SECURE

IMPLEMENTING POLICIES AND ASSESSING RISK

Lesson Plan Advance Sheet

Title: Suicide Prevention: Implementing Policies and Assessing Risk

Hours: 2 hours

Target Audience: Health Care Professionals (OH 1)

Terminal Individual Objective
Tasks: Implement Policies and Assess Risk for Suicide

The Mission: The Army Suicide Prevention Program (ASPP) is based on trained and ready personnel at all levels. Our mission is to encourage help-seeking behavior and to attain proficiency in the principles of this training module. (OH 2) The Mental Health Community is vital to the success of the ASPP. (OH3)

Learning Objectives (OH 4)
Participants will be able to:

1. Become knowledgeable about Army suicide policies and procedures
2. Conduct Advanced Risk Assessment

Soldier Preparation
Gatekeeper Lessons 1-3 or equivalent

Instructional Procedures
Conference.

Instructor Note: This lesson provides a framework for Army policies and procedures needed to address suicidal behavior. It also contains an overview of advanced screening techniques for professional gatekeepers. This is intended as a refresher and an update for trained individuals. If some individuals have not received prior training in suicide screening, a skills training program that includes practice and feedback is recommended.

Instructor's Notes

Instructor Note: Keep in mind that the introduction of a very sensitive topic requires an equally sensitive approach. You must assume that the class will include people who have been touched by a suicide, and some class members who have seriously contemplated or attempted suicide. Care must be given in discussing this topic. Also, you will seek to motivate members of the unit to become concerned for the well-being of friends and neighbors. Another task for the instructor is to encourage an attitude of hope and renewal.

Instructor Note: When a question is asked, take time to field answers from the class before proceeding.

Policies and Procedures
The first part of the secure procedure is the *wide dissemination* of clear **policies and procedures** that ensure a coordinated rapid response to referrals of suicidal persons. Everyone should at least know whom to turn to if he (she) encounters an at-risk or actively suicidal individual. In turn, those designated referral sources should know exactly what steps to take to provide or ensure an initial supportive contact and brief assessment, and how to obtain a comprehensive professional assessment.

Instructor note: Different commands may require different procedures and this manual cannot provide specific Army procedures. The Suicide Prevention Task Force (see page 5) provides ASPP administrative guidance to the local commander for implementing policy. What is provided here are guidelines to be used as a reference point for your specific command. When providing this training, copies of the appropriate policies should be handed out or referred to.

Policies and Procedures are needed that spell out the steps to be taken and the referral sources to be contacted in response to **(OH 5 a, b)**:

- Individuals suspected of being at risk for suicide
- Individuals who are talking about/threatening suicide.
- Individuals who attempt suicide.
- Completed suicide.

The chaplain is the primary unhindered referral source. Service members can go directly to the chaplain, Community Mental Health, the local MTF emergency room or consult the chain of command to receive information on available help on Post.

In general, then, during the day, suicidal individuals or individuals showing warning signs can be brought directly to Company Commanders and/or chaplains or unit aid stations. From there, they may be referred to the post hospital if there is a clear risk for suicide. After hours, at-risk service members can be brought to the attention of duty officers or duty chaplains who can decide if a referral to the post hospital is called for. Again, specific procedures must be worked out locally and made known to all service members.

General Assessment Guidelines
The second part of the secure procedure consists of the assessment and initial crisis interview with the suicidal individual. This section provides an overview of the basics of assessing and

conducting an initial interview with a suicidal person. It in no way is a substitute for the comprehensive training that is required to assess and manage suicidal persons. In order to develop the *skills* (as opposed to simply knowledge) necessary to conduct interviews, skill practice and feedback is necessary. This section outlines the basic strategies that must be learned through further skills training. Resources are listed at the end of this section for more detailed information on the assessment and management of suicidal persons.

Steps in Suicide Assessment (OH 6)
A suicide risk assessment can be completed by performing the following steps.

- *Set the stage for the interview.*
- *Assess for risk factors and warning signs for suicide.*
- *Inquire about suicidal ideation.*
- *Determine the level of suicide risk.*

Set the stage for the interview.
Certain steps should be completed for successful communication and assessment. This is called "setting the stage for the interview". The following steps are suggested:

- Ensure privacy. The trust of persons may be forfeited if they are not given private time to speak with you.
- Ensure confidentiality and explain situations in which confidentiality cannot be maintained. Confidentiality does not hold if a person is suicidal, homicidal, or abused. You must make this clear.
- Establish trust. Before asking any private questions, you must establish trust with the person. This involves the helping interview approach that was referred to in Gatekeeper Lesson 3, pages 50-55.

Assess for risk factors and warning signs for suicide.
This is covered in Gatekeeper Lesson 3, pages 50-55.

Inquire about suicidal ideation.
This was covered in Gatekeeper Lesson 2, pages 41-49. This section expands on that material by focusing on characteristics of the individual's current state that can enhance the degree of risk. These characteristics are: perturbation, cognitive constriction, intentionality, and lethality of the plan **(OH 7)**.

Perturbation is "the degree of upset, disturbance, tension, anguish, turmoil, discomfort, dread, hopelessness, or other excessive psychological pain." It can reach a point at which it is no longer tolerable. At this point, a person becomes motivated to do something about it. To assess someone's feelings about suicide, ask questions such as the following:

"How bad is the hurt?
"Is it bearable?"
"Is the feeling of unhappiness so strong that sometimes you wish you were dead?"

Cognitive constriction "can be defined generally as dichotomous thinking, tunnel vision, or a narrowing of the range of options to two and ultimately one." As a gatekeeper, you need to determine: (1) if suicide is an option for the person you are assessing, and (2) if suicide is now seen as the only option. Perturbation often contributes to cognitive constriction. That is, anguish or anxiety causes a narrowing of cognitive processes called "tunnel thinking". Edwin

Shneidman, a pioneer in the field of suicide prevention, said that "only" is the four-letter word in suicide.

Cognitive constriction may be assessed by asking the "sometimes" question:
"Sometimes when people feel this way, they think about hurting themselves or killing themselves. Have you ever thought about hurting yourself or killing yourself?" "Is this your only option?"

Intentionality refers to the conscious aim, goal, or purpose in seeing suicide as a viable option and eventually the only option in alleviating perturbation." Intentionality includes both of the following: (1) the insight or thought that cessation of consciousness is the solution for unbearable psychological pain, and (2) "the decision for action". Most people who complete suicide deliberately plan to do so. In the case of younger people, however, a suicide plan is a less important sign of risk, given their history of, or tendency toward impulsive behavior.

Lethality is the dangerousness of a planned or likely action, [e.g., if one puts a loaded gun to my head and pulls the trigger, death is the likely result (high lethality)]; if one ingests six aspirin with intent to kill oneself, one would have low lethality. To assess lethality, you must assess the how, when, what, and where of a person's plan for suicide.

A suicide plan can only be discovered through **direct questioning**. The counselor must assess three areas: specificity, lethality and availability **(OH 8)**:

<u>Specificity of the Plan:</u>

A person who has a well thought-out suicide plan, including time, place, and circumstances, as well as a highly lethal method, is at very high risk. Ask the following type of direct question:

"Do you have a plan worked out for killing yourself?"

When assessing for a plan, you also need to determine if it includes any rescue possibilities. Persons who contemplate a plan likely to end in discovery may be more attached to people and/or more ambivalent than other people who plan for their suicide to occur in an isolated setting, one where there is a low likelihood of being rescued. You must determine the place and time. Asking the following types of questions:

- *"What time of day do you plan to do this?"*
- *"Where do you plan to do this?"*
- *"Is there likely to be anyone else around at that time?"*

Also important in understanding the suicide plan (and its underlying intent) is an understanding of fantasies and death wishes, (e.g., *"What do you hope to accomplish?")* There may be a wish for reunion or rebirth, for joining a deceased loved one, etc. Death may also have a positive meaning or a person may have a particular view of death. Many people who become suicidal do not really wish to die; instead, they want to bring about a change that will help make life more livable.

Method:

Methods vary in their lethality. High lethal methods include the use of a gun; large doses of sleeping pills, barbiturates, acetaminophen, antidepressants, particularly tri-cyclic antidepressants (TCAs), taken under conditions of the low possibility of rescue; hanging; jumping; from significant height, drowning; and vehicular crashes at high speed.

Low lethal methods include those where there is a high degree of possibility of rescue, (i.e., where there will be an amount of time sufficient for intervention to occur before death might result; or where the agent, (e.g., drugs), are of insufficient quantity and dosage to be lethal, (e.g., many over-the-counter drugs). [An excellent resource for evaluating lethality is: Smith, K., Conroy, R. W., & Ehler, B. D. (1984). Lethality of suicide attempt rating scale. *Suicide and Life-Threatening Behavior, 14* (4), 215-242; although the table referring to lethal dosages of medications needs to be updated].

You must ask a suicidal person about his or her method for completing suicide. You may ask the following question:

"What are you thinking of doing?"

Availability and Accessibility of Means:

Ask the following types of questions to determine the availability and accessibility of means:

- *"Do you have pills?" or "How do you plan to get the pills?"*
- *"Do you have a gun?" or "How do you plan to get the gun?"*
- *"Do you know how to use a gun?" and "Do you have ammunition?"*

You may ask questions by following the (TIPM) assessment (Rosenberg, 1997):

T = Thoughts
I = Intent
P = Plan
M = Means

The "Assessment of Risk level for Suicide" can be used as a tool for gathering data related to risk factors and warning signs. See Table 3 (HO 10, page 62

Additional guidelines for risk assessment are provided for your information in handout 11, pages 63-66. These are not meant as a burdensome set of questions that must be covered step by step. They basically serve as reminders of areas that may need to be covered in your inquiry. The material contained in them, this lesson, and the additional references provided should be organized to fit an approach and protocol that you are comfortable with on a case-by-case basis. For example, you may obtain sufficient information to make a clinical decision as to the necessary action after inquiring about the individual's current plan and resolve. Your clinical sense of the interaction and how the patient is responding in the interview are also important data for making your decision.

The Use of Suicide Scales
There are a variety of suicide scales that have been developed to aid in the assessment of suicidal risk. These scales are *not* a substitute for a careful clinical interview. Getting well acquainted with an individual through an *interaction* can provide better understanding of his or her suicidality than adding up "risk factors" presented as a scale for suicidal risk (Motto, 1999). Nevertheless, scales can help to organize and keep track of appropriate areas of inquiry. Portions of the Los Angeles Suicide Prevention Center Scale are presented below as an example of a scale that can serve as a guideline for a suicide assessment interview.

Los Angeles Suicide Prevention Center Scale (HO 12, pages 67-68)
The Los Angeles Suicide Prevention Center Suicide Potential Scale is designed to serve principally as a clinical aid in the evaluation of a client (e.g., an office patient or a caller to a telephone crisis service) who has identified himself or herself as suicidal. The pressing need at this point is to evaluate how seriously suicidal is the person. The answer to that question determines whether the process is continued in the office or the phone, whether emergency procedures are initiated to hospitalize, whether other resources such as family, relatives, neighbors, etc. are enlisted, or other resources and actions are considered.

The LASPC Scale is aimed at providing the assessor with a ready reference list of significant factors in estimating the current suicidal risk. Although numbers are used to arrive at a final score, the score does not imply a rigidly defined level of self-destructive status, but rather a general level which may guide appropriate and adequate response.

Scoring of the Suicide Potential Scale is clinically oriented. Ten categories are listed containing varied numbers of items in each. After each item, numbers are given suggesting the usual range of score for each item. Scoring Instructions and guidelines are available from:

The Prediction of Suicide (pp. 74-79) edited by A. T. Beck, H.
L P. Resnik, and D. J. Lettieri, 1986. Philadelphia, PA The Charles Press
Publishers. Copyright 1974 by Dr. Norman Farberow.

Other commonly used standardized scales are presented in handout 13, page 69. When working with suicidal individuals, it is important for you and for the patient to make these reasons explicit and discuss them as part of your assessment of the risk of imminent suicidal behavior. Additional resources for screening and management of suicidal individuals are provided in handout 12, pages 67-68.

Mental Health Professionals are key to the success of our Army Suicide Prevention Program, as we conduct a "full court press" to reduce senseless loss of life through suicide. (OH 9)

Handout 10: Table 3

Assessment of Risk Level for Suicide

Immediate Risk of Suicide	***Indicators of Risk***
No Predictable Risk	• no history of a suicide attempt • no suicidal ideation • close contact with significant others • social support system is satisfactory

Low Risk	• suicidal ideation • low lethal suicide methods • no history of suicide attempts • no recent serious loss • personal or social resources are present but problematic • risk of an attempt, repeat attempt, and eventual suicide is high, depending on what occurs after the threat or attempt • risk is increased if drugs or alcohol are abused
Moderate Risk	• suicidal ideation • high lethal suicide method with no specific threats or plan; *or* • low lethal suicide method with a suicide plan • includes attempts in which the chance of rescue is precarious • ambivalence is strong-life and death are seen as equally favorable • risk for a repeat attempt and eventual suicide is higher than low risk if no life changes occur
High Risk	• current high lethal suicide plan • obtainable means to complete suicide • history of previous suicide attempts • not able to communicate with a significant other • lean more in the direction of death than life • immediate and long-range risk of suicide is very high • attempt would probably be fatal without rescue unless help is available and accepted immediately • chronic self-destructive behavior increases risk even further
Very High Risk	• current high lethal suicide plan • available means to complete suicide • history of previous suicide attempts • cut off from resources • attempt would probably be fatal without rescue • lean more in the direction of death than life • immediate and long-range risk of suicide is very high unless help is available and accepted immediately • chronic self destructive behavior increases risk even further

Handout 11 **Additional Guidelines for Identification and Assessment**

Following are sections from Risk Management Foundation of the Harvard Medical Institutions. (D. G. Jacobs (Ed). Guide to Suicide Assessment and Intervention, 1999, San Francisco: Jossey-Bass).

Purposes

- To provide a model for the assessment of suicidality in all clinical settings.
- To provide information to be incorporated into institution-specific protocols.

These guidelines are not to be construed or to serve as a standard of care. Standards of medical care are determined on the basis of all clinical data available for an individual case and are

subject to change as scientific knowledge and technology advance and patterns evolve. This model should be considered only as a guideline. Adherence to it will not ensure a successful outcome in every case. It should not be construed as including all proper methods aimed at the same results. The ultimate judgment of suicidality regarding a particular patient must be made by the clinician in light of the clinical data presented by the patient and other available information (adapted from Practice guidelines for major depressive disorder in adults. Am J Psychiatry 1993; 150[suppl4]).

When to Use These Guidelines

Assessment and documentation of suicidality are integral components of any psychiatric evaluation and become primary concerns in that evaluation at the following times:

1. During initial interview or on admission to a facility or program.
2. With the occurrence of any suicidal/self-destructive behavior or ideation.
3. On the occasion of any noteworthy clinical change (e.g., significant new symptoms, mental status changes, stressors).
4. For inpatients who have been assessed to be suicidal, the following situations may prompt any additional assessment:
   a. On progression to a less restrictive level of precautions or privileges (including therapeutic passes).
   b. At time of discharge from hospital.

The assessment of suicidality is an active process during which clinicians evaluate:

- Suicidal intent and lethality.
- Dynamic meanings and motivation for suicide.
- Presence of a suicidal plan.
- Presence of overt suicidal/self-destructive behavior.
- The patient's physiological, cognitive, and affective states.
- The patient's coping potential.
- The patient's epidemiologic risk factors.

Many of these observations are made during the general psychiatric evaluation and mental status examination. However, a number of suicide specific questions may be included in this process.

Handout 11, con't. **Detection of Suicidality: Expanded Outline and Questions**

Suicidal Intent and Lethality

1. Are suicidal thoughts/feelings present?
   a. What are they?
   b. Are they active/volitional or passive/non-volitional?
   c. When did they begin?
   d. How frequent are they?
   e. How persistent are they?
   f. Are they obsessive?
   g. Can the patient control them?
   h. What motivates the patient to die or to continue living?

2. Dynamic meanings and motivation for suicide.
3. What form does the patient's wish for suicide take?
   Is there a wish to die, to hurt someone else, to escape, to punish self?
4. What does suicide mean to the patient?
   a. Is there a wish for rebirth or reunion?
   b. Is there an identification with a significant other?
   c. What is the person's view of death and relationship to it?
   d. Does death have a positive meaning for the patient?
5. Has the patient lost an essential sustaining relationship?
6. Has the patient lost his/her main reason for living? (These losses can be threatened.)

Presence of a Suicidal Plan

1. How far has the suicide planning process proceeded?
2. Specific method, place, time?
   a. Available means?
   b. Planned sequence of events?
   c. Intended goal? (e.g., death, self-injury, or another outcome)
3. Feasibility of plan? Access to weapons (Document any conversation about access to guns or other lethal weapons. Consider the possibility of misinformation.)
4. Lethality of planned actions?
   a. Objectively assess danger to life.
   b. Objectively question patient's conception of lethality.
   c. Avoid terms such as gesture or manipulation, because they imply a motive that may be absent or irrelevant to lethality.
   d. Bizarre methods have less predictable results and may therefore carry greater risk.
   e. Pay attention to violent, irreversible methods such as shooting or jumping.
5. Likelihood of rescue? Patients who contemplate a plan likely to end in discovery may be more ambivalent and/or attached to people than others who plan their suicidal behavior to occur in an isolated setting.
6. What preparation has the patient made (e.g., obtaining pills, suicide note, making financial arrangements)?
7. Has the patient rehearsed for suicide (e.g., rigging a noose, putting gun to head, driving near a bridge)?

Handout 11, con't.

History of Overt Suicidal/Self-Destructive Behavior

1. Have suicidal behaviors occurred in the past?
2. It is useful to explore the circumstances of any past suicide attempts. If the patient can describe the past event, this may provide the best window into the current state of mind. Absence of previous suicidality, however, does not eliminate the risk of current or future attempts.
3. Statistical relationships of suicide attempts to suicide completion are:
   a. Attempters are at increased risk for suicide over the general population by 7-10 percent.
   b. 18-38 percent of those who died by suicide have made a prior attempt.
   c. 90 percent of attempters do not go on to complete suicide.
   d. 1 percent of past attempters kill themselves each year.
4. Has the patient engaged in self-mutilating behaviors?
   a. Wrist-cutting or other self-mutilation suggests consideration of the diagnoses of Post Traumatic Stress Disorder (PTSD) or dissociative disorders among others.

b. Although self-mutilation is frequently an act of self-soothing rather than an attempt to die, patients who self-mutilate do sometimes commit suicide.
c. In assessing risk of further self-mutilation, one useful question is, "How do you calm yourself down?"

The Patient's Physiological, Cognitive, and Affective States

1. Does the patient's mental state increase the potential for suicide?
   a. Does the patient have the capacity to act?
      (1) Suicide requires both the ability to organize and the energy to implement a plan.
      (2) Suicide potential may be heightened when there is greater energy (as in early recovery from depression) or lowered inhibition (as during intoxication or rage).
   b. Is the patient hopeless?
      (1) Hopelessness is a key psychological factor in suicidal intent and behavior.
      (2) It is often accompanied by pervasive negative expectations.
2. Are depression and/or despair present? Depression is a mood state or syndromal disorder associated with vegetative symptoms. Despair is a cognitive state that features a sense of futility about alternatives, no personal sense of a future role, and a lack of human connections that might offer support.
3. Is a diagnosable psychiatric disorder present that is correlated with suicidality or poor treatment compliance?
4. Does the patient's physiologic state increase the potential for suicide? (illness, intoxication, pain)
   a. Are intoxicants present?
      (1) Acute intoxication or withdrawal can lead to an acute increase in suicide risk.
         a. State dependent: decreased inhibition, poor judgment, denial
         b. Importance of precipitants such as interpersonal loss
      (2) Thorough evaluation difficult when patient is intoxicated.
         a. Provide safe place until sober
         b. Reassess suicide risk when sober

Handout 11, con't.

(3) Chronic abuse or dependence leads to a chronic risk.
   a. Trait dependent self-destruction and decreased self-care
   b. Suicide risk can be elevated when a relapse occurs

5. Is the patient vulnerable to painful affects such as aloneness, self-contempt, murderous rage, shame or panic?

The Patient's Coping Potential

1. Are there recent stressors in the patient's life?
   a. Is the patient facing a real or imagined loss, disappointment, humiliation or failure?
   b. Has there been a disruption in the patient's support system (including treatment)?
2. What are the patient's capacities for self-regulation?
   a. Does the patient have a history of impulsive behavior?
   b. Does the patient need, and can he or she use external sustaining resources to regulate self-esteem?
3. Is the patient able to participate in treatment?
   a. Does the patient verbalize a willingness to comply with treatment plan?
   b. Does the patient possess the capacity for making an alliance?

Handout 12

Los Angeles Suicide Prevention Center Scale

Note: This is not the complete scale.

AGE AND SEX (1-9)	**Rating for Category**
MALE	
50 plus (7-9)	( )
35-49 (4-6)	( )
5-34 (1-3)	( )
Female	
50 plus (5-7)	( )
35-49 (3-5)	( )
15-34 (1-3)	( )
Symptoms (1-9)	
Severe depression: sleep disorder, anorexia, weight loss, withdrawal, despondency, loss of interest apathy (7-9)	( )
Feelings of hopelessness, helplessness, exhaustion (7-9)	( )
Delusions, hallucinations, loss of contact, disorientation (6-8)	( )
Compulsive gambling (6-8)	( )
Disorganization, confusion, chaos (5-7)	( )
Alcoholism, drug addiction, homosexuality (4-7)	( )
Agitation, tension, anxiety (4-6)	( )
Guilt, shame, embarrassment (4-6)	( )
Feelings of rage, anger, hostility, revenge (4 6)	( )
Poor impulse control, poor judgment (4-6)	( )
Other (describe):	
Stress (1-9)	
Loss of loved person by death, divorce, or separation (5-9)	( )
Loss of job, money, prestige, status (4-8)	( )
Sickness, serious illness, surgery, accident-loss of limb (3-7)	( )
Threat of prosecution, criminal involvement, exposure (4-6)	( )
Change(s)) in life, environment, setting (4-6)	( )
Success, promotion, increased responsibilities (2-5)	( )
No significant stress (1-3)	( )
Other (describe):	
Acute Versus Chronic (1-9)	
Sharp, noticeable and-sudden onset of specific symptoms (1-9)	( )
Recurrent outbreak of similar symptoms (4-9)	( )
No specific recent change (1-4)	( )
Other (describe)	
Suicidal Plan (1-9)	
Lethality of proposed method-gun, jumping, hanging, drowning, knife, pills, poison, aspirin (1-9)	( )
Specific detail and clarity in organization of plan (1-9)	( )
Specificity in time planned (1-9)	( )
Bizarre plan (1-9)	( )
Rating of previous suicide attempt(s)) (1-9)	( )
No plans (1-3)	( )

Handout 12, con't.

Other (describe):

		Rating for Category
Resources (1-9)		
No sources of support (family, friends, agencies, employment) (7-9)		( )
Family and friends available, unwilling to help (4-7)		( )
Financial problems (4-7)		( )
Available professional help, agency or therapist (2-4)		( )
Family and/or friends willing to help (1-3)	( )	
Stable life history (1-3)		( )
Physician or clergy available (1-3)		( )
Employed (1-3)		( )
Finances no problem (1-3)		( )
Other (describe):		
Prior Suicidal Behavior (1-7)		
One or more prior attempts of high lethality (6-7)		( )
One or more prior attempts of low lethality (4-5)		( )
History of repealed threats and depression (3-5)		( )
No prior suicidal or depressed history (1-3)		( )
Other (describe):		
Medical Status (1-7)		
Chronic debilitating illness (5-7)		( )
Pattern of failure in previous therapy (4-6)	( )	
Many repealed unsuccessful experiences with doctors (4-6)		( )
Psychosomatic illness, e.g., asthma, ulcer, hypochondria (1-3)		( )
No medical problems (1-2)	( )	
Other (describe):		
Communication Aspects (1-7)		
Communication broken with rejection of efforts to reestablish by both patient and others (5-7)		( )
Communications have internalized goal, e.g., declaration of guilt, feelings of worthlessness, blame, shame (4-7)		( )
Communications have interpersonalized goal, e.g., to cause guilt in others to force behavior, etc. (2-4)		( )
Communications directed toward world and people in general (3-5)		( )
Communications directed toward one or more specific persons (1-3)		
Other (describe):		
Reaction of Significant Others (1-7)		
Defensive, paranoid, rejected, punishing attitude (5-7)		( )
Denial of own or patient's need for help (5-7)		( )
No feelings of concern about the patient; does not understand the patient (4-6)		( )
Indecisiveness, feelings of helplessness (3-5)		( )
Alternation between feelings of anger and rejection and feelings of responsibility and desire to help (2-4)		( )
Sympathy and concern plus admission of need for help (1-3)		( )

Handout 13

The Scale for Suicide Ideation. Beck, A. T., Kovacs, M., & Weissman, A. (1979). Assessment of suicidal intent: The Scale for Suicide Ideation. Journal of Consulting and Clinical Psychology, 47, 342-352.

The Hopelessness Scale. Beck, A. T., Weissman, A., Lester, D., & Trexler, L., (1974). The measure of pessimism: The Hopelessness Scale. Journal of Consulting and Clinical Psychology, 42, 861-865.

The Suicidal Ideation Questionnaire. Reynolds, W. M. (1987). Odessa, FLA: Psychological Assessment Resources (PAR, Inc.).

The Reasons for Living Inventory. Linehan, M. M., Goodstein, J. L., Nielsen, S. L., & Chiles, J. K. (1983). Reasons for staying alive when you are thinking of killing yourself: The Reasons for Living Inventory. Journal of Consulting and Clinical Psychology, 51, 276-286.

Spirituality and Resilience Assessment Packet Version 4.2. Kass, Jared D. & Lynn (2000) Greenhouse Inc. 46 Pearl Street, Cambridge Massachusetts 02139 Ph. (617) 492-0050
Military contracted source: http://chppm-www.apgea.army.mil/dhpw/default.htm

Note: These scales are copyrighted and cannot be reproduced here. They can be obtained from the above sources. Updated reviews from the National Institute of Mental Health and other sources of currently available suicide scales are on track to be published in the spring or summer of 2000.

Handout 14

Additional Reference Materials

Additional material on prevention and the assessment and management of suicidal persons is available from the following sources.

Bongar, B. (1991). The suicidal patient: Clinical and legal standards of care. Washington, DC: American Psychological Association. *Very good treatment of assessment. One of the most thorough overview of assessment and outpatient management issues available.*

Chiles, J. A., & Strosahl, K. D. (1995). The suicidal patient: Principles of assessment, treatment, and case management. Washington, DC: American Psychiatric Press. *Clearly written practical strategies and the philosophical issues involved in working with acute and chronic suicidal cases.*

Hoff, L. A. (1995). People in crisis: Understanding and helping. San Francisco: Jossey-Bass. *This, along with Kleespies, is one of the better general texts on crisis intervention.*

Jacobs, D. G. (Ed.). (1999). Guide to suicide assessment and intervention. San Francisco: Jossey-Bass. *The most current and thorough treatment of this topic.*

Kleespies, P. M. (Ed.). 1998). Emergencies in mental health practice. NY: Guilford.

Maris, R. W., Berman, A. L., Maltsberger, J. T., Yufit, R. I. (1992). Assessment and prediction of suicide. NY: Guilford. *A comprehensive and detailed resource on assessment by leading authorities in the field.*

Mitchell, J. T., & Everly, G. S. (1995). Critical incidence stress debriefing: Cisd: An operations manual for the prevention of traumatic stress among emergency and disaster workers. Baltimore: Chevron Publishing. *Mitchell is the founder of CISD, and this is one of a number of practical step-by-step books available from Mitchell's group through Chevron.*

Shea, S. C. (1999). The practice of suicide assessment: A guide for mental health professionals and substance abuse counselors. New York: John Wiley & Sons. *This is an excellent practical source that contains detailed guidelines and verbatim examples for assessing suicide risk.*

Switzter, David K. (1986). The minister as crisis counselor. Nashville, TN: Abington Press. *This is a classic source for basic crisis counseling with special considerations for clergy.*

Worden, J. W. (1991). Grief counseling and grief therapy. NY: Springer Publishing. *The best practical guide in this area.*