

SRA Interpretation Guide

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Purpose of the Phoenix SRA

In VISN 18, suicide is the #1 reportable incident. Phoenix VAMC experiences about one suicide per month among its enrolled veteran patients. Focused Reviews of those suicides have suggested that some might have been prevented if a better suicide risk assessment (SRA) had been performed by the patient's clinicians. Thus the need for a tool to guide clinicians in the SRA and subsequent decision-making was recognized.

Our goal was to promote a standard of care that corresponds to the state-of-the-art in suicide risk assessment and prevention, thereby maximizing our ability to detect and protect at-risk patients from self-harm. ***Used properly, this SRA tool provides a framework for a thorough, evidence-based, legally-defensible, and consistently competent suicide risk assessment.*** It can be used for staff training as well. The Phoenix SRA is a critical element in our VISN-driven suicide prevention initiative.

Our SRA form, shown in Attachment 1, includes 7 "Risk Factors." All have been shown by various research studies to be correlated with suicide. However, attempts by researchers to devise point-scoring systems that yield an accurate risk estimate for clinicians have failed. Therefore, the estimation of suicide risk remains a clinical judgment — one that must be based on the right type of information. Proper use of this SRA helps assure that this occurs. Effort was made to keep this SRA as brief as possible while still retaining the necessary coverage of key risk factors.

Using this SRA Effectively:

Q: Who should use this SRA?

A: Clinicians who have had a brief training/orientation to the SRA, in the context of a clinical interview.

Q: How and when should I use the "May We Ask" screen?

A: Use it anywhere to help detect patients that may be contemplating suicide. For example, in Primary Care it could be used in conjunction with a depression screen, or, given only to patients who score positive on the depression screen. You can hand the Screen to the patient and ask them to either write their answers on it or tell you their answers verbally.

Q: Do I always need to probe into all 7 Risk Factors?

A: No. In some situations, it may be appropriate to skip some of the Risk Factors. For example, in a phone call from a suicidal patient, you would not give the "May We Ask" Screen. In addition, if the patient's suicide plan and intent indicate imminent suicide danger, you would skip Risk Factors 3 through 7 and go directly to Step 3 ("Estimate Suicide Potential").

Q: What if my patient denies suicide ideation but has many other Risk Factors?

A: In this situation, it is unwise to assume that suicide risk is low/none. Probe further into feelings of discouragement vs. reasons for living. Try to assure the patient that suicidal thoughts are very common and that it's okay to disclose them. If your patient continues to deny suicide ideation, but you still have an uncomfortable feeling, then identify him/her as moderate or high long-term risk and monitor him/her closely at future visits by repeating the SRA. Similarly, if your patient voices no suicidal ideation to you, but had done so previously with another staff member, extra probing is required.

Q: What if I suspect that my patient is faking a suicide crisis, that is, "malingering" or "feigning?"

A: Just as in the case of suicide crisis that is genuine, this SRA tool helps provide the information you need to justify your clinical decisions. Malingering patients may be seeking shelter, attention, or help with a life problem. The best approach is to determine how to meet the actual needs of the patient without feeling "emotionally blackmailed." It would be a serious mistake to dismiss any non-lethal suicide attempt as a "manipulative gesture." Our patients are capable of extreme measures under the right circumstances and may engage in lethal behaviors resulting in accidental death. Again, the best treatment begins with a thorough SRA.

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Risk Factor Interpretation:

Risk Factor #1: "May We Ask¹..."

- The two questions of this screen are shown below with instructions on how to interpret.

1) "It is a fact that nearly everyone has, at some time, **felt discouraged**.

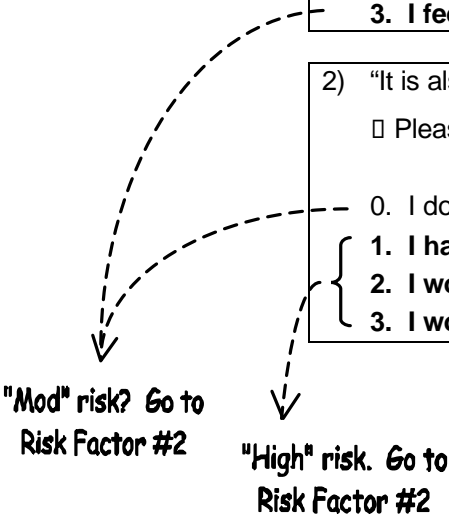
Please circle the number below (0, 1, 2, or 3) that best describes how you feel right now:

0. I am not particularly discouraged about the future.
 1. I feel discouraged about the future.
 2. I feel I have nothing to look forward to.
3. I feel that the future is hopeless and that things cannot improve.

2) "It is also a fact that many people **have had thoughts of ending their lives**.

Please circle the number below (0, 1, 2, or 3) that best describes how you feel right now:

0. I don't have any thoughts of killing myself.
1. I have thoughts of killing myself, but I would not carry them out.
2. I would like to kill myself.
3. I would kill myself if I had the chance.



INTERPRETATION TABLE:

As indicated by the arrows above...

IF... response to Question #1 is:	AND... response to Question #2:	THEN... rate Severity as:	AND... do this:
0, 1, or 2	0	Low/None	Skip to Risk Factor #3 if more info is desired. Else, go to Step 3 .
3	0	Mod	Ask Pt. to elaborate, and go to Risk Factor #2. Probe for suicidal ideation, which may be present, but Pt. may be reluctant to admit it. Don't be afraid to ask directly about suicidal thoughts.
Any number	1, 2, or 3	High	Ask Pt. to elaborate, and go to Risk Factor #2 to assess planning. A "2" or "3" suggests that risk is <i>imminent!</i>

¹ These two questions are adapted from two very similar items on the Beck Depression Inventory that have been shown to be predictive of suicide (Beck, AT & Steer, R.A. (1987). *Manual for the Revised Beck Depression Inventory*. San Antonio, TX: Psychological Corporation).

Risk Factor #2: "Suicide Ideation, planning, & intent"

1. Suicidal Talk:

- 2/3 of "Verbalizers" reveal suicidal ideation to family/friends... but not to clinicians. *Verbalizers* are 30x at risk.
- So, probe and be alert for clues! You may need to question family members about patient's talk and behavior.
- Verbalizations: Overt: "I'm going to kill myself."
 Covert: "Life has lost its meaning to me." "It's just too much to put up with."
 "Nobody needs me anymore." "I just can't go on any longer."

2. If suicidal ideation is present, assess planning. Risk is greatest when planning involves:

- r **High specificity** — Detailed, well thought out plan. Pt has probably been thinking about it for a long time.
- r **Lethal means** — Handgun, hanging, jumping from tall building, etc.
- r **Access to means** — E.g., owns a gun.
- r **Rescue prevention** — Plan prevents others from blocking attempt or giving medical aid post-attempt.
- r **Short timeframe** — Plans to act this week. Specifying any "date of death" increases risk vs. no date.
- r **Believability** — Given patient's resources, plan is well-conceived, realistic, and genuine.
- r **Intent is death** — Evidence from verbalizations or actions indicates that patient's wish is to die.

- ✘ **Evidence of intent/wish to die:** (FACT: 80% of suicidal people give clues before acting)
 - r Termination behavior (Gives away possessions, prepares will, inappropriate thanks/good-byes, makes amends, severs relationships, signs of preparing for suicide—e.g, buys a gun).
 - r Verbalizations & Veiled suicidal threats, e.g., "I can't take this pain much longer" (see #1 above).

3. Examples of NONE/LOW, MOD, HIGH Severity of Planning/Intent Elements:

NONE	LOW	MOD	HIGH
<u>Specificity of Plan:</u> <input checked="" type="checkbox"/> one:			
<input type="checkbox"/> -No plan, or passive only	<input type="checkbox"/> -Vague, few details	<input type="checkbox"/> -Fairly specific	<input type="checkbox"/> -Specific & well conceived!
<u>Lethality of Means:</u>			
<input type="checkbox"/> -No means specified	<input type="checkbox"/> -Low (e.g., cuts/scratches)	<input type="checkbox"/> -Mod (e.g., drowning, O.D.)	<input type="checkbox"/> -High (e.g., gun)!
<u>Access to Means:</u>			
<input type="checkbox"/> -No means specified	<input type="checkbox"/> -Yes, with difficulty	<input type="checkbox"/> -Yes, probably	<input type="checkbox"/> -Yes, definitely (e.g., owns gun)!
<u>Rescue Prevention:</u>			
<input type="checkbox"/> -N/A	<input type="checkbox"/> -High (e.g., others nearby)	<input type="checkbox"/> -Moderate	<input type="checkbox"/> -None (Alone, Remote, or access blocked)!
<u>Acuity / Timeframe:</u>			
<input type="checkbox"/> -Unspecified (e.g., "someday")	<input type="checkbox"/> -Unspecified (e.g., "soon")	<input type="checkbox"/> -This week/month	<input type="checkbox"/> -Now or today!
<u>How genuine & believable:</u>			
<input type="checkbox"/> -Not at all	<input type="checkbox"/> -Somewhat	<input type="checkbox"/> -More than not	<input type="checkbox"/> -Very much so!
<u>Intent</u>			
<input type="checkbox"/> -Goal <u>other than</u> death	<input type="checkbox"/> -Death, but ambivalent/hesitant	<input type="checkbox"/> -Death	<input type="checkbox"/> -Death + Termination behavior!

4. Ideation & Planning: Examples of Severity Ratings:

High	Mod	Low
Patient has well-conceived, believable, lethal plan with genuine intent to use within the coming week. (This Pt. is in imminent danger).	Plan is vague and suicidal thoughts are infrequent, but Pt has a gun and that's "probably what I'd use."	Passive death wishes only (hopes for disease acceleration, or to "not wake up one morning" but would not take matters into own hands).
Persistent and preoccupying thoughts involving lethal method. Has access to lethal means.	Occasional suicidal thoughts but with vague plan involving low-moderate lethality method (such as: "Maybe I'll take some pills... I'm not really sure.")	Has plan that is unrealistic (difficult to implement, would not work, and/or has high rescue probability). Example: wheelchair-bound NHCU patient will "jump off roof" but has no idea how to access the secured roof.

NOTE: Recall duty to protect and to warn (patient, if suicidal, and others, if suicide plan involves potential harm to them).

RF #3: Previous Attempts:

- r Patients with previous attempt within the past year are at high risk relative to non-attempters (80x for women, 200x for men).
- r Previous attempt with high-lethality method (e.g., jumping from 2 or more stories) is more serious than one with low lethality (e.g., superficial wrist cuts).

RF #4: Behavioral Clues:**A. Favorable Attitude Towards Suicide:**

- r Suicide is only solution to problems/suffering.
- r Suicide is noble or socially acceptable.
- r Other people would not care or suffer.
- r Wish to make others suffer or "pay."

B. Malignant Interactions:

- r Negates or rejects help/alliance.
- r Hostile, aloof, or guarded.

C. Emotional Distress:

- r Anxiety, panic, mental turmoil.
- r "Stressed out," can't cope.
- r Hx of chronic stress with exhaustion.

D. Termination Behavior:

- r Gives away possessions.
- r Prepares will.
- r Inappropriate thanks/good-byes.
- r Makes amends and/or severs relationships.
- r Signs of preparing for suicide, e.g., buys gun.

E. Agitated and/or ...:

- r Poor impulse control; prone to act, not think.
- r Hx of impulsive aggression.
- r ↓Judgment, insight, reasoning, problem-solving.

RF #5: Predisposing Mental Disorders/Traits:

- r **Depression:**
 - r Hopelessness, especially if it continues between depressive episodes. Believes that nothing can be done to improve situation or future).
 - r Loss of pleasure/interest: No longer enjoys previously enjoyed activities; "doesn't care about anything anymore." Decrease in self-care and socialization.
 - r Mood is sad or irritable.
 - r Sense of worthlessness.
 - r Poor concentration.
 - r Other signs of depression (insomnia, fatigue, change in appetite).
 - r In elderly, depression may be masked by somatic complaints. Look for increased medical utilization since 70% of elderly suicidants see Primary Care provider during the month before their suicide. See "High Risk Groups" below.

RF #5: Predisposing Mental Disorders/Traits (continued):

- r Substance Abuse/dependence.
- r PTSD.
- r Schiz.
- r Borderline or Antisocial PD.
- r Panic Disorder
- r Hx Impulsive-Aggression.

RF #6: Match to Predisposed High-Risk Group:

- r **Elderly (>64 y/o) with...**
Depression (often masked with somatization and increased Tx-seeking) + isolated/alooof + serious physical illness + losses + substance abuse + white male + hostility.
- r **Terminally ill with...**
Depression/hopelessness + uncontrolled pain + sees self as burden + exhaustion/weakness + recent loss or bereavement.
- r **Affective Disorder/Depressed, with...**
Hopelessness + anx/panic + anhedonia + insomnia + indecision + poor concentration + acute ETOH + obsessive-compulsive features.
- r **Schizophrenia with...**
Depression + now in early course of illness + good pre-morbid functioning + painful awareness of disease impact.
- r **Alcoholism with...**
Depression + acute disruption of major relationship + abusing 2nd drug.
- r **Impulsive-aggressive Traits with...**
Hx of harm to self/others + substance abuse + mood swings + anger + interpersonal conflicts + lack of long-term caring relationships.
- r **Hx of previous suicide attempt with...**
Current depression + substance abuse + stressor.

RF #7: High-Risk Life Circumstances:

- r Has gun.
- r **Few/no offsets** (Not responsible for minor, no spiritual/cultural/family taboos against suicide, no shame, few/no reasons to live).
- r **Stressors:** Any perceived loss or hardship, humiliation, or failing health with pain, disfigurement, loss of function, terminal Dx.
- r Discharge from Inpt MH in past month
- r Weak family/community support, no companion.
- r **Living environment adds to risk** (access to lethal methods, influence of others who abuse substances, involved in toxic relationship, etc.).

Step 3: Estimating Suicide Risk

Estimating IMMINENT Risk (risk of suicide this week)

- Integrate all information gathered and make a clinical judgment.
- In general, suicide risk increases with the number and severity of risk factors.
- In 90-95% of cases, **suicide is caused by a crisis superimposed on a mental disorder.** So the presence of a mental disorder (uni- or bipolar depression, substance abuse, severe anxiety/panic, PTSD, schizophrenia, borderline or antisocial personality) increases risk greatly.
- Depression is the most important mental disorder for suicide... but it can sometimes be difficult to detect, so be sure not to miss it if its there!
- **Suicide planning & intent is the single most important factor for estimating imminent risk.** For guidance on *planning*, see "Risk Factor #2: "Suicide ideation, Planning, & Intent", on page 3.
- When estimating imminent risk during phone calls from suicidal patients, always determine their current situation/environment by asking questions such as:
 - Are you alone or is someone else there?
 - Does anyone else know what you're thinking/doing right now?
 - Is there anything there that you're thinking about using to harm yourself?

Example of patient that would be judged to be at IMMINENT RISK:

- Cogent LETHAL PLAN with access to means and intent to use soon.
- Agitated, angry, distraught, with evidence of poor impulse control.
- Depressed/hopeless.
- Intoxicated.
- No available support system.
- Aloof, distant, hostile... you can't establish rapport / trust.

“WHEN IN DOUBT, ADMIT!” — Assure survival!

In MED/SURG Inpatient Units: It has been found that patients who commit suicide...

- Are more anxious, agitated, distressed, and depressed;
- Have less social support (from family or staff)
- Give clues to their intent by word or behavior;
- Are more concerned with body functions, and *were less able to tolerate pain.*

Estimating LONG-TERM Risk (risk of suicide weeks/months from now)

When estimating long-term risk, the most important risk factors are (in order of importance):

1. Previous suicide attempt/s.
2. Presence of predisposing mental disorder.
3. Chronic hopelessness, even during periods of remission from depression.
4. Membership in a High-Risk group.
5. Adverse Life circumstances. (Has predictive power only in the presence of the "predisposing" factors listed above (1-4).

Step 4: Action/Intervention Needed at this time

1. If patient is an outpatient, and you estimate **IMMINENT** risk to be **HIGH** (patient in acute suicide danger), **then consider:**

- Your TOP PRIORITY is to assure patient's safety! *assure survival!*
- Urgent psychiatric consultation and probable hospitalization with:
 - Close observation, 1:1, seclusion room, or other appropriate safety precautions.
 - Immediate initiation of meds to increase central serotonergic activity (one of the SSRI's).
 - Anxiolytics or sedating neuroleptic PRN to reduce anxiety/ agitation/ turmoil.
 - Immediate initiation of supportive counseling.
 - Identification of people in the patient's support system (including other providers) so they can be recruited as much as possible into treatment & discharge planning — especially with regard to post-discharge living environment and life circumstances.
 - Identification of *predisposing* and *triggering* causes of patient's suicidal episode (with incorporation into Treatment Plan). NOTE: If causes are not attacked, the suicidality will return.
 - On Treatment Plan, list suicidal thoughts/behavior as a separate/distinct problem to be addressed.
 - Reassess suicide thoughts/risk frequently during the inpatient treatment and especially before D/C.
- Once crisis resolved, develop treatment plan that:
 - Addresses the individual's unique causal path, e.g., depressive episodes, perceptions of events;
 - May help prevent recurrence of suicidal behavior.

2. If patient is an outpatient, and you estimate **IMMINENT** risk to be **MODERATE** or **LOW...** (i.e., "no acute suicide danger," and patient can survive as an outpatient because he/she has):

- Some type of reliable/helpful social support net (family, friends, clergy, clinicians, etc.) that is willing/able to monitor patient and support the treatment/safety plans;
- Living environment that can be made safe from lethal means;
- Desire/reasons to live that are stronger than the wish to die;
- Sufficient insight, reasoning, judgment, and self-control to effectively participate in the outpatient treatment and safety plan.
- Adequate treatment/meds for any predisposing mental disorders;
- No current substance abuse;
- Therapeutic alliance with one or more clinicians, to work to overcome his/her suicidality.

...then consider continuing outpatient status, but only if you can:

1. Immediately involve patient's support people in a **Safety Plan** that is agreeable to all and includes:
 - Patient's consent and participation;
 - Restricting access to lethal methods while closely monitoring patient's thoughts/behavior.
 - Joint problem-solving to weaken modifiable risk factors / root causes;
 - Decrease of social isolation, anxiety, turmoil, agitation, and/or impulsivity, if present
 - Actions to be taken (and by whom) if active suicidality returns.
2. Devise a Treatment Plan that lists suicidal thoughts/behavior as a distinct problem to be addressed;
3. Schedule appointments frequently enough to provide effective support and suicide risk re-assessments;
4. Assure that patient has 24-hour access to some type of urgent/crisis care;

3. **If IMMINENT risk is UNCERTAIN (unable to determine)...**

Consider gathering additional information (contact family, request another clinician's input, or administer scales such as the Beck Hopelessness Scale or others shown in the "Clinician's Desk Reference").

Step 5: Other Salient Information

The following notes describe other issues that you may need/want to document during the SRA.

Evaluation of patient's competency to participate in treatment decisions and his/her willingness/ability to form a therapeutic alliance. The former is usually evaluated against criteria such as patient's ability to:

- 1) Express a cogent/reasoned preference concerning treatment options;
- 2) Achieve a factual understanding of the issues at hand;
- 3) Rationally examine the information presented to him/her;
- 4) Appreciate the nature of the situation and consequences of the decision.

Failure in ANY of these standards may warrant a judicial determination of competence (Hoge & Applebaum, 1989, cited in: Bongar, 1991, page 177).

Awareness of the limits of "contracting for safety." For example, a patient who is at high imminent risk may be experiencing intolerable pain/suffering/hurt/distress with one or more elements of depression and/or other major mental disorders (e.g., muddled thinking, impaired problem solving, impaired concentration & memory, paralysis of will, difficulty doing the things they know they should do or difficulty resisting things they should not do, and impulsive/aggression with behavioral disinhibition exacerbated by any substances patient may use). To assume that a person in such a mental state would be able to adhere reliably to a no-harm contract is truly wishful thinking. A clinician who contracts in this manner with a potentially suicidal patient needs to remember that the likelihood of the contract reducing suicide risk is nil. Clearly, the persons in the patient's support net must be recruited to make up for the patient's current incapacities.

The limits of confidentiality were explained to patient at outset of Tx. (i.e., confidentiality will be maintained until/unless situation arises where it is necessary to help assure safety of patient or others).

The Crisis Intervention/Plan:

- Takes into account patient's estimated suicide risk, ability/willingness to form tx alliance, and weighs the risks vs. benefits of each of a range of Treatment options and levels of care available.
- Involves patient and family in Tx planning process whenever possible.
- Involves all the current treating clinicians.

Considerations When Tx Planning With A Chronically Suicidal Inpatient:

Sometimes, clinician/team may decide to tolerate short-term risk to foster long-term growth. According to Maltzberger (Maltzberger, J.T. Chap. 15: Calculated risk-taking in the treatment of suicidal patients: Ethical and legal problems. In Lenaars et al., *Treatment of Suicidal People*, Taylor & Francis, 1994), **under such circumstances, clinicians' entries in the Patient Record should show that:**

- Patient participated in discussion of risks/benefits of the discharge and the OutPt safety and Tx plans;
- Patient understood the info and had a good grasp of its implications;
- Patient's ability to think rationally and make good judgments was not impaired by hallucinations, delusions, or severe mood disorder;
- Patient's support system agrees with the plan;

In addition, the Patient Record should include:

- Patient's signed Informed Consent.
- Explanation and rationale for the decision/s made.

Risk of Violent Behavior: If patient has potential/thoughts of harm/violence to others, exercise and document your duty to inform others. Patients with definite intent to harm self or others require voluntary or involuntary emergency psychiatric treatment. In assessing violence, the patient's past behavior is critical. One or more of the following is sufficient to obtain a mental health consultation or referral: past history of violent acts, active substance use, active mental illness (especially paranoia, delusions, and command hallucinations), and means of violence. (DHHS pub. no. 95-3061, 1995, APA, 1993)