QPRT Suicide Risk Assessment and Treatment Training Supplement

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This workbook supplement provides additional key information and resources for those completing the QPRT Suicide Risk Management and Risk Assessment training program.

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QPR Institute, Inc.

Current Status of Suicide Risk Assessment

To date, there is no "standardized" fool-proof method of suicide risk assessment accepted by all professions at this time. However, much has been learned about the elements required to make a reasonable and professional assessment of suicide risk and, with that assessment, determine levels of care, monitoring, and dispositions.

The suicide assessment and management method you will be taught in this course, and the specific questions you will use to converse with and initially assess someone contemplating suicide, have been asked of more than 250,000 suicidal people to date, many of them while being evaluated for psychiatric hospitalization or in emergency situations.

This training program is listed in the American Foundation for Suicide Prevention/Suicide Prevention Resource Center's Best Practice Registry at: www.sprc.org/sites/sprc.org/files/**bpr/QPRT**.pdf

Personal Experience with Suicide

As a healthcare student or professional you may have lost a patient to suicide. Or, you may have a lost a friend, colleague or family member to suicide. Few of us that reach middle age have not been personally touched by suicide. While suicide is a difficult subject, even for professionals, in this course we will make every effort to make talking about suicide as comfortable as possible. We do this because lives depend on it.

Having lost a patient to suicide or having personally survived a suicide crisis can teach important lessons, lessons you may have the opportunity to share with other suicidal persons, fellow students, your supervisor, or other professionals. If you have had personal experience as a suicide survivor (lost a friend, loved one, family member, or patient to suicide), we wish you to understand that some portions of this course may be upsetting to you. If they are, we encourage you to discuss the matter with your instructor, supervisor, a therapist, or a close advisor. You may also choose to take a break from the course and otherwise see to your own emotional needs.

We also wish to acknowledge all survivors of suicide and to let you know that we are sensitive to your needs and situation. We hope to support your brave efforts to help others avoid the pain you have experienced. If you are recently bereaved, it may be too soon to take this course. Only you can make this decision.

You may already have started down the road to healing and are on your way to recovery and helping others. If you are concerned about your emotional capacity for proceeding with this course, again, please see your supervisor or personal advisor.

Last, because suicidal behavior is not an uncommon occurrence among human beings, it is possible that you, personally, may have seriously considered suicide at some time in your life, or perhaps even made a suicide attempt. Should you be actively considering suicide as you read this, we strongly recommend you let your instructor, supervisor, or someone who can help know, and that you put off taking this course until you have received an appropriate evaluation and/or professional services.

It is our belief that persons currently experiencing suicidal thoughts or feelings should not work with suicidal persons. Similarly, anyone who has very recently suffered the loss of a family member or loved one to suicide should be referred to a grief counselor, survivor of suicide group, or other qualified professional. This referral is made, however, with the welcome-to-return mat out.

If you are "clinician-survivor" of a patient suicide, online resources are available through American Association of Suicidology at www.suicidology.org, and you are welcomed to join a support list serve.

Key definitions

- *Suicide* – self-inflicted death with evidence (either explicit or implicit) that the person intended to die.
- *Suicide attempt* – self-injurious behavior with a nonfatal outcome as well as evidence (either explicit or implicit) that the person intended to die.
- *Aborted suicide attempt* – potentially self-injurious behavior with evidence (either explicit or implicit) that the person intended to die but stopped before physical damage occurred.
- *Suicidal ideation* – thoughts of serving as the agent of one's own death. Suicidal ideation may vary in seriousness depending upon the specificity of suicide plans and degree of suicide intent.
- *Suicidal intent* – subjective expectation and desire for a self-destructive act to end in death.
- *Lethality of suicidal behavior* – objective danger to live associated with a suicide method or action. Lethality is distinct from and may not always coincide with an individual's expectations of what is medically dangerous.
- *Deliberate self-harm* – willful self-inflicting of painful, destructive or injurious acts without intent to die.

Source: O'Carroll, P.W., Berman, A.L., Maris, R.W., Moscicki, E.K., Tanney, B.L., & Silverman, M.M. (1996). Beyond the Tower of Babel: a nomenclature for Suicidology. *Suicide & Life Threatening Behavior*, 26, 237-252.

A Failure to Communicate: the Perils of Suicide Risk Assessment Interviewing

Of all the things that can go wrong while conducting a suicide risk assessment, interviewer fear has to be near the top of the list, second only to patient fear.

If you do not know what the two people in this exchange are experiencing by way of fear, and how they respond to that fear, you cannot know or predict how the enterprise will turn out, or whether a quality assessment was achieved.

Unacknowledged fear has a direct and often powerful influence on what does, or does not, happen during a suicide risk assessment interview. Unacknowledged fear can lead to an abbreviated, incomplete assessment and, thusly, to poor clinical decision making that may endanger patient safety.

Clinician fear
Clinician fear about assessing suicide risk is created by lack of knowledge, lack of skill, dread of the subject, and no, poor, or inadequate training.

What frightens a therapist most? A suicidal patient!

According to a national survey 97% of psychologists rated client suicide as their number one fear and, to quote one of the authors, "such feelings, when unacknowledged or inadequately addressed, may have devastating consequences" - including that whatever action is taken may be more about addressing the clinician's feelings than the patient's needs (Pope & Tabachnick, 1986).

One of the reasons published suicide risk assessment research fails to answer some of our most fundamental questions about the utility of the assessment process is that the clinician "fear factor" has remained largely unstudied.

Because we have not studied this fear and how clinicians react to it, it safe to assume we've done a poor job of following the adage, "Healer! Know thyself!"

Nothing is more important to know about how well or poorly a given clinician carries out a suicide risk assessment interview than to know the answers to two questions:

1. How fearful is the clinician of suicidal patients in general and this suicidal patient in particular?
2. How does this clinician react to fear?

In training students to do this work for 30 years, any clinician who is not afraid of what a suicidal patient might do is simply not got his or her head "in the game." That, or they are simply too naive to be a therapist in the first place.

Fear is good – pilots respect it, commercial fishermen own it, and anyone who takes responsibility for the lives of others should honor it as the most reliable guide available to prevent injury and death.

Being fearful of suicidal patients and their potential for harmful acts against themselves is the right emotion, so long as the clinician does not deny it. It's denying one's fear during an encounter with a suicidal patient that puts both parties at risk.

The best way to deny the fear generated by a potentially suicidal patient is to believe the myth that "talking about suicide will put the idea in their head."

Believing this myth does not reduce fear in the patient, but masks clinician fear – which is why this particular myth is so stubborn and difficult to change.

The world is a dangerous place for suicidal people, not because help is not available, but because those who should and could provide calm, confident, competent clinical screening, assessment, management, and care can appear to suicidal patients as ignorant of their pain and suffering, or worse, indifferent to it. If indifference is one mask fear wears; arrogance is the other.

Entering the abyss of a patient's suicidal despair and desire for death is not for the timid. It takes genuine courage to go where their loved ones, friends, and even their family doctor dare not go. But to *not* go there - and to covertly agree with the patient that the subject (suicide) is just too unpleasant to talk about - is to add to the patient's isolation and suffering, not subtract from it.

Patient fear

We know that most clinicians are afraid of suicidal patients and that, as a direct result of avoiding this, they do not bother to learn the very details of the barren, lunar-like emotional landscape of the hopeless suicidal mind; the very landscape the clinician must traverse to fully grasp the gravity of suicidal thought, intent, desire and capacity for self-destruction. This clinician fear is observable in almost any rooky clinician interview with a suicidal patient, and even in role-play with a non-suicidal colleague.

What, we might ask, is the impact of this observable clinician fear on the suicidal patient's own fears?

One impact might be the following covert message: therapist-to-patient: "I can't talk about this! Please help me out here. Please change the subject!"

Patients are polite. So is it any wonder that when patients see and smell this fear they not only stop disclosing the very data the clinician needs to understand the stakes of the game, but may even deny suicidal ideation they just admitted to on an intake screening tool or even in their presenting complaint?

Even causal observation of clinicians in role-play with a suicidal client is obvious: broken eye-contact, arm crossing, glances at the clock, postural shifts in the chair, awkward note taking, non-therapeutic pauses, reaching for a drink of water, rushing in with a quick-fix suggestion, and – if you are close enough to see them - dilated pupils.

Are we really surprised, then, that suicidal patients do not fully disclose how they really feel? Are we surprised they deny suicidal desire, intent, and plan when, in fact, they have a loaded gun at home? Should we be so surprised that, only hours after seeing one of us for therapy, we learn they have taken their own lives?

Given that a sense of burdensomeness is one of the conditions Tom Joiner (Joiner, 2005) argues is a necessary condition for suicide, how must a suicidal patient feel when his or her provider of care telegraphs by word and deed the following subtext: "If you are suicidal right now you are creating burden of care for me that I cannot tolerate. So, would you please just lie to me about your current state of mind? Thank you!"

What patients say

After many years of exploring the question of how other clinicians dealt with patient suicidality, and why patients were afraid to say all they knew about their own risk of killing themselves, here are few things I've learned.

To other providers, suicidal people denied suicidal ideation, intent, desire, past attempts and current planning for:

- Fear that full disclosure would lead to voluntary hospitalization (which could be unavailable, unaffordable, shameful, inconvenient, etc. etc.).
- Fear that full disclosure would lead to involuntary hospitalization (the 'booby hatch," and for all the same reasons as above).
- Fear that full disclosure would prevent discharge from hospital where they had been admitted for being suicidal or making a suicide attempt.
- Fear that full disclosure will lead to arrest and possibly incarceration (jail lock up where no treatment facility was available).
- Fear that full disclosure of suicidal desire and intent will lead to unwanted rescue.
- Fear that full disclosure would so upset the interviewing clinician they might have to be referred to another provider and obliged to tell their story "all over again."
- Fear that revelation of access to a firearm or drugs may implicate personal or third party illegal ownership of same.
- Fear that the interviewer is neither benevolent nor trustworthy.

- Fear that the interviewer is not competent to assess and help me manage my suicidal thoughts, feelings, impulses, and doesn't know what is causing them (confirmed by telltale interviewer anxiety and incompetence).

- Fear that the revelation of a suicide plan may expose a double suicide, suicide pact, or planned murder-suicide.

- Fear that disclosure of suicidal desire, intent, rehearsal or past suicide attempts will lead to shame and censure, possible job loss, discharge from duty as a police officer, EMT, firefighter, military discharge, pilot's license, and security risk status in a high security facility, e.g., Hanford Nuclear Reservation.

Bottom line

In a suicide risk assessment interview there are two players, sometimes three if a spouse or family member is present. In our professional roles we have been trained to believe that if something goes wrong in our trying to help someone, it is the patient's fault, not ours.

Times have changed. This position is no longer defensible.

Lives are unnecessarily lost because too many clinicians do not understand the fear created in them when interviewing suicidal patients. Even worse, they do not know how they respond to their own fear. In the absence of this self-knowledge, the quick retreat to risk denial and reliance on protective myths against asking difficult questions assures that some patients will die by suicide that didn't need to.

If fear is not the right word, then discomfort will do..., but the emotion is the same; ancient and essential to human survival and only overcome with awareness, knowledge, and courage.

So long as therapists refuse to accept and honor this fear, and learn how to do their jobs in spite of it, they will continue to minimize the very real potential that the patient sitting across from them may soon die from a horrific violent act of self-injury.

(Note the QPR Institute is currently conducting an international study on the role of fear, training, and experience and how these impact working with suicidal patients. P Quinnett.)

References:

Joiner, T. (2005). Why people die by suicide. Cambridge, MA: Harvard University Press.

Pope, K. S. & Tabachnick, B. G. (1993). Therapists' anger, hate, fear and sexual feelings: National survey of therapist responses, client characteristics, critical events, formal complaints, and training. *Professional Psychology: Research and Practice*, 24, 142-152.

Our Philosophy

The key element in any successful suicide prevention intervention is to establish a positive relationship with the person in distress. You no doubt know this, but it is helpful to underscore that your willingness to listen and to be empathetic sends a message of hope, and the restoration of hope is one of the key elements in reducing immediate suicide risk.

From experience, we know that without a working alliance with a distressed and suicidal person, inadequate or incomplete risk data will be collected and your decision about next steps will be difficult. Our decision making and assessment of potential risk for suicide hinge on the following:

- *What we know about the conditions necessary to produce suicidal thoughts, suicidal desire, intentions and plans*
- *How much we learn from the person and how much we can learn from significant others*
- *The context in which suicide is being considered*
- *Suicide warning signs present*
- *Risk factors, including the presence of means of suicide, e.g., belt, gun, shoelaces, sharps, medications and other means of suicide*
- *Protective factors or buffers against suicide, including reasons for living, commitments to others, responsibilities for children, duties at work and even responsibility for pets*
- *What the suicidal person is willing to do to help us save his or her life*

As a guided interview, data gathered from the QPRT protocol flow into a decision tree and invites the suicidal person and his or her significant other(s) to agree to a safety management plan based upon the assessed risk. The ultimate goal of this collaborative plan is to immediately reduce known risk factors while enhancing known protective factors in an effort to avert a suicide attempt or completion. For a suicide attempt to take place, there must be both opportunity and means available to the sufferer; restrict these during the crisis and risk is reduced.

Whether the suicide crisis is both acute and state-dependent, and therefore amenable to usual and customary intervention and treatment, or trait-dependent and requiring longer term personality-focused treatment, the QPRT serves as a collaborative risk reduction intervention. Most importantly, a QPRT risk management plan engages the suicidal

person directly in his or her own survival plan and encourages him or her, if emotionally and cognitively competent, to acknowledge and accept responsibility for personal safety.

Research Summaries

The QPRT Suicide Risk Management and Risk Assessment protocol and training program was originally developed in 1996 by a multidisciplinary team of mental health professionals at Spokane Mental Health, in Spokane, Washington, USA.

Working with the Washington Institute for Mental Illness Research and Training, and after surveying senior members of the American Association of Suicidology for "most recommended" suicide risk assessment questions, teaching content was selected, tested, and evaluated using an objective 27-item test developed to assess the training effect of the eight hour QPRT Suicide Risk Management and Risk Management course. The exam questions were divided into four sub-scales intended to tap information in the following areas: Epidemiology and Statistics (8 items), Suicide Risk Factors (5 items), Suicide Risk Assessment (6 items), and Suicide Risk Management (8 items). Treatment content items were included in the assessment and management subsets.

Since the initial 1996 evaluation of the QPRT training program, the following groups or organizations have conducted training and content evaluations. Full reports and these findings and training evaluations are available at www.qprinstitute.com QPRT Reports.

Year	Organizations	Evaluations
1998	Spokane Mental Health	Clinicians trained/tested N=200
1999	Spokane Mental Health	35 consumers (consumer satisfaction)
1999	Joint Commission	Published as patient safety "best practice"
2002	American Psychiatric Assoc.	Featured as patient safety "best practice"
2004	Devereux Foundation	Clinicians trained/tested N=1,100
2004	University of Georgia	Clinicians trained/tested N =231
2005	University of Georgia	Clinicians trained/tested N =225
2006	University of N Illinois	Clinicians trained/tested N = 1,136
2010	SAMHSA/AFSP	Best Practice Registry
2011	CASA New Zealand	Clinicians trained/tested N = 251

The QPRT is currently undergoing additional research in the following areas:

- Reliability and validity studies (Devereux Foundation)
- Training impact on clinical practice (University of South Florida)

Adaptations

In additional to mental health and CD providers, the QPRT Suicide Risk Assessment and Risk Management training program has been adapted and customized for the following:

- Nurses, physicians, physician assistants
- School counselors, pastoral counselors, MFT, LPC
- Those serving elders, youth, and Native Americans
- Outpatient, residential and inpatient settings

QPRT INTERVIEW PROTOCOL CHECKLIST

Like surgeons preparing for an operation, checklists have proven very effective in reducing medical errors, e.g., wrong site surgery. This checklist is a post-training *prompt* to facilitate your coverage of the minimum recommended assessment queries and safety plan elements to help you avoid "optimist bias" - the belief that other people may make errors, but not you.

Clip and carry this with you until you have memorized the QPRT stem questions.

Your memory may be great, but as expert surgeons have observed, checklists "keep you honest."

Minimum assessment probes

- Suicide risk detected? Yes? No?
- What's wrong? Problem narrative elicited
- Why now? Recent life changes/anticipated changes
- With what? Suicide means/access determined
- Where and when? Plan/place/time
- Where and when in the past? History of SI/attempts
- Who's involved? Role of social others/current conflicts
- Why not now? Protective factors elicited
- Risk stratification/disposition decision make
- Persuaded to accept help/referral

Collaborative safety plan

- Agreement to remain sober
- Agreement to follow medical advise
- Agreement to means restriction
- Agreement to no self-harm
- Agreement to access emergency services
- Acceptance of personal responsibility for safety
- Family/significant others educated about resources
- Family/significant others provided print materials
- Needed releases signed
- Signature secured (optional)

QPRT Interview Protocol Checklist - Pediatric Version
Surgeon's find checklists very effective in reducing medical errors, e.g., wrong site surgery. The following checklist is a post-training *prompt* to facilitate your coverage of all recommended assessment probes. A checklist "formalizes" a practical approach to suicide risk assessment to ensure no important areas of inquiry are missed. Your memory may be great, but as expert surgeons have observed, checklists "keep you honest." To help you avoid "optimist bias" (the belief that other people may make errors, but not you), let's make sure you cover all the topics research has shown contribute to suicide risk in young people.

Clip and carry with you or post where you can see it while interviewing:
Assessment queries:

- Suicide risk detected? Yes? No?
- Upset about? Problem narrative elicited
- How would attempt?
- With what/when/where?
- Suicide means/access determined/mitigated
- Where and when? Plan/place/time
- Where and when in the past? History of SI/attempts
- If attempted with what (medical) result?
- Familiarity with death of someone close?
- What happens when you die?
- Who can help you?
- Why not now? Protective factors elicited
- Risk stratification/disposition decision make
- Persuaded to accept help/referral

- Additional assessment questions-
- Who knows about your plans?
- Who will find you if you die?
- What's happening in your family, e.g., family fights?
- Do you feel safe?
- Do you feel sad?
- Are you ever angry at others or break things?
- Have bad dreams?
- Feel bad about things you do or say?
- Your greatest fear?
- How's school going?
- Getting along with friends?
- Using any drugs or alcohol?
- Want to die, 1 to 10?

Safety plan checklist (as age appropriate)
- Agree to accept help and be safe?
- Agreement to remain sober

III. NOTICE OF RIGHTS AND ACKNOWLEDGMENTS

The QPR Institute holds the exclusive rights to the QPRT Suicide Risk Management Inventory© and its derivations.

The QPRT Suicide Risk Management Inventory© hereinafter referred to as the QPRT was originally researched and tested through the offices of Greentree Behavioral Health, a Division of Spokane Mental Health in Spokane, Washington.

The rights to the QPRT and all QPR Institute programs were gifted to the QPR Institute in 1999 and now constitute key elements of the QPR Institute's Suicide Risk Reduction Program. This system is the first integrated, comprehensive, community-based suicide prevention, intervention, assessment and postvention program of its kind in the United States. The authors wish to acknowledge and thank Spokane Mental Health for its assistance, funding, and vision in the development and testing of these suicide prevention tools and training programs.

As developed and implemented by Spokane Mental Health (now Frontier Behavioral Health), the QPR Suicide Risk Reduction Program was the winner of the Mental Health Risk Retention Group's National 1998 J.J. Negley President's award for avoiding suicide malpractice.

For more information about the QPR Institute's comprehensive suicide risk reduction programs call (509) 536-5100 or (888) 726-7926.

Printing QPRT forms

This inventory is a proprietary and copyrighted assessment tool and its use requires a) purchase of the inventories in hard copy from the QPR Institute (www.qprinstitute.com), b) a license to print the inventory, or c) a license to use the inventory in an electronic medical record system. The cost of the inventory is negligible when licenses to print in unlimited volume are purchased by agencies and typically adds less than one dollar in cost to each episode of care. Please contact the QPR Institute with any questions or for a license to print. Unauthorized use of the QPRT Suicide Risk Management Inventory© is subject to federal copyright laws and substantial fines.

Thank you for having the courage to learn how to help save lives from suicide.

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