder (21%)
  - Substance Dependence or Abuse (61%)
- Axis II Mental Illness – 74%
  - Antisocial Personality Disorder (43%)
  - Personality Disorder NOS with antisocial, borderline and narcissistic traits (14%)
  - Borderline Personality Disorder (9%)

Suicide History Findings

- Childhood trauma
  - Experience of physical or sexual abuse, neglect, observation of domestic violence, and family history of suicide attempts were correlated with # of attempts
- Cognitive difficulties
  - History of cognitive disorders, and head traumas correlated with # of attempts
- Juvenile delinquency
  - Juvenile arrest, incarceration, gang affiliation, and drug abuse correlated with # of attempts

Suicide Risk Measures

- Standardized suicide risk measures are valid and reliable in an inpatient correctional sample (Cronbach's alpha = .68-.95; Spearman's rho = .29-.68, p<.01)
- As number of past attempts increased, scores were significantly higher on ALL measures
- The 'multiple attempter' threshold from previous literature proved to be the most meaningful cut point in the present analyses
  - A growing body of literature on multiple attempters is relevant to understanding suicide risk in incarcerated mentally ill patients (Forman, Berk, Henriques, Brown, & Beck, 2004; Rudd, Joiner & Rajab, 2001)

Multiple Attempters vs. Nonattempters/Single Attempters

	0 – 1 Attempts (N = 152)	**2 or More Attempts** (N = 432)
ASIQ	30.5	63.9
BSS	4.7	12.1
BHS *(N = 64; N = 213)	6.9	9.8
RASQ Internal	16.3	20.4
RASQ Extra	16.4	17.6

Multiple Attempters vs. Nonattempters/Single Attempters

	0 – 1 Attempts (*N* = 64)	2 or More Attempts (*N* = 213)
SRAC Static	3.6	3.6
SRAC Slow Chg	2.7	2.7
SRAC Dynamic*	3.5	5.6
SRAC Protective	5.2	5.2

*Significant Dynamic Items = Suicide preparation, depression, hopelessness, helplessness, guilt, worthlessness, fearfulness for safety, agitation, affective instability and insomnia (each within the past month)

Normative Comparisons

	Original Sample	Ideators or Attempters	Present Study
ASIQ	*x* = 30.66 (inpatient)	*x* = 52.53 (inpatients with 1 or more attempts)	Two Attempts *x* = 63.9 0-1 Attempts *x* = 30.5
RASQ Int	*x* = 9.4 (prison mental health setting)	*x* = 20.33 (community sample with 1 or more attempt)	Two Attempts *x* = 20.4 0-1 Attempts *x* = 16.3
RASQ Ext	*x* = 11.47 (prison mental health setting)	*x* = 16.54 (correctional sample with 1 or more attempt)	Two Attempts *x* = 17.6 0-1 Attempts *x* = 16.4
BSS	*x* = 7.5 (depressed inpatient and outpatient)	*x* = 15.63 (inpatient 'suicide ideators')	Two Attempts *x* = 12.1 0-1 Attempts *x* = 4.7
BHS	*x* = 10.10 (depressed inpatient and outpatient)	*x* = 11.67 (inpatient 'suicide ideators')	Two Attempts *x* = 9.8 0-1 Attempts *x* = 6.9

Area under the curve (AUC)

ASIQ	.78
BSS	.73
BHS	.63
RASQ Int	.67
RASQ Extra	.55
SRAC Dynamic	.75

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CAI

CHRONIC			
1. Multiple attempts	0	1	2
2. Childhood trauma	0	1	2
3. Cognitive deficits	0	1	2
4. Habituation to pain, death or dying	0	1	2
ACUTE			
5. Persistent suicidal ideation in the past month	0	1	2
6. Suicidal desire or intent	0	1	2
7. Suicide preparation	0	1	2
8. Absence of positive emotions	0	1	2
9. Severe negative emotions	0	1	2
10. Anguish which motivates suicidal ideation	0	1	2
11. Negative view of self	0	1	2
IDIOSYNCRATIC			
12. Current or impending triggers	0	1	2
13. Ineffective risk management	0	1	2
14. Poor connection to sources of support	0	1	2
15. Lack of protective religious, cultural, familial or personal beliefs about suicide	0	1	2

Chronic Factors

1) Number of prior attempts

2) Childhood trauma
   - Hx of physical or sexual abuse, neglect, witnessing DV or suicide within the family

3) Cognitive difficulties
   - Hx of special education and/or TBIs

4) Habituation to pain, death or dying
   - Hx of SIB, substance abuse, juvenile criminal bx, or gang affiliation

Acute Factors (Critical Items)

5) Persistent suicidal ideation
   - Adult Suicidal Ideation Questionnaire (ASIQ) appears to be gold standard

6) Suicidal desire or intent
   - Beck Scale for Suicidal Ideation (BSS), particularly the screening items, appears to be a valid measure of desire

7) Suicide preparation
   - Observed or stated evidence or preparation
   - Methods, timing, writing notes, giving away possessions

Acute Factors (Affective Items)

8) Absence of positive emotions
- Depression, helplessness, hopelessness (BHS items may apply, but not total score)

9) Severe negative emotions
- Agitation, affective instability, fear for safety

10) Anguish which leads to ideation
- Psychache (RASQ items may apply, but not total score)

11) Negative view of self
- Self-perceptions of worthlessness or guilt
  - (Burdensomeness currently being explored in phase 2 of study)

Idiosyncratic Factors

12) Current or impending triggers
- Events or situations which activate unique suicidal crisis/mode

13) Barriers to current risk management availability and effectiveness
- Safeguards by family, friends, institutional staff; means restriction

14) Minimal participation in/connection to treatment and support
- In relation to family, friends, mental health staff, education, religion/spirituality

15) Lack of protective religious/spiritual/personal beliefs
- Individual's beliefs or attitude about consequences of suicide

Interrater Reliability

Intraclass Coefficients

CAI Chronic	.95
CAI Acute	.97
CAI Idiosyncratic	.88
CAI Total	.97

Convergent Validity

	BSS	ASIQ	RASQ-Int
CAI Chronic	.45**	.47**	.43**
CAI Acute	.68**	.63**	.41**
CAI Idiosyncratic	.59**	.46**	.35**
CAI Total	.72**	.65**	.47**

**p<.01

*Item 6 on Acute Scale was removed with BSS
Item 5 on Acute Scale was removed with ASIQ
Item 10 on Acute Scale was removed with RASQ-Int

Multiple Attempters vs. Nonattempters/Single Attempters

	0 – 1 Attempts (N =71)	2 or More Attempts (N = 178)
CAI Chronic	3.5	4.4
CAI Acute	5.5	8.1
CAI Idio	2.1	3.9
CAI Total	11.2	16.5

*Item 1 removed for all analyses

Area under the curve (AUC)

CAI Chronic	.67
CAI Acute	.71
CAI Idio	.76
CAI Total	.77

Clinical Implications

- Validation of the CAI still in process to develop a structured professional judgment risk assessment procedure in correctional inpatient settings
  - Prediction of attempts after participation
  - CAI applied to death reviews
  - Phase 2 measures
- Future direction – validation in other settings
  - Certain setting-specific factors may need to be added, such as age, ethnicity, hx of mental illness, etc.
  - In the present study, these factors were not associated with risk due to the extreme nature of the participant pool (74% multiple attempters; 100% with a Major Axis I Disorder)

Improving Suicide Risk Evaluation

Phase 2 of the DSH Suicide Risk Assessment Study

Improving Suicide Risk Evaluation

Phase 2 of the DSH Suicide Risk Assessment Study

Let's start with some questions…

Question 1

If an inmate states that he has no current suicidal ideation, it is safe to assume:

a. Chronic suicide risk is low

b. Acute suicide risk is low

c. There is no indication that a suicide risk evaluation is needed

d. It is not safe to assume level of risk based on this single statement

A finding to ponder…

When interviewed about how long it took to go from deciding to commit suicide to acting upon the decision, suicide survivors reported:

* 40% made their decision w/in 5 minutes of the act
* 70% made their decision w/in the preceding hour

(Simon, et al., 2001)

A finding to ponder…

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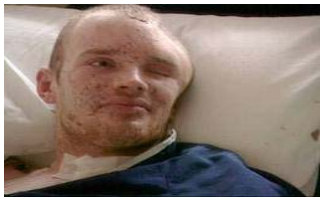
(Simon, et al., 2001)

Implication: We need to know who's at most risk to make such a decision…

Question 2

If an inmate states that he made a suicide attempt because of pressure from gang members, the lethality of his attempt is likely to be low.

a. True
b. False



Australian Prison Study

Dear, Thomson, & Hill (2000) found that correctional clinicians underestimated the potential lethality of inmates who attempted suicide if told the reason for the attempt was gang pressures, prison politics, etc. They found no difference in potential lethality for prisoners between those who attempted based on family losses, depression, or within prison reasons.

Question 3

An inmate describes to you that he now thinks he could be forgiven by God if he kills himself, that it would be better for his loved ones if he did so, and that he no longer fears death. He describes this in a matter-of-fact manner. This description can best be thought of as:

a. Hopelessness
b. Perceived Burdensomeness
c. Acquired capability
d. Chronic readiness

Let's talk more about this one…

Phase II

- With a very large percentage of multiple attempters, the second phase of the study aimed to find measures, constructs, or processes that further differentiated those at highest chronic risk within this very high risk population. We also sought to tailor assessment more towards the realities of and the unique setting of correctional inmates.
- A striking lack of ambivalence regarding dying by suicide was noted qualitatively during Phase I; we sought to assess this observation

Phase II

- Following case 345, several measures were no longer administered (BHS, SRAC) and (4) new measures were added to evaluate:

1. The applicability of the Interpersonal-Psychological Theory of Suicide (Joiner, 2005) to incarcerated men
2. What specific cultural, interpersonal, and religious/ spiritual beliefs are applicable (and protective?) for prisoners
3. Whether we could determine trajectories towards suicide in high risk, multiple attempters

Phase II Measures

- Acquired Capability for Suicide Scale (ACSS, Joiner, et al., 2010) –20 Items related to level of comfort with dying by suicide
- Interpersonal Needs Questionnaire (INQ, Joiner et al., 2010) 25 items indicating the degree one feels like a burden to loved ones or society, and the degree to which one feels like he belongs within his social group

Phase II Measures

- The ACSS and INQ were added to attempt to verify the Interpersonal-Psychological Theory of Suicide (ITPS) on a correctional sample. Prisoners may naturally feel that they are a burden to others (families, society) and may perceive themselves as no longer belonging to family, community, etc.
- Do the ACSS and INQ add to the ability of clinicians to identify prisoners at highest chronic risk? *(We'll see later…)*

Phase II Measures

Sample ACSS* questions (Acquired Capability):

"I can tolerate a lot more pain than most people"

"I am not at all afraid to die"

"It does not make me nervous when people talk about death"

*Joiner, 2009

Phase II Measures

Sample INQ* questions (Burdensomeness):

"These days the people in my life would be happier w/o me"

"These days I think my death would be a relief to the people in my life"

Sample INQ* questions (Belongingness):

"These days I feel disconnected from other people"

"These days I rarely interact with people who care about me"

"These days I don't think I matter to the people in my life"

Suicide Risk Evaluations

What are protective factors in prison settings?

The Culture and Protective Suicide Scale for Incarcerated Persons (CAPSSIP; Horon, Williams & Lawrence, 2013)—Inmates rate 22 items associated with whether or not cultural, religious/spiritual, interpersonal or individual barriers to suicide would dissuade them from making a suicide attempt.

Phase II Measures

The CAPSSIP also asks inmates to discuss their adherence to cultural, familial, and religious/spiritual prohibitions to suicide.

Phase II Measures: Culture and Protective Suicide Scale for Incarcerated Persons (CAPSSIP, Horon, et al. 2010)

How important are the following factors to you in considering whether you could commit suicide?

0	This definitely would not stop me
1	This applies to me, but would probably not stop me
2	I'd consider this, but would still lean towards making an attempt
3	This makes me less likely to make an attempt
4	This makes me very unlikely to make an attempt
5	Because of this I definitely will not make an attempt

Phase II Measures: Culture and Protective Suicide Scale for Incarcerated Persons (CAPSSIP, Horon, et al. 2010)

Sample items:

1.) My religious or spiritual beliefs don't allow for suicide

2.) I have a family that cares for and supports me in or out of prison

7.) I can live a meaningful life in and/or outside of prison

16.) With the help of my people, I can cope with my incarceration

21.) People in my community would think badly of me or my family if I killed myself

Suicide Risk Evaluations

- Per Horon, McManus et al. (2013):
  - Older inmates report an elevated amount of psychache on the RASQ (.16*)
  - Younger inmates report more affective distress during interview (.15*)
  - As length of time served increased, so did:
    - psychache (.18**),
    - hopelessness (.20**), and
    - suicidal desire (.14*).
  - However, as length of time served increased, the importance of job performance was more **protective against suicide** (.14*)

*Significant at the .05 level

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Suicide Risk Evaluations

What are protective factors in prison settings?

Study finding suggest that protective factors may erode in correctional settings. Shoring up or restoring protective variables is a meaningful preventative avenue for intervention.

Cultural Suicide Risk Formulation

The CAPSSIP adds a cultural formulation, as: "Without particular attention to cultural variation in suicide risk expression, suicide risk may be under-detected and managed improperly (Joe & Kaplan, 2001)."

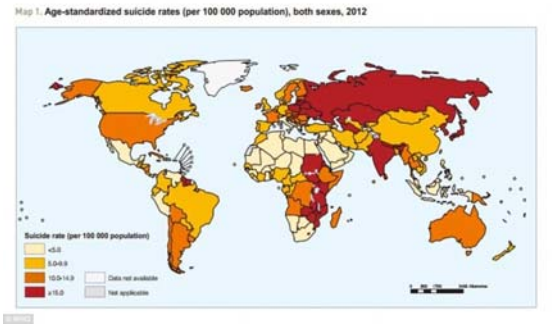
Cultural Suicide Risk Formulation

"…stereotypes and knowledge based on Western culture may result in misdirected assessment and treatment of suicide… (Burr, 2002)."

Cultural Suicide Risk Formulation

* The CAPSSIP assumes incarceration and asks specific questions regarding adherence to familial, religious, and cultural prohibitions to suicide.
* The degree of cultural, familial, and individual beliefs about the acceptance of suicide and the existence of an afterlife predicts rates worldwide (Stack & Kposowa, 2011). Strong adherence to cultural and religious prohibitions to suicide are most protective. These are key assessment variables.

Worldwide Suicide Rates: 2012



Cultural Suicide Risk Formulation

Individuals who describe letting go or rejecting familial, cultural, and religious prohibitions to suicide may be seen as advancing towards a suicidal demise.

Cultural Suicide Risk Formulation

Similarly, inmates who describe eschewing prohibitions involving the afterlife, or discuss 'loopholes' regarding the afterlife can be seen as heading towards suicide (at least high chronic risk), e.g.: "jumping from a high enough place" or "time to repent before bleeding out"

Cultural Suicide Risk Formulation

The largest difference between multiple attempters and others on the CAPSSIP administered to inmates was a belief that suicide would not negatively affect the afterlife and/or no belief in an afterlife.

Phase II Measures

The Chronic Readiness Questionnaire (CRQ; Horon, 2011)—12 items related to how patients rate their readiness to die by suicide along interpersonal, emotional, behavioral, and spiritual/ existential domains. Ambivalence about dying by suicide is also assessed.

Phase II Measures: CRQ

Please rate below what best describes your feelings about possibly dying from suicide based on the following scale:

1. This doesn't describe me at all
2. This mostly doesn't describe me
3. This is about half right, half wrong for me
4. This mostly describes me
5. This describes me exactly

Phase II Measures: CRQ

Sample items:

1.) I've gotten used to the feelings that go along with death by suicide.

4.) I don't have spiritual beliefs that keep me from committing suicide

5.) I understand how to commit suicide, having mentally prepared for it

9.) I no longer have ambivalence (back and forth feelings) about suicide

Phase II Measures: CRQ

The CRQ was designed to measure 5 constructs:

* Emotional Readiness for Death: getting used to the feelings associated with dying, overcoming anxiety or fear, etc.
* Family and Interpersonal: disengaging from family and other supports, lack of significant relationships

Phase II Measures: CRQ

The CRQ was designed to measure 5 constructs:

* Existential and/or Spiritual: Adherence to cultural and religious prohibitions to suicide, and/or distortions of such beliefs; the impact of these beliefs on pursuing death
* Behavioral: Rehearsing suicide, preparing for the pain of death…
* Trajectory: How ready does the person feel now vs. 6 months ago; how long has the person felt ready to die by suicide

Evaluating chronic risk

Imagine what it would take you to prepare for death by suicide…

- Emotional: getting used to the feelings associated with dying, overcoming anxiety, etc.
- Family and Interpersonal: disengaging from family and other supports
- Existential and/or Spiritual: cultural and religious beliefs, and distortions of such beliefs, in pursuing death
- Behavioral: Rehearsing suicide, adjusting to the pain of death…

Evaluating chronic risk

This is the sort of contemplation and process of overcoming barriers to suicide that the CRQ is designed to assess.

How did the measures do?

And what information do they add to suicide risk evaluation?

Phase II Findings—Mean scores for Multiple attempters vs. those with 0 or 1 attempt

Green—difference at the .01 level of significance	0 – 1 Attempts (N =68)	2 or More Attempts (N = 176)
Thwarted Belongingness	36.1	41.9
Perceived Burdensomeness	44.8	57.2
Acquired Capability	40.9	46.2
CAPSSIP	77.2	54.4
CRQ *(N = 34; N = 98)	25.5	37.2

Phase II Findings—CAPSSIP **subscale** means: Multiple attempters, single attempters and non-attempters

	No Attempts	1 Attempt	2 or More Attempts
Feeling of support from family and loved ones	15.6	13.8	10.4
Sense of purpose, meaning, and ability to contribute	18.8	16.8	12.5
Acceptance of community and religious prohibitions to suicide	27.8	20.6	15.0

Evaluating chronic risk: Prediction of multiple attempter group membership

Receiver Operating Characteristics (ROC curve)

- Area Under the Curve (AUC) – probability that a person who is known to have multiple attempts will score high on predictor measures, and that a person with 0 or 1 attempts will score low
  - AUC of .50 = no predictive power, chance classification
  - AUC of .70 = moderate to large
  - AUC of .75+ = large (75% chance of correct classification

Phase II Findings—Area Under the Curve

ACSS	.63
INQ-Belongingness	.62
INQ-Burdensomeness	.70
CAPPSIP	.71
CRQ	.76

Listening for chronic readiness

The patient informed his treatment team that he has contemplated suicide "for awhile" and has determined it to be the "solution to my situation" (i.e., life sentence), stating, "I wouldn't call it a feeling, I'd call it a commitment, I've made a decision and I'm okay with it."

Listening for chronic readiness

The patient repeatedly stated that he has no intention of completing his long prison sentence, and will take his life "the first chance" he gets. He set fire to his cell just one week ago… The patient stated he would refuse program, leisure activities, etc. as he only wants to die… He acknowledged family contact, but was adamant in stating that having children is not enough to keep him from killing himself.

Listening for chronic readiness

"The patient explained he has thought about cutting on himself and to ask for help at the last minute with the hope that it will be too late and he will bleed out. This way he can say to God that he tried to change his mind at the last minute and be forgiven."

Suicide Risk Evaluations

A Suicide risk evaluation should include: (Jacobs, 2006)

1. A suicide specific inquiry, to address imminent and acute risk (BSS, ASIQ, CAI acute, SRAC Dynamic)…
2. An understanding of chronic risk factors, including chronic factors that are modifiable (CRQ, CAI Chronic)
3. An assessment of protective factors (CAPSSIP, CAPSSIP cultural formulation, CAI Idiosyncratic)
4. A determination of acute & chronic risk level
5. The development of a risk management response

Thank you

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