

SAFE-T: Application to Clinical Practice

Douglas Jacobs, M.D.

Facts and Figures:

Suicide is one of the leading causes of death in the United States. In 2013 alone, 41,149 people were documented to have killed themselves in the United States. In the same year, suicide was the tenth leading cause of death among persons of all ages and the second leading cause of death among 15-24 year-olds and 25-34 year-olds (CDC, 2013).

Findings indicate that suicides were more likely to be males, non-Hispanic whites, American Indians/Alaska Natives, and aged 45-54 years. In addition, suicide most frequently occurred in a house or an apartment and involved the use of firearms. The primary precipitants for suicide were relationship problems, interpersonal conflicts and recent crises (Parks et al., 2014).

Studies have shown that 90% to 95% of persons who died by suicide had a psychiatric illness, though half of these decedents had never had any psychiatric contact (Cavanagh et al., 2003; Nock et al., 2008). About a quarter of decedents had been in mental health treatment at the time of the suicide. Approximately five percent of suicides occur on hospital grounds (APA, 2003). Moreover, nearly half (45%) of suicide decedents had seen a primary care provider within the month before their suicide and 77% had contact with a primary care provider in the past year (Luoma et al., 2002). Treatment providers and mental health clinicians are tasked with conducting thorough suicide risk assessments. Factors which increase as well as decrease the likelihood of suicide have been identified (APA, 2003). However, it is important to acknowledge that “even under the best of care, suicides do happen” (APA 2003). Ultimately, the suicide assessment is the quintessential clinical judgment (APA 2003).

Definition of terms:

Definitions of suicide and suicide attempts vary, complicating our understanding of the literature. According to the CDC, a suicide is a “death caused by self-directed injurious behavior with an intent to die as a result of the behavior” (CDC website). A suicide attempt is a “non-fatal, self-directed, potentially injurious behavior with an intent to die as a result of the behavior” (CDC website).

In this article, suicide will be defined as a “self-inflicted death with evidence (either explicit or implicit) that the person intended to die” (APA, 2003). A suicide attempt will be defined as “self-

injurious behavior with a nonfatal outcome accompanied by evidence (either explicit or implicit) that the person intended to die" (APA, 2003). In terms of the difficulty with preventing suicide as a phenomenon, studies have shown that as many as 60% of suicide decedents die by suicide on their first attempt (APA, 2003).

The FDA includes additional definitions of suicidality (Posner et al., 2007).

C-CASA Definitions* (Posner et al., 2007): Suicidal Events

Preparatory Acts Toward Imminent Suicidal Behavior — Individual takes steps to injure self, but is stopped by self or others from starting the self-injurious act before the potential for harm has begun (i.e., rehearsal, aborted/interrupted attempt)

Suicidal Ideation — Passive thoughts about wanting to be dead or active thoughts about killing oneself, not accompanied by preparatory behavior, Important to determine nature of ideation (i.e., lethal, reversible)

The Suicide Assessment:

The suicide assessment is a critical element in any psychiatric evaluation. Through direct questioning and observation, the clinician obtains information about the patient's presenting problem, recent and past psychiatric history, medical history, current mental state, and suicidal thinking and behavior. This information enables the clinician to identify factors that may increase or decrease the risk for suicide, address the client's immediate safety needs, determine the most appropriate treatment setting, and develop a differential diagnosis to further guide treatment (Jacobs, Assessment and Assignment of Suicide Risk, p. 5-6).

A suicide assessment is indicated in the following clinical situations; an intake evaluation, emergency department or crisis evaluation in depressed persons where there is anticipation or experience of a significant interpersonal loss or psychosocial stressor (e.g., divorce, financial loss, legal problems, personal shame or humiliation), at the onset of certain physical illness (particularly if life threatening, disfiguring, or associated with severe pain or loss of function) (Jacobs, Resource materials, p. 10), and with any subsequent suicidal behavior, increased ideation, or pertinent clinical change. For individuals who are hospitalized in inpatient settings, suicide assessments are conducted on admission, prior to increasing privileges or granting a pass, when there is a change in mental status, and at discharge.

The breadth and depth of the suicide assessment will vary depending on the setting, the ability or willingness of the patient to provide information, previous and current mental state, and the availability of information from previous contacts with the patient or from other sources if available (e.g., mental health professionals, medical records, family members). Research has shown that nearly 70% of decedents had communicated their suicidal intention to a significant other prior to their suicide (Robins, 1959).

SAFE-T:

The SAFE-T is a five step suicide assessment protocol (**Suicide Assessment Five-step, Evaluation and Triage**) for Mental Health Professionals, that was originally conceived by the author and developed as a collaboration between Screening for Mental Health, Inc. and the Suicide Prevention Resource Center (see SAFE-T card). It draws upon the American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors (APA, 2003). The five steps in SAFE-T are: 1) Identify risk factors; 2) Identify protective factors; 3) Conduct suicide inquiry; 4) Determine risk level/intervention, and 5) Document.

1. **Identify Risk Factors:** One of the objectives of the suicide assessment is to identify risk factors for suicide. Although research has shown that multiple factors can increase one's risk for suicide (see Table 4 – Resource Materials, p. 12), there is no study indicating that there is one single factor or set of factors that are predictive of suicide. The factors that have been correlated with (but not causative of) increased suicide risk include demographics, psychiatric symptomatology, psychiatric illness and comorbidity, family history, personality disorder/traits, substance use/abuse, severe medical illness, life stressors, suicidal behavior, psychological vulnerability, and access to weapons.

Some demographic groups are at higher risk of suicide than others. Men are about four times more likely to commit suicide than females (CDC, 2013), though females are three times more likely than males to make suicide attempts. Middle age persons between the ages of 45 and 54 are at greater risk than persons in other age groups. Persons who are single, widowed, or divorced – especially if they are male – are at greater risk.

During the suicide assessment, a clinician attempts to identify factors that may increase the individual's suicide risk. As with any psychiatric or medical examination, the initial focus is on the "why now," what it is about the person's life, psychiatric/medical history, circumstances and/or connections that have led them to consider or act on suicidal thoughts and impulses. The clinician will inquire about

suicidal thinking and behavior, specifically the history of prior self-injurious behavior or suicide attempts, including aborted or interrupted attempts. Although suicide attempts are statistically correlated with suicide, they may or may not inform current suicide risk. In fact, nearly 75% of persons who make suicide attempts do not go on to complete suicide in their lifetime and the annual risk of suicide in persons who have made a suicide attempt is 0.55% (APA, 2003).

The clinician also assesses current and past psychiatric disorders, especially mood disorders, psychotic disorders, alcohol and substance use, Attention Deficit Hyperactivity Disorder, Traumatic Brain Injury, Post-Traumatic Stress Disorder, Cluster B personality disorders, and conduct disorders (antisocial behavior, aggression, impulsivity). Comorbidity and recent onset of illness increase risk. Symptoms associated with increased risk of suicide, specifically anhedonia, impulsivity, hopelessness, global insomnia, anxiety/panic, insomnia, or command hallucinations may be present (APA, 2003). Changes in providers or treatment setting can also be significant.

In terms of family history, it is useful to explore if there is a family history of suicide, suicide attempts, or Axis I psychiatric disorders requiring hospitalization. Suicide appears to be an independent, inheritable risk factor. Studies have shown that relatives of suicidal subjects have a four-fold increased risk compared to relatives of non-suicidal subjects. Adoption studies show a greater risk of suicide among biologic than adoptive relatives. Additionally, twin studies found a higher concordance of suicidal behavior in identical twins than fraternal twins (APA, 2003).

Childhood physical and sexual abuse, as well as parental neglect and separations, have been correlated with a variety of self-destructive behaviors in adulthood. Although research has long shown that exposure to traumatic events, especially childhood sexual abuse, is associated with an increased risk of attempted suicide, it is only recently that researchers have begun to think that the increased risk of attempted suicide may be primarily related to the development of Post-Traumatic Stress Disorder (PTSD). Wilcox and colleagues (2009) found that PTSD, not the trauma itself, was an independent correlate of attempted suicide. Exposure to traumatic events without developing PTSD was not associated with subsequent suicide attempts. Similarly, a study analyzing data from the National Comorbidity Survey also found a robust relationship between PTSD and suicide ideation or attempts, even after controlling for comorbid mood and personality disorders (Hudenko, Homaifar & Wortzel, 2015).

Finally, for patients with suicidal ideation, it is important to inquire about access to lethal methods, especially firearms, whether or not a plan is present. Firearms account for 55-60% of suicides and having a firearm at home significantly increases the risk for adolescent suicide (APA, 2003; Brent et al., 1991). If the patient has access to a firearm, the clinician, by discussing with the client and/or the significant other the importance of restricting access to or removing the firearm can make an important intervention (Jacobs, Resource Materials, p. 8). It is important to document not only the instructions provided, but also the response.

2. Identify Protective Factors: Protective factors are defined as those factors that decrease the likelihood of suicide. The following protective factors have been identified; children in the home, sense of responsibility to family, pregnancy, religiosity, life satisfaction, reality testing ability, positive coping skills, positive problem-solving skills, positive social support, and positive therapeutic relationship (APA, 2003). However, one of the most critical protective factors is the status of connection to significant others. These significant others can be loved ones, friends, and/or family. Unfortunately, a patient's support system can also be paradoxical and may also be the cause of stress.

A number of researchers (e.g., Johnson et al., 2011; Lundman et al, 2011) have examined the concept of resiliency with respect to suicidality. Resiliency in regards to suicidality has been defined as "the ability, perception or set of beliefs which buffers individuals from the development of suicidality in the face of risk factors or stressors" (Johnson et al., 2011). Resiliency has also been defined as a positive outcome in the face of adversity. Lundman et al (2007) identified five characteristics of resilient individuals; a balanced perspective of life, a sense of purpose in life, the ability to keep going despite setbacks, the belief in one's self and capabilities, and a recognition of one's unique path and the acceptance of one's life (Lundman et al, 2007).

3. Conduct Suicide Inquiry: The third step of the SAFE-T in determining suicide risk is a detailed and thorough suicide inquiry that can begin with questions that address the patient's thoughts and feelings about living and dying (see Table 3, Resource Materials, page 8). Depending upon the responses to these questions, they may lead to specific questions about suicidal thoughts, plans, behaviors, and intent. Again if there are affirmative responses to suicidal thoughts, understanding the frequency, intensity, and duration of suicidal thinking in the last 48 hours, as well as the worst or most intense ideation ever experienced, can be a useful guide in determining the patient's propensity towards suicide.

It is known that asking about suicidal ideation does not necessarily ensure that accurate or complete information will be received. Busch, Fawcett, and Jacobs (2003) found in a study of 76 inpatient hospital suicides that 78% denied suicidal ideation at their last communication with staff. Clinicians should not accept a denial at face value. If the clinical presentation seems inconsistent with an initial denial of suicidal thoughts (e.g., if depressive symptoms - especially anhedonia, anxiety, and insomnia – are severe), then additional questioning as to why the patient does not feel suicidal is indicated. Asking additional questions about the client's reasons for living and what has changed or improved, as well as questions regarding the patient's past experience with suicidal ideation, can be useful.

If suicidal ideation is present, asking about the specific plans for suicide and whether any steps have been taken to enact the plans or prepare for death, can help determine the severity of suicidal ideation. Inquiry about the timing, location, and lethality of the plan as well as the availability of means, particularly firearms, can add additional critical information. The clinician should assess the extent to which the client expects to carry out the plan and whether the client believes the plan to be lethal as opposed to self-injurious.

If there is a history of past attempts, understanding the precipitants, timing, intent, method, and consequences of these suicidal behaviors and actions, can help determine the seriousness of a patient's suicidality. Suicidal behaviors and/or ideation occur in the context of one's life. Appreciating the importance of that context can be invaluable when assessing for risk and determining a treatment plan.

In terms of alcohol and substance use, understanding whether or not the suicidality occurred in association with intoxication or acute/chronic use of alcohol or other substances can be significant. Studies have shown that individuals with alcohol dependence have a nine-fold increased risk of suicide, and that acute use of alcohol in the final hours of life confers an even greater risk for suicide attempt and suicide than the risk attributable to chronic alcohol use alone. Kaplan et al. (2013), for example, found that 24% of male and 17% of female suicide decedents in their sample were intoxicated at the time of death.

4. Determine Risk Level/Intervention: As was stated earlier, it is impossible to predict suicide due to the statistical rarity of suicide and suicidal behaviors, even in populations at risk. Knowledge of risk factors, either alone or in combination, will not permit a clinician to predict when and if a particular client will commit suicide (Harris & Hawton, 2005; Pokorny, 1983; Pokorny, 1993; Wand,

2012). However, appreciating that a particular risk factor can increase an individual's likelihood of suicide can inform the treatment plan, including the determination of a treatment setting.

When assessing suicide risk, it is critical to have an understanding of the psychosocial context, including acute psychosocial crises as well as chronic psychosocial stressors, especially triggering events that lead to humiliation, shame, or despair. Factoring into the risk assessment of the patient, current employment, living situation, and any history of abuse or neglect can be useful. Attention to the presence or absence of external supports, with particular emphasis on the family constellation and the quality and status of relationships is also useful. Understanding the patient's cultural or religious beliefs about death and suicide is another element that sometimes can provide helpful information.

Once a clinician has understood as reasonably as one can the life situation, relationships, risk factors, protective factors, and suicidality of the patient, risk level can be determined. A critical element of assigning suicide risk is appreciating the patient's level of suicidal intent, which includes a patient's understanding of the potential lethality of the method chosen and the expectation that they will carry it out. Those judged to be at high risk for suicide may be those who have made a potentially lethal suicide attempt or have strong intent. High risk patients also tend to have psychiatric disorders with severe symptoms or an acute precipitating event. In contrast, those deemed to be at low risk for suicide may have thoughts of death, but no plan, intent, or behavior. Low risk patients often have modifiable risk factors and strong protective factors. Possible interventions in low risk cases include outpatient referral, symptom reduction, and giving out emergency/crisis numbers.

Hospital Admission: Hospital admission is sometimes, but not always, indicated after a suicide attempt or interrupted/aborted attempt. Hospitalization is generally indicated after an attempt if the patient is psychotic, impulsive, severely agitated or has poor judgment. Hospitalization is also generally indicated if the attempt had lethal intent, was premeditated, if precautions were taken to avoid rescue or discovery, or if the patient regrets surviving.

Hospitalization is sometimes indicated even in the absence of a suicide attempt or aborted attempt. For example, if there is suicidal ideation with specific plan with high lethality (e.g., plans to shoot self with a gun), suicidal ideation with high suicidal intent, or suicidal ideation with severe anxiety, agitation, or perturbation, the client is usually hospitalized (JCAHO Resource Guide).

There are also certain other circumstances where hospitalization may be necessary in the presence of suicidal ideation. For example, hospitalization may be considered in the presence of suicidal

ideation if there is a contributing medical condition or if there is a need for ECT, a trial of medication, clinical tests, diagnostic assessments, or skilled observation that require a structured or supervised setting.

Finally, hospitalization may be considered even in the absence of suicide attempts or reported suicidal ideation, plan, or intent, if there is evidence from the psychiatric evaluation and/or collateral history that suggests a high level of suicide risk or a recent increase in suicide risk (JCAHO Resource Guide).

Guidelines for Inpatient Suicide Assessments: Inpatient suicide assessments are conducted when the patient is admitted, when there is a change in privilege level (or before granting a pass), when there is a change in mental status, and before discharge. Both verbal and written communication of suicide risk is important because there are multiple members of a treatment team (JACHO Resource Guide).

Once a patient is admitted to the hospital for suicidality, a complete psychiatric evaluation and suicide assessment will determine observation level. The monitoring of the suicidal patient includes a range of frequency of observation from continuous observation (1:1) to 15 or 30 minute checks. In the hospital setting, there are also different categories of restriction, such as supervised bathroom use, restriction to the unit or to public areas, supervised sharps, and placement in hospital clothing. The determination of the level of risk will depend on the level of risk assessed. Additionally, staff must be aware of the challenges of transporting a suicidal patient. The increased risk associated with the transport must be balanced by the benefit of the transport (JCAHO Resource Guide).

5. **Documentation:** The final step in a suicide assessment is documentation that includes the assessed risk level and the reason and rationale for the risk level. Concomitant with this is the documentation of the interventions to reduce suicide risk as well as plans for follow-up treatment. To reduce suicidality, clinicians can consider psychotherapy, medication, ECT, treatment setting, contact with significant others, and consultation with current or previous providers. Furthermore, when dealing with suicidal youths, the treatment plan should discuss a role for the parent(s) or guardian(s). Communication with these contacts as well as any specific instructions given about firearms or other methods can be useful areas to include (Jacobs, Assessment, p. 9-10).

¹Risk Assessment Instruments:

There are a number of rating scales, both self-reported and clinician-administered, that are purported to measure suicidal thoughts, behaviors, and/or symptoms. In 2003, the APA Work Group analyzed a few of these assessment scales (e.g., Scale for Suicide Ideation, Suicide Behavior Questionnaire, Suicide Intent Scale, Reasons for Living Inventory) and found them to be reliable and to have adequate concurrent validity. However, the general impression was that although the rating scales that were available at that time may have application in research settings, their usefulness and generalizability to clinical settings was limited to such things as tracking clinical symptoms over time or assisting clinicians in the development of a more thorough line of questioning regarding suicidality. The APA Work Group did not recommend the clinical use of rating scales to estimate suicide risk for individual patients (APA, 2003).

The APA Work Group was particularly concerned about the fact that most of the scales had been tested in non-representative samples (e.g., college students) and, as a result, had not yet been tested adequately across various groups of patients (e.g., elderly patients, minorities) or in certain settings (e.g., primary care offices, emergency departments), both of which have significant numbers of suicidal patients. In addition, few of these scales had been tested prospectively, and those that had been showed very low positive predictive values and high rates of false positive findings. For example, in a 10-year prospective study of patients hospitalized for suicidal ideation, the Beck Hopelessness Scale was able to distinguish those who died by suicide and those who did not, however its positive predictive value was extremely low and its rate of false positive findings was high (APA, 2003).

In the past ten years, some new rating scales have been developed, the most notable of which is the Columbia Suicide Severity Rating Scale (C-SSRS) (Posner et al., 2011). The authors sought to develop a single standardized measure that assesses both suicidal ideation and behavior for clinical trials, an instrument that had been lacking in the field to date. The C-SSRS was specifically designed to differentiate suicidal ideation from various suicidal behaviors. Four constructs are measured: 1) severity of ideation; 2) intensity of ideation; 3) suicidal behavior (actual, aborted, and interrupted attempts; preparatory behavior; and non-suicidal self-injury); and 4) lethality (actual and potential). The inclusion

¹ *For further reading see- Fochtman, LJ, Jacobs, DG. *Suicide Risk Assessment and Management in Practice: The Quintessential Clinical Activity*. ACAD Psychiatry (2015) 39: 490-491.

of both interrupted attempts (not just actual attempts) and preparatory behavior in the C-SSRS scale was based on studies showing both to be associated with subsequent suicides (Posner et al., 2011).

In a 2011 paper published in the American Journal of Psychiatry, Posner and colleagues discussed the C-SSRS's convergent validity, divergent validity, predictive validity, sensitivity, specificity, sensitivity to change, and the internal consistency of its intensity subscale. The team points out that other indices of reliability could not be examined because of the study design; but that the C-SSRS's inter-rater reliability has been demonstrated in previous studies (e.g., Mundt et al., 2010). Posner's team concludes in the article that the C-SSRS is suitable for the assessment of suicidal ideation and behavior in both clinical and research settings.

In 2012, the Food and Drug Administration made the C-SSRS the “gold standard” for the assessment of suicidal ideation and behavior in clinical trials. Since that time, however, there has been some criticism of the C-SSRS. For example, there is concern that the C-SSRS may fail to identify some cases of suicidal ideation and over-identify or misclassify others (Giddens, Shaheen & Shaheen , 2014). Giddens, Sheehan, and Sheehan (2014) state that the most serious criticism of the C-SSRS is that “it does not cover the full spectrum of suicidal ideation” (p. 68). For example, it does not detect “the thought that you would be better off dead” which is sometimes “an immediate antecedent to impulsive suicidality” (Giddens et al., 2014, p. 70). Although the C-SSRS risk version does consider other factors, the typical version of the C-SSRS tries to identify risk based solely on aspects of suicidal ideation/plans/etc. and past suicidal thoughts/behaviors.

Currently hospitals and healthcare facilities are using the C-SSRS as a risk assessment tool in making decisions about admission and level of privileges. Given that the focus of the C-SSRS is primarily on suicidality, it is insensitive to changes in the patient's condition. Clinical decisions about level of risk, privileges, and appropriate treatment setting can be complicated in that there are high risk patients that can present without suicidal ideation or behavior, or their level of ideation and/or behavior would not reach critical thresholds identified in the C-SSRS. Thus, a complete and comprehensive suicide risk assessment will increase the likelihood that false negatives will be minimized and that the judgment of suicide risk will be the ultimate determinate for clinical decision making.

Suicide Contracts:

Suicide contracts are also commonly used, despite the fact that there are no studies demonstrating their ability to reduce suicide (Wand, 2012). A suicide contract is not a legal document,

whether or not it is signed. One problem with suicide contracts is when they are used pro forma, without the evaluation of the patient by the psychiatrist or trained clinician. Using them in emergency settings can be especially problematic. Suicide contracts can have potential utility in the context of a positive therapeutic relationship. They can be used to emphasize the availability of the clinician to the patient. Furthermore, rejection of a contract does have significance.

Risk management:

Suicide accounts for a large proportion of the malpractice lawsuits filed against mental health professionals (Roberts, Monteferrari, Yeager, 2008). The most common allegations regarding suicide are failure to properly identify the risk of suicide, failure to take appropriate precautionary measures, failure to admit voluntarily or commit involuntarily to a mental health facility, failure to prescribe appropriate medications, and failure to provide an adequate and timely follow up plan.

The essence of risk management is providing thoughtful care that is based upon a complete psychiatric examination as possible. The examination includes indicators of suicide risk that involves a judgment of the assessment of suicide risk. Requesting that the patient sign a release of information can be useful, as it will allow clinicians to consult with past providers or receive records, including prior medical and mental health records. Also, it can be useful to keep as detailed of a listing as possible of all the current medications being taken by the patient. Referral or coverage plans in place for suicidal patients during vacations or prolonged absences from the office may be indicated. Additionally, if a note in the record needs to be amended, the timing of that amendment should be indicated. Requesting consultations on difficult patients can be useful along with documenting the recommendations, if any, of the consult.

Conclusion:

Suicidal ideation and behavior warrants thorough assessment, even though most patients with suicidal ideation or behavior will not go on to complete suicide.

Psychiatric disorders are present in nearly all patients who complete suicide. Questions about recent stressors, thoughts about suicide, family history, and other factors associated with increased risk are useful inquiries in assisting the clinician in assessing suicide risk.

Although It is not possible to predict which specific patient will die by suicide, it is possible to assess and develop a plan for reducing an individual's risk of suicide. Interventions can focus on

modifiable risk factors, such as treating psychiatric disorders and symptoms, addressing psychological stressors, and strengthening social support networks. Understanding the legal issues involved in treating suicidal patients, careful suicide assessments and thorough documentation of the clinician's findings have both clinical and risk management utility.

References

American Psychiatric Association (2003). Practice Guideline for the assessment and treatment of patients with suicidal behaviors. *American Journal of Psychiatry*, 160(11): 1-117.

Brent DA, Perper JA, Allman CJ, et al. (1991). The presence and accessibility of firearms in the homes of adolescent suicides: a case-control study. *JAMA*, 266:2989-2995.

Busch KA, Fawcett J, Jacobs DG (2003). Clinical correlates of inpatient suicide. *J Clin Psychiatry*, 64(10): 14-19.

Centers for Disease Control and Prevention (CDC). Web-based injury Statistics Query and Reporting System (WISQARS) [Online]. (2013). National Center for injury Prevention and Control, CDC (producer). Available from URL www.cdc.gov/injury/wisqars.index.html.

Cavanagh JT, Carson AJ, Sharpe M, et al. (2003). Psychological autopsy studies of suicide: a systematic review. *Psychol Med*, 33:395-405.

Giddens JM, Sheehan KH, Sheehan DV (2014). The Columbia-Suicide Severity Scale (C-SSRS): Has the "gold standard" become a liability? *Innov Clin Neurosci*, 11(9-10): 66-80.

Harris L, Hawton K (2005). Suicide intent in deliberate self-harm and the risk of suicide: the predictive power of the suicide intent scale. *Journal of Affective Disorders*, 86: 225-233.

Hudenko W, Homaifar B, Wortzel H. (n.d.). The relationship between PTSD and suicide. <http://www.ptsd.va.gov/professional/co-occurring/ptsd-suicide.asp>. Accessed on November 22, 2015.

Johnson J, Wood AM, Gooding P, Taylor PJ, Tarrier N (2011). Resilience in suicidality: The buffering hypothesis. *Clinical Psychology Review*, 31: 563-591.

Kaplan MS, McFarland BH, Huguet N, Conner K, Caetano R, Giesbrecht N, Nolte KB (2013). Acute alcohol intoxication and suicide: a gender-stratified analysis of the National Violent Death Reporting System. *In J Prev*. 19(1): 38-43.

Lundman B, Strandberg G, Eisenmann M, Gustafson Y, Brulin C (2007). Psychometric properties of the Swedish version of the resilience scale. *Scan J Caring Sci*, 21: 229-237.

Luoma JB, Martin CE, Pearson JL. Contact with mental health and primary care providers before suicide: A review of the evidence. *American Journal of Psychiatry*, 159(6): 909-916.

Nock MK, Borges G, Bromet EJ, Cha CB, Kessler RC, Lee S (2008). Suicide and suicidal behavior. *Epidemiol Rev*, 30(1): 133-154.

Parks SE, Johnson LL, McDaniel DD, Gladden M. (2014). Surveillance for violent deaths- national violent death reporting system, 16 states, 2010. *MMWR*, 63(1): 1-33.

Pokorny A.D. (1983) Prediction of suicide in psychiatric patients: report of a prospective study. *Arch Gen Psychiatry*, 40:249-257.

Pokorny, A. D. (1993). Suicide prediction revisited. *Suicide and Life Threatening Behavior*, 23, 1-10.

Posner K, Brown GK, Stanley B, et al. (2011) The Columbia-Suicide Severity Rating Scale: initial validity and internal consistency findings from three multisite studies with adolescents and adults. *Am J Psychiatry*, 168: 1266-1277.

Posner K, Oquendo MA, Gould M, et al. Columbia Classification Algorithm of Suicide Assessment (C-CASA): Classification of Suicidal Events in the FDA's Pediatric Suicidal Risk Analysis of Antidepressants. *Am J Psychiatry* 2007; 164:1035-1043.

Roberts AR, Monferrari I, Yeager KR (2008). Avoiding malpractice lawsuits by following risk assessment and suicide prevention guidelines. *Disclosures Brief Treat Crisis Interv*, 8(1): 5-14.

Wilcox H, Storr CL, Breslau N (2009). Posttraumatic stress disorder and suicide attempts in a community sample of urban American young adults. *Arch Gen Psychiatry*, 66(3): 305-311.

Wand T (2012). Investigating the evidence for the effectiveness of risk assessment in mental health care. *Issues Ment Health Nurs*, 33(1): 2-7.