A STUDY OF SUICIDE RISK ASSESSMENT IN PRISON: FINDINGS, CONCLUSIONS, AND TOOLS FOR MENTAL HEALTH CLINICIANS

Robert Horon, Ph.D., Suicide Prevention Coordinator
Department of Correctional Health Care Services
California Department of Corrections and Rehabilitation
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Presentation Overview

1. Introduction and objectives
2. Review of the DSH Suicide Risk Assessment Study: purpose, population, measures used and measures developed
3. Key study findings and applications
4. Clinical vignette and practice
5. Increasing precision in suicide risk evaluation

INTRODUCTION AND OBJECTIVES
Introductory Comments

1. Correctional and forensic agencies and institutions must have comprehensive suicide risk prevention programs. Needed components include:
   1. Suicide-resistant architecture and environmental safeguards; e.g. safe cells, custodial and nursing rounds, etc.
   2. Ongoing suicide risk assessment processes (screening at specific timelines, e.g. intake and placement in segregated housing, in-depth assessments, tracking during mental health contacts).


Introductory Comments

3. Meaningful suicide prevention training for all employees
4. Suicide precautions practices that are not punitive or demeaning
5. Recognition that inmates viewed as manipulative can be suicidal
6. Written policies and procedures that are revised as needed

Introductory Comments

While the majority of today's talk will be on in-depth suicide risk evaluation, all aspects of a comprehensive program need to be functioning well for suicide prevention to work.
**Introductory Comments**

Suicides per 100,000 inmates, U.S. Jails and Prisons (Source: BJS)

- Jail Rate
- Prison Rate

**Suicide Prevention Heroes**

Image of a guard at a prison gate

Image of a bridge with suicide prevention signage

Image of a guard at a prison gate with a sign that reads, "Suicide is never the answer."
Suicide Prevention Heroes

Dr. Schneidman’s “the 3 clarifications”:
1. Acute suicidal crises are of relatively short duration, counted in hours or days, not months or years. The peak of self-destructiveness is short-lived.
2. Ambivalence about suicide death is typical; “It is possible for a suicidal individual to cut his throat and cry for help at the same time.”
3. Suicide is relational and dyadic both during contemplation of death and following the death (relationship to dying vs. relationship to living...)

Learning Objectives

Attendees will:
- Identify key findings from the DSH-V suicide risk assessment study
- Apply findings to a clinical vignette illustrating key findings
- Identify three steps to improving personal precision in suicide risk evaluation using a self-assessment tool

THE DSH-V SUICIDE RISK ASSESSMENT STUDY: PURPOSE, POPULATION, MEASURES USED AND MEASURES DEVELOPED
What sources of information do we have to evaluate suicide risk?
1. Patient records
2. Reports from others (staff, family, etc.)
3. Interview
4. Observation
5. Risk measures for Suicide

PRIORS works as an acronym as it reminds us of the prominence of prior attempts as a key to risk assessment and risk management.

What do measures add in evaluating suicide risk?
1. A different avenue of gaining information
2. The patient responds to an item, rather than a person (removes response to nonverbal communication, pairs auditory and visual processing)
3. May be indirect (not a direct question about suicidality)
4. May be more direct than most suicide inquiries
5. May have indications of + or – impression management
6. Measures are repeatable & reflect change, clinician memory may not be and clinicians change
7. Likely increases considerably the number of suicide-specific questions asked

I first proposed a study of suicide risk assessment tools at the then Department of Mental Health-Vacaville Psychiatric Program (DMH-VPP) in 2006. The project was started in 2007. The goals of the study were:

- Explore reliability, validity, and clinical utility of commonly used suicide risk measures in a correctional setting
- Generate a normative comparison group to help clinicians interpret assessment results
DSH-V Suicide Risk Assessment Study

- Evaluate current forms and procedures processing suicide risk.
- Assess other variables related to risk within the population, such as violence history, history of past attempts, etc.
- Determine which variables and test findings most relate to high risk within the study population.

DSH-V Suicide Risk Assessment Study

Dependent variables:
- Number of prior attempts
- Number of future attempts based on CDCR self-harm tracking database and DSH-V Serious Incident Reports

The study sample consisted of 620 male inmates admitted to the Department of State Hospitals-Vacaville between May, 2007 and February, 2015.
- All inmates were referred for inpatient psychiatric care, with nearly equal numbers admitted for acute psychiatric services (average stay of 75 days) as those admitted for intermediate care services (average stay of 180 days).
The Department of State Hospitals-Vacaville is a large inpatient psychiatric facility that admits 1,200-1,400 patients per year. Approximately 84% of admissions for the Acute Psychiatric Program (APP) are for suicidality (ideation/attempts/intent).

Study procedures:
- Acute and intermediate units scheduled at least 1 hour per week for research participation. The inmate’s most recently admitted to each were asked to participate.
- For patients giving consent, the hour was spent on a structured (coding) interview, administration of instruments, and unit file review; each administration included a trained practicum student or intern and a study psychologist or postdoctoral fellow.

Several steps taken to ensure valid participation. Non-research staff were not able to overhear interview or test answers, custody observations occurred from behind windows, and informed consent procedures discussed disclosing information only in the event of imminent risk of harm to self or others.
Study procedures:
- Information provided by patients was verified when possible by medical and custodial chart review. Interviews also included lengthy sections re: reported suicide attempts, with scales of medical consequences and degrees of preparation included.

Demographic characteristics:
- N = 620
- 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

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### Measures (Phase 1)

1. **Beck Scale for Suicidal Ideation (BSS)**
   - 21 items scored 0, 1, or 2, including 5 screening items related to desire to die/desire to live followed by 14 questions related to suicidal planning and preparation.

2. **Beck Hopelessness Scale (BHS)**
   - 20 true/false items reflecting pessimism about the future; no direct questions about suicide.

3. **Adult Suicidal Ideation Questionnaire (ASIQ)**
   - 25 items measuring the frequency of suicidal contemplation within the past month and lifetime.

4. **Reasons for Attempting Suicide Questionnaire – Internal Perturbation (RASQ-Int.)**
   - 6 items of internally motivated reasons for suicide attempts (psychache/inner anguish).

5. **RASQ – Extrapunitive/Manipulative (RASQ–Extra)**
   - 8 items of externally-motivated reasons for suicide attempts.
   - Hypothesized to be unrelated to suicidal intent.
   - All RASQ items are on a 5 point scale from completely agree to completely disagree.

6. **Suicide Risk Assessment Checklist (SRAC)**
   - Numerous checklist items categorized as Static, Slowly-Changing, Acute, and Protective (present/not present format).
   - Exploratory research question to validate procedure.

Near the conclusion of Phase 1, a summary measure was created using principles of a Structured Professional Judgment approach to suicide risk assessment. This measure was called the CAI, referring to:

- **C:** Chronic risk variables related to multiple attempts status in the study population.
- **A:** Acute risk variables related to multiple attempts status.
- **I:** Idiosyncratic factors that require clinical risk formulation (e.g., willingness to engage in treatment; effectiveness of past treatment to reduce suicide risk).
Chronic-Acute-Idiosyncratic Risks for Suicide

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

Measures (Phase 2)

- Following case 345, several measures were no longer administered (BHS, SRAC) and four (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. What differentiates risk profiles within the high risk, multiple attempter group

Measures (Phase 2)

- Interpersonal-Psychological Theory of Suicide measures:
  - Acquired Capability for Suicide Scale (ACSS, Joiner, et al., 2010)–20 items related to fearlessness about death, pain tolerance, etc.
  - Interpersonal Needs Questionnaire (INQ, Joiner et al., 2010)–25 items indicating the degree one feels like a burden to loved ones or society (Perceived Burdensomeness), and the degree to which one feels a sense of belonging with others (Thwarted Belongingness).
Measures (Phase 2)

Interpersonal-Psychological Theory of Suicide measures:
- The ACSS and INQ were added to evaluate the Interpersonal-Psychological Theory of Suicide (ITPS) on a correctional sample.
- Do the ACSS and INQ add to the ability of clinicians to identify prisoners at highest chronic risk?

Sample INQ questions (Burdensomeness): “These days…
“…the people in my life would be happier w/o me”
“…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”
“…I rarely interact with people who care about me”
“…I don’t think I matter to the people in my life”

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”

What are protective factors in prison settings?
The Culture and Protective Suicide Scale for Incarcerated Persons (CAPSSIP; Horon, Williams & Lawrence, 2013)—Inmates rate items associated with cultural, religious/spiritual, interpersonal or individual barriers to suicide.

Measures (Phase 2)

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

Sample CAPSSIP items:
- My religious or spiritual beliefs don't allow for suicide
- I have a family that cares for and supports me in or out of prison
- I can live a meaningful life in and/or outside of prison
- With the help of my people, I can cope with my incarceration
- People in my community would think badly of me or my family if I killed myself
Measures (Phase 2)

The Chronic Readiness Questionnaire (CRQ; Horon, 2011) — 12 items related to how patients rate their readiness to die by suicide, indicating whether interpersonal, emotional, behavioral, and spiritual/existential barriers to death are or are not present.

CRQ Scale: 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

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
STUDY FINDINGS AND IMPLICATIONS

Reliability and validity

Just two slides on this…

Reliability and Validity of Suicide Risk Measures

- Standardized suicide risk measures were answered in a consistent (reliable) manner within this inpatient correctional sample (Cronbach’s alpha = .68-.95).

- As number of past attempts increased, scores were significantly higher on ALL measures, providing evidence of the validity of the measures (Spearman’s rho = .29-.68, p<.01).

- The ‘multiple attempter’ threshold from previous literature proved to be the most meaningful cut point in the present analyses (multiple cut points were evaluated).
Implications: Reliability and Validity of Suicide Risk Measures

- Correctional and state hospital clinicians can, in the aggregate, use these measures with a degree of confidence.
- Positive and negative impression management should be evaluated, as with any self-report measure.
- Remember the study involved reading measures to ensure comprehension; check for understanding on at least a few items per measure.
- More to say on multiple attempters coming up.

Attempt Status

What this indicates, why it’s important, and how it affects measure interpretation...

Study Sample Suicide History Findings

- 87% engaged in at least one suicide attempt, with a sample mean of 4.3 attempts
  - 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 number of prior suicide attempts
- Presence of Axis I and Axis Disorders
  - Uncorrelated with number of prior suicide attempts
- 58% reported engaging in self-harm without intent to die
- 66% psychiatrically hospitalized prior to being incarcerated
On Multiple Attempters...

Rudd, Joiner, & Rajab (1996) first described the unique vulnerabilities of ‘multiple attempters.’ Compared to single attempters & non-attempters, multiple attempters have chronically elevated scores on indices of:

- Suicidal ideation
- Coping skills deficits & perceived stress
- Hopelessness & depression
- Poor interpersonal functioning, and
- Acceptance of suicide

Scores on lethality measures do not differ between multiple attempters and single attempters.

Study Suicide History Findings

A sample mean of 4.3 attempts is higher than other published means in inpatient setting, which typically have means below 1.0.

Number of attempts was carefully evaluated in the study. Thus, the study reflects a uniquely high risk group.

Study Suicide History Findings

Let’s look within the sample at the differences between multiple attempters, single attempters, and non-attempters.
A Study of Suicide Risk Assessment - Horon

Normative Comparisons

<table>
<thead>
<tr>
<th>Original Sample</th>
<th>'Ideators' or Attempters</th>
<th>Present Study</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ASIQ</td>
<td>Two attempts x = 63.8</td>
</tr>
<tr>
<td></td>
<td>RASQ Int</td>
<td>One attempt x = 36.9</td>
</tr>
<tr>
<td></td>
<td>RASQ Ext</td>
<td>No attempt x = 24.7</td>
</tr>
<tr>
<td></td>
<td>BSS</td>
<td>Two attempts x = 20.2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>One attempt x = 17.9</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No attempt x = 14.2</td>
</tr>
<tr>
<td></td>
<td>RASQ Int</td>
<td>Two attempts x = 17.5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>One attempt x = 17.3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No attempt x = 14.8</td>
</tr>
<tr>
<td></td>
<td>RASQ Ext</td>
<td>Two attempts x = 20.2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>One attempt x = 17.9</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No attempt x = 3.8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Two attempts x = 9.9</td>
</tr>
<tr>
<td></td>
<td></td>
<td>One attempt x = 8.0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No attempt x = 6.0</td>
</tr>
</tbody>
</table>

Multiple Attempters vs. Single and Non-Attempters, Phase 1 Measures

<table>
<thead>
<tr>
<th></th>
<th>0 – 1 Attempts (N = 152)</th>
<th>2 or More Attempts (N = 432)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASIQ</td>
<td>30.5</td>
<td>63.9</td>
</tr>
<tr>
<td>BSS</td>
<td>4.7</td>
<td>12.1</td>
</tr>
<tr>
<td>BHS (&lt;N = 46, N = 233)</td>
<td>6.9</td>
<td>9.8</td>
</tr>
<tr>
<td>RASQ Internal</td>
<td>16.3</td>
<td>20.4</td>
</tr>
<tr>
<td>RASQ Extra</td>
<td>16.4</td>
<td>17.6</td>
</tr>
</tbody>
</table>

Yellow indicates differences at the .01 significance level

Area Under the Curve: 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).
**Area under the curve (AUC), Phase I Measures**

<table>
<thead>
<tr>
<th>Measure</th>
<th>AUC</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASIQ</td>
<td>.78</td>
</tr>
<tr>
<td>BSS</td>
<td>.72</td>
</tr>
<tr>
<td>RASQ Int</td>
<td>.69</td>
</tr>
<tr>
<td>BHS</td>
<td>.63</td>
</tr>
<tr>
<td>RASQ Extra</td>
<td>.55</td>
</tr>
</tbody>
</table>

**Multiple Attempters vs. Single and Non-Attempters, Phase I Measures**

<table>
<thead>
<tr>
<th>Measure</th>
<th>0 – 1 Attempts (N=64)</th>
<th>2 or More Attempts (N=213)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SRAC Static</td>
<td>3.6</td>
<td>3.6</td>
</tr>
<tr>
<td>SRAC Slow Chg</td>
<td>2.7</td>
<td>2.7</td>
</tr>
<tr>
<td>SRAC Dynamic*</td>
<td>3.5</td>
<td>5.6</td>
</tr>
<tr>
<td>SRAC Protective</td>
<td>5.2</td>
<td>5.2</td>
</tr>
</tbody>
</table>

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

**Multiple Attempters vs. Single vs. Non-Attempters, Phase I Measures**

<table>
<thead>
<tr>
<th>Measure</th>
<th>0 Attempts (N=30)</th>
<th>1 Attempt (N=35)</th>
<th>2 or More Attempts (N=168)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAI Chronic</td>
<td>3.5*</td>
<td>4.7**</td>
<td>6.4</td>
</tr>
<tr>
<td>CAI Acute</td>
<td>4.9</td>
<td>5.9</td>
<td>8.1</td>
</tr>
<tr>
<td>CAI Idio</td>
<td>1.6</td>
<td>2.5</td>
<td>3.9</td>
</tr>
<tr>
<td>CAI Total</td>
<td>9.8</td>
<td>13.1</td>
<td>18.4</td>
</tr>
</tbody>
</table>

*white=NS  **yellow=significant at .01 level
On Multiple Attempters...

Phase 1 measures stress the importance of interpreting test results based on attempts status, echoing findings from prior studies of the characteristics of multiple attempters. 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.

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

<table>
<thead>
<tr>
<th>Measure</th>
<th>0 – 1 Attempts (N = 68)</th>
<th>2 or More Attempts (N = 176)</th>
</tr>
</thead>
<tbody>
<tr>
<td>INQ—Thwarted Belongingness</td>
<td>36.1</td>
<td>41.9</td>
</tr>
<tr>
<td>INQ—Perceived Burdensomeness</td>
<td>44.8</td>
<td>57.2</td>
</tr>
<tr>
<td>ACSS—Acquired Capability</td>
<td>40.9</td>
<td>46.2</td>
</tr>
<tr>
<td>CAPSSIP</td>
<td>77.2</td>
<td>54.4</td>
</tr>
<tr>
<td>CRQ <em>(N = 54; n = 56)</em></td>
<td>25.5</td>
<td>37.2</td>
</tr>
</tbody>
</table>
Phase II Findings—CAPSSIP subscale means:
Multiple, single, and non-attempters

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

Phase II Measures—Area Under the Curve

<table>
<thead>
<tr>
<th>Measure</th>
<th>Area Under the Curve</th>
</tr>
</thead>
<tbody>
<tr>
<td>CRQ</td>
<td>.76</td>
</tr>
<tr>
<td>CAPPSIP Total</td>
<td>.71</td>
</tr>
<tr>
<td>INQ-Burdensomeness</td>
<td>.70</td>
</tr>
<tr>
<td>ACSS</td>
<td>.63</td>
</tr>
<tr>
<td>INQ-Belongingness</td>
<td>.61</td>
</tr>
</tbody>
</table>

Implications: Attempt Status

- Multiple attempters in the sample presented a pattern of results that was very clear and striking. This pattern included:
  - Greater endorsement of the desire to die and of some preparation or planning for suicide (BSS)
  - More frequent contemplation of suicide and a broader range of thoughts related to suicide (ASIQ)
  - An absence of emotional, spiritual, behavioral, or interpersonal barriers to suicide (CRQ, CAPSSIP, CAI-Id.)
**Implications: Attempt Status**

**Multiple attempter characteristics:**
- Greater endorsement of painful emotional experiences, such as worthlessness, agitation, and psychache (CAI-Acute, RASQ-Internal)
- More problematic clinician ratings—suggesting a likelihood of the patient resisting suicide prevention/risk management efforts (CAI Idiosyncratic)
- Fewer protective factors or less of a sense that available protections are significant barriers (CAPSSIP)
- A greater sense of being a burden to others, such as family and loved ones (INQ-Perceived Burdensomeness)

**Implications: Attempt Status**

**Multiple attempter characteristics:**
- Increased historical vulnerability to suicide related to early traumas, exposure to violence and dysfunction, etc. (CAI-Chronic)
- Factors that were found not to distinguish groups include no difference between endorsement of extrapunitive or manipulative reasons for suicide attempts, little difference regarding fearlessness about death, and an only slightly increased endorsement of feelings of lack of belonging.

**Implications: Attempt Status**

- Inmates and patients with a history of ideation or a single attempt who show a similar pattern to multiple attempters should be very carefully evaluated and frequently monitored.
- Suicide risk is enhanced in many psychiatric and personality disorders; however, treating such conditions is not the same as suicide-specific treatment.
Implications: Attempt Status

What works with patients at high risk for suicide:
- Collaborative Assessment and Management of Suicidality (CAMS; Jobes, 2016): CAMS treatment focuses on working collaboratively with the patient to understand what fuels suicidal desire. Treatment is suicide-specific and relies on skill building within the context of a safety and stabilization plan. What fuels suicidal desire and what is working or not working within a safety/stabilization plan is reassessed each session.

Implications: Attempt Status

What works with patients at high risk for suicide:
- Fluid Vulnerability Theory (FVT; Rudd, 2006): FVT focuses on identifying the patterns of thoughts, behaviors, feelings, etc. associated with suicidal crises in high risk/vulnerable individuals. FVT works by helping the patient to self-monitor for indications of a looming suicidal crisis, by allowing earlier identification of the crisis possible, and by helping the clinician to describe to others (e.g. staff members; the patient's loved ones) what to look for in order to recognize and manage risk.

Assessing Barriers to Suicide

Assessing barriers to suicide can give us insight into who is in most need of intervention.
Assessing Barriers 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.

Assessing Barriers to Suicide

- Most mental health clinicians are either not used to or unaware of how to inquire about cultural, familial, or religious prohibitions to suicide nor degree of adherence of the patient to these beliefs.
- The CAPSSIP provides a structured way to ask specific questions regarding adherence to these prohibitions to suicide. The measure also includes a brief sent by structured interview to assess whether the patient has abandonment previously held barriers or prohibitions to suicide.
Assessing Barriers to Suicide

The largest difference between multiple attempters and others on the CAPSSIP administered to inmates was a more frequent belief that suicide would not negatively affect the afterlife. Inmates who professed no belief in an afterlife were also more likely to be multiple attempters in the sample.

Assessing Barriers to Suicide

Individuals who describe letting go of or rejecting familial, cultural, and religious prohibitions to suicide may be seen as at higher risk than those who retain these barriers.

Assessing Barriers to Suicide

Similarly, inmates who discuss ‘loopholes’ regarding the afterlife can be seen as at heightened chronic risk, e.g.: “jumping from a high enough place” or “time to repent before bleeding out”
### Assessing Barriers to Suicide

The Chronic Readiness Questionnaire (CRQ) was designed to measure five areas:

- **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
- **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

However, factor analytic procedures of the CRQ suggest a single factor structure for the measure. This is informative—all items get at one thing, whether or not the individual feels ready and prepared to die by suicide. Multiple attempters, to varying degrees, exhibit a striking lack of barriers to suicide. They can often discuss how they overcame such barriers and/or what caused these barriers to erode over time.
Assessing Barriers to Suicide

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…

Assessing Barriers to Suicide

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

Assessing Barriers to Suicide

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
Assessing Barriers to Suicide

- The CAI includes assessing barriers to suicide as part of a structured professional judgment of risk. This item falls in the idiosyncratic section.
Case P

You are asked to evaluate a 47-year-old male admitted for inpatient psychiatric care within a correctional setting. The patient has served 4 years of a 9-year sentence. He recently was taken to a community hospital following an overdose. The patient claimed the overdose was accidental. However, the amount of a prescribed medication taken was excessive and was of a medication that does not produce a high. The patient's clinician therefore recommended hospitalization.

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Case P

Following admission, the patient is asked about his recent behavior by his treatment team. He shrugs, states “I'm not sure I meant anything by it,” and with further questioning reports, “I guess I've tried a few times.”

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Case P

As the patient is reporting rather vague information about his suicidal history and recent behavior, and as record review yields little information, you decide to administer several test measures and conduct a semi-structured interview. Test measure results are found in your packet.

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Case P

- Please break into small groups of 4-6 people and review the patient’s responses to the test measures.
- Discuss in your groups a conceptualization of the patient’s risk. How did the measures aid in your risk formulation? What risk management/treatment information is now clear?

Self Assessment

Now please complete the self-assessment found in your packet.
- What can you take from today’s presentation to increase your precision and evaluating suicide risk?

Conclusion

Suicide risk evaluation and risk management in prisons in state hospital facilities is a complex undertaking. We need a set of tools to evaluate risk, a broad knowledge base, and an understanding of the phenomena of suicide to avoid underestimation and overestimation errors.
Conclusion

Questions?
Comments?
Answers?

Thank you

I appreciate your attendance and her interaction on this topic. Please fell free to contact me at

Robert.Horon@cdcr.ca.gov