# Suicide Risk Assessment in Forensic and Correctional Settings: *Strategies for Improving Clinical Decision Making*

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## Disclaimer

- The presenter has no financial relationship to the content in this program.
- The views expressed in this presentation are those of the speaker and do not necessarily represent the views, policies, and positions of the American College of Forensic Psychology.

Limitations

- Suicide within correctional settings is a complex health problem that is driven by a number of biopsychosocial, psychiatric, medical, institution specific, economic, and other latent variables. This presentation is not intended as a **comprehensive training** in suicide risk assessment, rather, the focus will be on discussing strategies to improve clinical decision making when assessing individuals in forensic settings who are at risk for, or are reporting suicidal ideation, planning, or intent.

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## Bio-Sketch | Craig Wetterer

- Licensed Clinical-Forensic Psychologist in CA & NV
- Licensed Attorney in California (2007-Present)
- Clinical experience as a staff psychologist in acute care psychiatric forensic hospital settings, including a max security prison & state hospital in NV.
- Prior experience as clinical director of a licensed psychiatric crisis bed unit at CA State Prison, Sacramento, supervising an interdisciplinary treatment team of psychologists, psychiatrists & social workers.
- Performed thousands of suicide risk assessments and treated hundreds of psychiatrically hospitalized patients (2015-present)
- Trained hundreds of police officers in crisis intervention and suicide prevention across California since 2019.
- Subject matter expert in assessment of suicide risk, treatment and prevention.

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## Objectives

- Briefly review the prevalence of suicide and self-harm in correctional and forensic settings
- Discuss some of the most salient dynamic and static risk variables for suicide in forensic inpatient/custody settings
- Describe the challenges embedded within suicide risk and self-harm evaluations in forensic inpatient/custody settings – emphasizing the role of the **feigning** of suicidal ideation, intent, or plan.
- Lastly, we will review and discuss the limitations of the current suicide risk and self-harm assessment tools, and introduce a proposed suicide risk and self harm evaluation that may enhance clinical decision making in these settings by including sub-scales that assess for subtle signs of impending suicide, and for the feigning of suicidal ideation, plan or intent.

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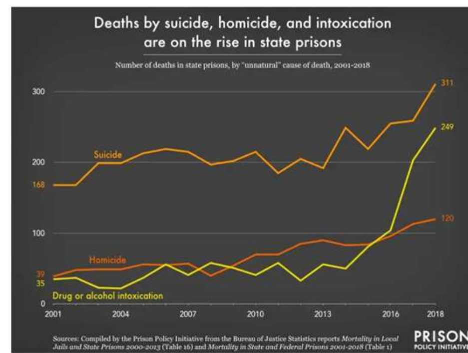
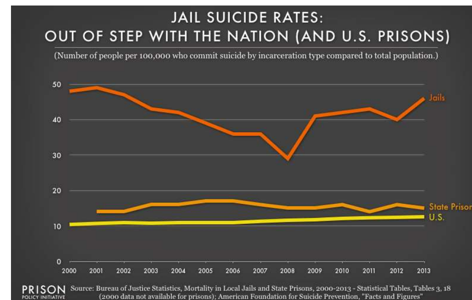
“Okay, Houston, we've had a problem here”

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## Suicide in Correctional Settings

- Suicide rates found to be 3-8 times higher than general population for males and >10 times higher for females (Fazel et al., 2017) based on a review of data from 10 different countries, including the U.S.

- The setting matters! Jail detainees are at substantially higher risk of suicide than convicted felons serving time in prison (Berman & Canning, (2021).

- Given this data, it is vitally important to develop a comprehensive risk analysis protocol to identify those patients who are at a heightened risk of suicide in these settings.

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## Static Risk Variables in Correctional Settings

- Family history of suicide
- History of serious mental illness
- Serious chronic medical conditions
- Demographic (Age > 35 | Ethnicity – Caucasian )
- Loss of status (e.g. dropout from gang, loss of job assignment)
- First term | New to prison | Life (LWOP) or long term
- Prior attempts: **two prior verified attempts = BIG WARNING**
- History of violence, substance abuse, being physically or sexually abused
- Impending parole – why would this be a chronic factor?

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## Dynamic Risk Variables | Potentially Modifiable

- Current ideation | Suicidal intent | VERIFIED recent attempt
- Hopelessness in presentation (collateral source verification)
- Current/recent depressive symptoms, anxiety symptoms, mood shifts
- Currently psychotic
- Recent VERIFIED bad news (e.g. picking up a new charge, death in family)
- Recent trauma (i.e. being physically or sexually assaulted)
- Isolating behavior, or acting out/anger – aggressive behavior
- Current/recent substance intoxication
- Housing changes (Single cell, AD-Seg Placement ) | Recent RVR
- Evidence of medication hoarding

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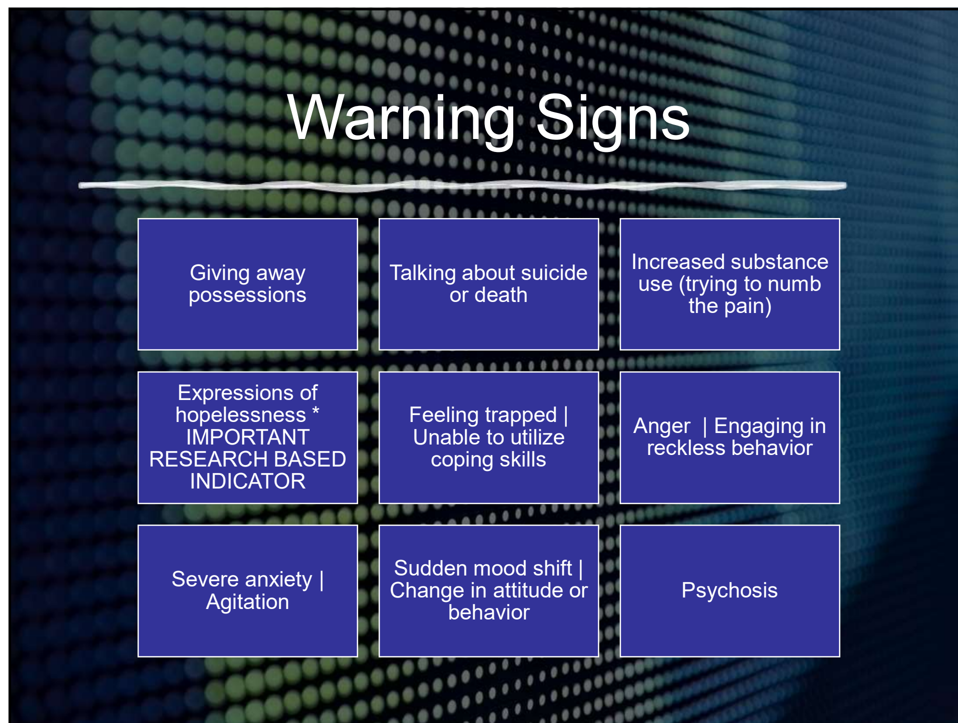


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## Assessing for Suicide Risk

Given the evidence that risk for suicide is significantly higher in correctional and forensic settings, ongoing monitoring and assessment should be incorporated into every correctional and forensic mental health program.

So, let's take a closer look at how suicide risk assessment is actually done in forensic and correctional settings. *Note. Please recognize that variation in protocols across jurisdictions is expected.

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## How is Risk for Suicide Assessed in Correctional/Forensic Settings ?

- Best practices
- Comprehensive psychiatric evaluation is the core element of the suicide assessment process (American Psychiatric Association, 2003)
- Take all reports of suicidal ideation or intent **SERIOUSLY!**
- Most correctional mental health systems have established protocols that incorporate available risk assessment tools into a comprehensive assessment of risk. These include:
  - Review of relevant medical, psychiatric, and custody records
  - Face-to face clinical interview and MSE of the inmate-patient
  - Inclusion of a validated risk assessment tool (C-SSRS???)
  - Written evaluation which includes a risk rating (low/moderate/high) and the clinical rationale for either hospitalization, or return to regular housing

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## But….What about Malingering?

- Do current suicide risk assessments in forensic settings include any formal assessment of malingering?
  - Answer: None of the forensic settings that this presenter has surveyed include any **formal** component of malingering assessment. Does the audience know of any such settings where this is the case?
- Practicality of including a validated symptom validity measure (e.g. MFAST, SIMS, SIRS-II). Probably not!
- Example: Current suicide/self-harm risk assessment within the California Department of Corrections & Rehabilitation includes the Columbia Suicide Severity Rating Scale (C-SSRS).
  - Is this assessment tool normed on forensic populations?
  - Several limitations
  - Does not include latent risk variables that are unique in correctional and forensic settings

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## How Does Malingering Assessment Fit into this Protocol?

- Some studies suggest rates of malingering may be as high as 60% for jail inmates seeking psychiatric services (McDermott, Dualan, & Scott (2013).

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**"I'm upgrading your condition from stable to malingerer."**

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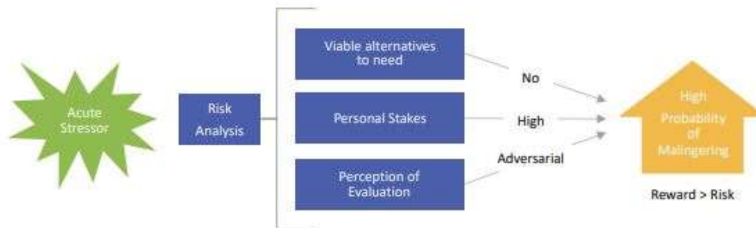
## Application of Roger's Adaptational Model of Malingering to the Suicide Risk Evaluation

### Adaptational Model of Malingering II




Rogers (1990); figure adapted from Simpson & Sharp (2017)

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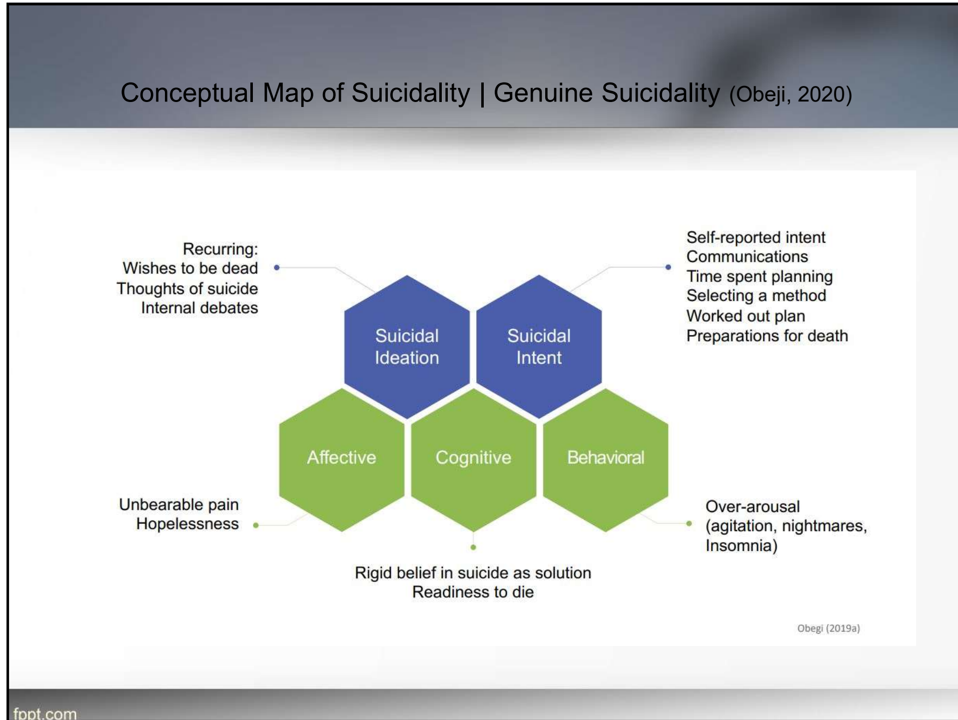


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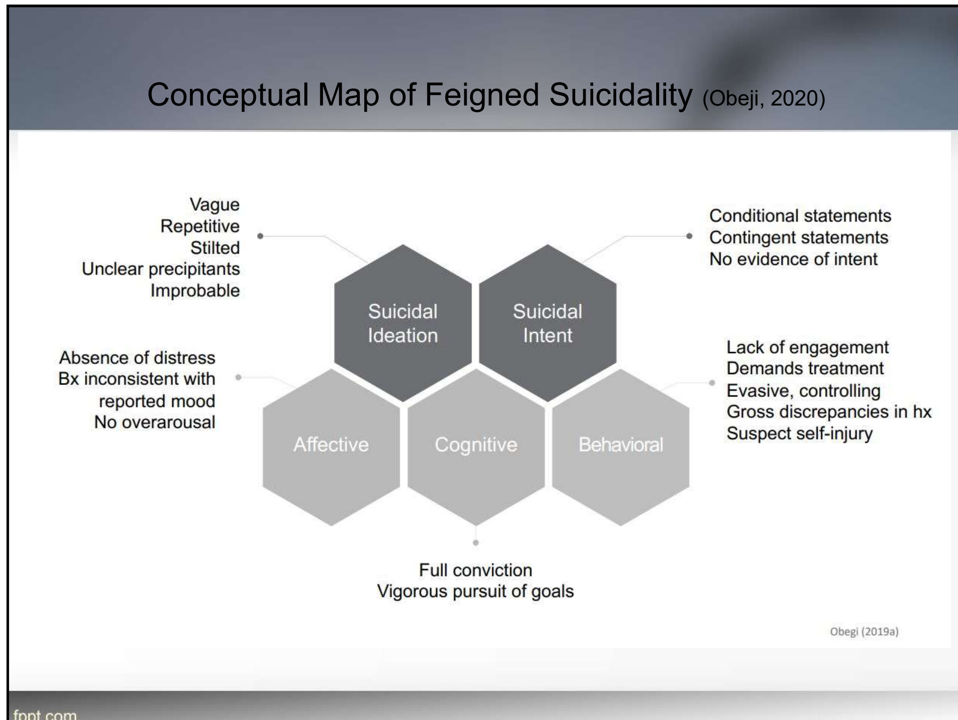


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## Current Assessment Paradigm in Many Forensic Settings: C-SSRS

- Columbia Suicide Severity Rating Scale (C-SSRS) – Used in some correctional and forensic settings
- May not be as psychometrically robust as thought (Giddens, et al., 2014)
- No evidence this scale is effective at differentiating between feigned and genuine suicidal intent
- May be adequate for use in community based populations….however…
- Does not appear to be as useful in forensic/correctional settings – Ignores Dissimulation and Subtle signs variables and secondary gain motives!

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## What About the Jail Suicide Assessment Tool (JSAT; Carlson, 2002)

- Developed for use by the Federal Bureau of Prisons
- Structured Interview Protocol covering static and dynamic risk variables tailored to correctional settings
- Does this assessment tool address malingering? – Yes; however….

- Sample Items from the JSAT:

**JSAT**
(Jail Suicide Assessment Tool)
**David K. Carlson, Psy.D. – Federal Bureau of Prisons**

+ n - **A. Important relationships:** who, last contact, support, well-being, concerns, unresolved loss
+ n - **B. Social status:** sudden change, culture shock, predator to victim, gang issues
+ n - **C. Legal status:** pre-trial, recently sentenced, 20+ year sentence, new charges, high-risk group
+ n - **D. Institutional adjustment:** current adjustment, history of disciplinary actions, perceived safety
+ n - **E. Physical health:** perception of health, medical/medication concern, life-threatening condition
+ n - **F. Physical pain:** pain, intensity, duration, ability to tolerate
+ n - **G. Chemical abuse/use:** history of substance abuse, signs of intoxication or withdrawal
+ n - **H. Psychiatric treatment:** counseling, medication, compliance, hospitalization, diagnoses
+ n - **I. Mental status:** orientation, mood, affect, thought content, agitation
+ n - **J. Depression (current signs):** severity, obvious symptoms, subtle signs
+ n - **K. Reality testing (current signs):** hallucinations, content, delusions, negative signs

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## The JSAT Malingering Item

- This is the ONLY item on the JSAT that addresses malingering in the context of a suicide risk evaluation.
- Is this sufficient?
- Can we do better?

+ n - **X. False presentation:** secondary gain, factitious features, rare symptoms, unusual clustering

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## Introduction of a Proposed Comprehensive Suicide/Self-Harm Risk Scale

Why is this needed?

Mental Health Treatment Resources are finite in correctional and forensic settings

Malingered suicidal ideation/intent significantly interferes with these finite resources, leaving less available resources for those in genuine need of help.

The proposed forensic suicide risk scale will include a subscale that TARGETS disingenuous claims of suicidal ideation/intent/plan

Empirically derived item development

Sub-scales to address Dissimulation and Malingering

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The Forensic Suicide Risk Scale (FSRS; Wetterer, 2022)
In Development – Phase I, Scale Construction

- Comprehensive, based on the current theoretical and conceptual models of suicide
- A validity sub-scale that targets feigned suicidality in the following dimensions:
  - Cognitive
  - Affective
  - Behavioral
- Improved clinical decision making
- Risk management benefits

Scale Components:

I. Static Risk Variables
II. Dynamic Risk Variables
**III. Subtle Signs/Dissimulation**
**IV. Validity Dimensions**

Proposed scoring paradigm:
Either:
Y = Present
N = Not present
O = Omit, or does not apply

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## Proposed Validity Sub-Scale Items “*Feigned Suicidal Presentation – FSP*”

- **Conditioned Statements (CS)**
  - *Patient expresses statements of self-harm predicated on the decision not to transfer or hospitalize*
- **Affect/Behavioral Incongruence (ABI)**
  - *Reported distress/suicidal intent is inconsistent with observed actions in other contexts*
- **Incongruent Psychiatric Symptoms (IPS)**
  - *Reported psychiatric symptoms (e.g. auditory hallucinations) that are rarely endorsed by genuinely mentally ill patients * Note. Based on empirical data from correctional specific settings*
- **Treatment Disengagement (TD)**
  - *Patient refuses to follow treatment recommendations, yet displays engagement in other activities (e.g. exercises, socializing with others, engaging in other goal directed activity)*
- **Uncorroborated Self-Reports (USR)**
  - *Patient reports a history of recent attempt (e.g. reports swallowing a razor blade or other dangerous object; reports overdosing on medication) and there is* ***no independent*** *medical corroboration*
  - **Note. These are proposed items currently under development.*

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# Subtle Signs (SS)

- New sub-scale targeting dissimulation
- Most prison suicides are not preceded by obvious warning signs!
- In many cases, the inmate-patient is experiencing internal distress that is not projected externally (concealment)
- Current assessment tools do not include this dimension

- Sample proposed items:
- **Thwarted Belongingness (TB)**
  - *Withdrawal from social connections, stops communication with family and friends*
- **Dissimulation (D)**
  - *Denial of SI when confronted with evidence (e.g. collateral sources)*
- **Mood/Affect Shift (MAS)**
  - *Mood/presenting affect shifting to euthymia from prior depressed mood*

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# A Parting Cautionary Statement

- Suicide is a complex phenomenon with multiple factors intersecting in a likely infinite number of combinations
- Identification of a pattern of feigned suicidality in an inmate-patient does not equate to **dismissal** of risk.
- Context matters. The use of a validity scale is intended to provide additional information to the clinician to assist in clinical decision making as to level of risk. It is never intended to be used independently as a basis to **classify** someone as low risk.

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# Questions?

- Feel free to reach out to me at:
- craig.wetterer@cnsu.edu
- or
- craig@carsonpsychological.com

- I welcome collaboration in the development of this scale. Any subject matter experts in suicide (particularly in assessment of risk in correctional/forensic settings) who are interested in working with me on the development of this scale, please reach out.

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