DEVELOPMENT OF AN OBSERVATIONAL MEASURE OF SUICIDE RISK ASSESSMENT AND SAFETY PLANNING COMPETENCIES

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Learning Objectives

- Describe rationale for a competency assessment project focused on suicide risk assessment and safety planning
- Describe standardized patient protocol
- Describe process for developing an observational coding measure for skill assessment
Why suicide?

- Suicide is a national public health crisis and a critical patient safety issue
- 10th leading cause of death overall and the 2nd leading cause in adolescents
- Suicidal ideation is very common
  - 17% of students in grades 9-12 seriously considered suicide in previous 12 months (Kann et al., 2013)
  - 3.9% of US adult population had suicidal thoughts in the past year (SAMHSA, 2014)
Figure 1. Age-adjusted suicide rates, by sex: United States, 1999–2014

NOTES: Suicide deaths are identified with codes U03, X90–X94, and Y87.0 from the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision. Access data for Figure 1 at: http://www.cdc.gov/nchs/data/databriefs/db241_table.pdf#1.

Goal 7. Provide training to community and clinical service providers on the prevention of suicide and related behaviors.

All community-based and clinical prevention professionals whose work brings them into contact with persons with suicide risk should be trained on how to address suicidal thoughts and behaviors and on how to respond to those who have been affected by suicide. These professionals include:
A Prioritized Research Agenda for Suicide Prevention: An Action Plan to Save Lives

Research Prioritization Task Force

## Figure 12. Final Aspirational Goals Ordered in Tiers.

<table>
<thead>
<tr>
<th>TIER</th>
<th>ASPIRATIONAL GOAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Goal 6 – Prevention of reattempts</td>
</tr>
<tr>
<td>1</td>
<td>Goal 9 – Enhanced continuity of care</td>
</tr>
<tr>
<td>1</td>
<td>Goal 7 – Provider training</td>
</tr>
<tr>
<td>1</td>
<td>Goal 8 – Access to affordable and effective care</td>
</tr>
<tr>
<td>2</td>
<td>Goal 4 – Treatment interventions for those at risk</td>
</tr>
<tr>
<td>2</td>
<td>Goal 1 – Risk: protective factor interactions</td>
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<tr>
<td>2</td>
<td>Goal 10 – Suicide reduction</td>
</tr>
<tr>
<td>2</td>
<td>Goal 11 – Person-based risk-reduction/resilience-building</td>
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<tr>
<td>2</td>
<td>Goal 3 – Prevention of imminent risk</td>
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<tr>
<td></td>
<td>Goal 5 – Implement biological interventions</td>
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<td></td>
<td>Goal 12 – Reduce access to lethal means</td>
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<tr>
<td></td>
<td>Goal 2 – Population- and setting-based screening</td>
</tr>
</tbody>
</table>
Why suicide?

- Patient safety is compromised when providers lack the knowledge and skills to assess and manage patients at risk for suicide.

- Suicide risk assessment is a highly anxiety-provoking clinical encounter for the learner and the supervisor.

- Reliable, observational methods to assess risk and safety planning competencies are needed for training.
Our program offered suicide prevention: Commitment to Living (CTL; Pisani et al. 2012)

- 3-hour large group workshop
- Suicide specific competencies in a person-centered risk assessment and safety planning framework

Individual supervision

- Program Competency Assessment tool items
Evaluation of the Commitment to Living (CTL) Curriculum
A 3-Hour Training for Mental Health Professionals to Address Suicide Risk

Anthony R. Pisani, Wendi F. Cross, Arthur Watts, Kenneth Conner

Accepted March 31, 2011
Published online July 6, 2011

DOI: http://dx.doi.org/10.1027/0227-5910/a000099

Abstract

Background: Finding effective and efficient options for training mental health professionals to assess and manage suicide risk is a high priority. Aims: To test whether an innovative, brief workshop can improve provider knowledge, confidence, and written risk assessment in a multidisciplinary sample of ambulatory and acute services professionals and trainees. Methods: We conducted a pre/post evaluation of a 3 h workshop designed to improve clinical competence in suicide risk assessment by using visual concept mapping, medical records documentation, and site-specific crisis response options. Participants (N = 338 diverse mental health professionals) completed pre- and postworkshop questionnaires measuring their knowledge and confidence. Before and after the workshop, participants completed documentation for a clinical vignette.
Identified needs

Skills-based, active-learning component

- Successful transfer of knowledge/skills into clinical practice behavior is essential for workshop education to result in suicide prevention (Pisani, Cross & Gould, 2011)

- Integrating skills into real-world practice behavior requires extensive active learning and skills rehearsal (Beidas, Cross & Dorsey, 2011; Knowles et al., 2005)

Objective measurement (Cross & West, 2011)
How to provide skills-based learning and assessment?

- Realistic
- Ethical
- “Real world” practice
- Feedback – multiple sources

Solution: Standardized Patients
- Holds “stimulus” constant, allows for variability in responses
- Video taped encounters

Logistics
Standardized Patient (SP) Scenario Development

- Two behavioral rehearsal scenarios
  - Adolescent
  - Older Adult
- Focused on suicidal thoughts and behaviors
  - But also allows for measurement of other more general competencies (e.g., empathy, rapport building, interviewing skills)
<table>
<thead>
<tr>
<th></th>
<th><strong>Brittany</strong></th>
<th><strong>Mr. M</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Demographics</strong></td>
<td>Adolescent lesbian, any race/ethnicity</td>
<td>Older adult, any race/ethnicity</td>
</tr>
<tr>
<td>**Depression/</td>
<td>Depressed mood</td>
<td>Depressed mood</td>
</tr>
<tr>
<td>Mental Health</td>
<td>Tearfulness</td>
<td>Social withdrawal</td>
</tr>
<tr>
<td>Symptoms</td>
<td>Low self-worth</td>
<td>Feel like a burden to others</td>
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<tr>
<td></td>
<td>Low energy</td>
<td>Low energy</td>
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<tr>
<td></td>
<td>Irritable</td>
<td>Psychomotor agitation</td>
</tr>
<tr>
<td></td>
<td>Hopeless</td>
<td>Hopeless</td>
</tr>
<tr>
<td></td>
<td>Sleep disturbance</td>
<td>Sleep disturbance</td>
</tr>
<tr>
<td></td>
<td>Difficulty concentrating</td>
<td>Difficulty concentrating</td>
</tr>
<tr>
<td></td>
<td>Increased appetite</td>
<td>Decreased appetite</td>
</tr>
<tr>
<td></td>
<td>Anhedonia</td>
<td>Anhedonia</td>
</tr>
<tr>
<td></td>
<td>Anxiety</td>
<td>Anxiety</td>
</tr>
<tr>
<td><strong>Stressors</strong></td>
<td>Break-up</td>
<td>Stroke 6 months ago (mobility issues)</td>
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<td></td>
<td>Change in schools</td>
<td>Arthritis</td>
</tr>
<tr>
<td></td>
<td>Conflict with parents</td>
<td>Widowed 3 years ago</td>
</tr>
<tr>
<td></td>
<td>Not out to parents</td>
<td></td>
</tr>
<tr>
<td><strong>Protective Factors</strong></td>
<td>Future plans to go to college</td>
<td>Catholic</td>
</tr>
<tr>
<td></td>
<td>Close family relationships</td>
<td>Children, grandchildren</td>
</tr>
<tr>
<td></td>
<td>Lives at home – can be monitored</td>
<td>Lives at assistive living center – some monitoring</td>
</tr>
<tr>
<td></td>
<td>Interests – art, photography, volunteering</td>
<td>Interests – poker, music</td>
</tr>
<tr>
<td></td>
<td>Open to getting help</td>
<td>Open to getting help</td>
</tr>
<tr>
<td><strong>Suicidality</strong></td>
<td>Father has gun</td>
<td>Gun owner</td>
</tr>
<tr>
<td></td>
<td>Access to meds</td>
<td>Access to meds</td>
</tr>
<tr>
<td></td>
<td>Rehearsal behavior (counted out pills)</td>
<td>Rehearsal behavior (loaded gun recently)</td>
</tr>
<tr>
<td></td>
<td>Thoughts</td>
<td>Thoughts</td>
</tr>
<tr>
<td></td>
<td>Family history of suicide</td>
<td>Family history of suicide</td>
</tr>
<tr>
<td></td>
<td>Intent (4 out of 10)</td>
<td>Prior suicide attempt</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Intent (4 out of 10)</td>
</tr>
</tbody>
</table>
Standardized Patient Training

Trained SP actors to reliably present the clinical symptoms and life context:

- demeanor/dress, physical presentation, demographics, personal and family histories
- presenting problem, symptoms (description, duration), suicidal ideation, plan, intent, risk factors, protective factors, and potential safety planning factors,
- specific phrases/responses to be delivered
- specific feedback targets for SPs to communicate to trainees following the interaction
Standardized Patient Protocol

Project assistant greets trainee

- Brief written backstory
- “Conduct a 30-minute interview using what was learned in the CTL workshop to assess and assist the patient to the best of your ability”
- Introduced to the SP, ushered into the CEL room
Standardized Patient Protocol

- SP interaction ends at 30 minutes
- SP has 5 minutes to generate feedback
- SP provides the trainee with 5 minutes of structured feedback about the encounter from the “patient’s” perspective
- Debrief trainee
- SP-trainee encounters
  - videotaped
  - uploaded to a secure server for storage access for observational measurement development and analyses
- Trainees and supervisors have access to the videos for education purposes
Importance of Standardized Patient Feedback

- Rare that clinicians get feedback from actual patients about their experience of risk assessment and safety planning
  - Feedback is formative, nonjudgmental
- Trainee and supervisor can review the SP feedback
- Trainees rated the feedback very highly
Standardized Patient Feedback

• Video here
Measure Development: Suicide Specific Items

<table>
<thead>
<tr>
<th>6. Develop and enact collaborative evidence base Tx/ Safety Plan Note: if decided on hospitalization may still receive points for some of these items.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worked collaboratively with patient to generate a safety plan during the session. (Code: 0 = no plan/ or trainee dictates or drives plan; Code: 1 = trainee shares thoughts, gets input from pt.)</td>
</tr>
<tr>
<td>Invites pt’s mother/parent to collaborate on plan</td>
</tr>
<tr>
<td>Facilitates communication between parent/pt.</td>
</tr>
<tr>
<td>Instills hope (Code 1 = communicates/implies hope; “it’s going to get better”, “we’re going to work together so you’re not feeling this way”; 0 = no communication about getting better, improving, hope)</td>
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<tr>
<td>0 1 0 1 0 1 0 1 0 1 0 1 0 1</td>
</tr>
<tr>
<td>Details from this pt’s assessment interview are incorporated in a specific/tailored plan including:</td>
</tr>
<tr>
<td>Action: Increase monitoring (Code 1 = discussed with mom, or clear indication will do so, regardless of quality of mom’s monitoring plan; Code 0 = vague or relies on pt to self monitor only, or to communicate with mom on her own)</td>
</tr>
<tr>
<td>Action: take away access to means identified during interview i.e., medications and gun (Code 1 = whatever means ID’d in interview is addressed in terms of restricting access; Code 0 = previously ID’d means not addressed or no means addressed/revealed in interview)</td>
</tr>
<tr>
<td>Includes coping skills when triggers occur (i.e., loneliness) (Code 0 = no coping skills identified/included, 1 = one coping skill, 2 = two coping skills)</td>
</tr>
</tbody>
</table>
Measurement Development: General Interview Items

- Based on our previous work coding interview skills (Cross et al., 2011; Cross, West et al., 2015)

1. Pacing/ focus
   - Moves to suicide risk and safety planning in a timely way

2. Overall quality
   - Response to individual differences (age, religion, sexual orientation)
   - Language
   - Balance of open-ended and direct questions
6. Collaborative, Evidence-Based Safety Plan

**NOTE:** clinician does not need to initiate completion of a safety plan element to obtain a 1, but simply to complete it; a code of 1 is given if the patient spontaneously asks about the safety element plan during the course of the encounter and the clinician completes the element; if clinician decides to hospitalize, may still receive points for safety plan items, provided the clinician completes them.

**Item 6.1: Worked Collaboratively with Patient to Generate a Safety Plan during the Session**

0 = no plan or trainee dictates or drives plan (not collaborative)  
1 = trainee shares thoughts on plan, gets input from patient

**Item 6.2: Invites Patient’s Mother to Collaborate on Plan**

0 = not observed  
1 = observed

**Item 6.3: Facilitated Communication between Parent and Patient**

0 = does not facilitate communication; allows patient and parent to talk about each other instead of to each other; does not redirect conflict or reframe parent’s or patient’s thoughts more positively  
1 = encourages patient and parent to talk to each other; reframes negative interpretations of what the other party said

**Item 6.4: Instills Hope**

0 = does not communicate hope, sense that patient will feel better  
1 = communicates/implies hope, e.g. “we’re going to work together so you’re not feeling this way”

**Details from this Patient’s Assessment Interview are Incorporated in a Specific/Tailored Plan:**

**Item 6.5: Action – Increase Monitoring**

0 = vague or relies on patient only to self-monitor, or relies on patient to communicate with mom about self-monitoring on her own  
1 = trainee discussed with mom, or clear indication that trainee will do so. If observed, scored 1 regardless of the quality of mom’s monitoring plan

**Item 6.6: Action – Remove Access to Means Identified during Interview (Medications and/or Gun)**

0 = previously identified means not addressed, or no means were addressed or revealed in the interview  
1 = trainee discusses restricting access to whatever means were identified in the interview

**Item 6.7: Discusses Coping Skills for When Triggers Occur**

**NOTE:** Coping skills should be appropriate for acute management of suicidal ideation. Although volunteering at the animal shelter is a great long-term coping skill, it will not likely help the patient in the middle of an episode of suicidal ideation. Therefore this section scores coping skills that can help in acute situations (e.g., calling a friend, listening to music, talking to mom, etc.)

0 = no coping skills identified/included  
1 = one coping skill discussed  
2 = two or more coping skills discussed
Experiential learning: Practice opportunity

- Video here
In progress

- Coding Team
  - Inter-rater reliability
  - Consensus meetings
- Item and codebook revisions
- “Gold standard” tapes
Future Directions
Future Directions

• Assess relationship between the observational items measure and relevant items on our Program Competency Assessment tool
  ▪ Risk assessment
  ▪ Therapeutic relationships
  ▪ Patient risk management
  ▪ Sensitivity to patient diversity

• Documentation
  ▪ Conducted in workshop
  ▪ Incorporate in future study