Predicting Suicide & Violence

An Organized Approach to Risk Assessment

David A. Frenz, M.D.
Diplomate, American Board of Preventative Medicine
Diplomate, American Board of Addiction Medicine
Diplomate, American Board of Family Medicine
Disclosures

- I’m a physician in private practice
- I work as an independent contractor
  - CentraCare Health
  - Hazelden Betty Ford
  - PreferredOne
- I was previously employed by
  - HealthEast Care System (medical director)
  - North Memorial Health Care (vice president)
Disclosures

• I’m on faculty at the University of Minnesota
  – Evidence-based medicine
• I don’t have any financial relationships with the pharmaceutical or medical device industries
• I don’t intend to discuss unapproved or investigational therapies
  – I’ll alert you if I’m “off label” should questions lead us there
Learning Objectives

1. Audience members will learn how to use validated scales and measures to assess clients for suicide and violence
2. Audience members will appreciate how population base rates impact test performance
3. Audience members will recognize that it’s much easier to rule out suicide and violence than to predict its future occurrence
Why Am I Interested in This?

• I’m the medical director for two county jails
  – Stearns County
  – Benton County
  – CentraCare Health
• Suicidal ideation, self-injury and violence are very common in these settings
  – Standardized, efficient, effective workflows are required to treat patients and protect staff and the public
Suicide Assessment
CONFIDENTIAL MEDICAL REPORT

David A. Frenz, M.D.
825 Nicollet Mall #1451
Minneapolis, MN 55402
T I 612-340-2510
F I 612-345-0360

Patient Name
Date of Birth

Patient Health History Form

Mental Health

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Please mark only one box for each row)

- Little interest or pleasure in doing things ........................................... [ ] [ ] [ ] [ ]
- Feeling down, depressed, or hopeless ........................................... [ ] [ ] [ ] [ ]
- Trouble falling or staying asleep, or sleeping too much .................... [ ] [ ] [ ] [ ]
- Feeling tired or having little energy ................................................ [ ] [ ] [ ] [ ]
- Poor appetite or overeating ............................................................ [ ] [ ] [ ] [ ]
- Feeling bad about yourself—or that you are a failure or have let yourself or your family down ........................................ [ ] [ ] [ ] [ ]
- Trouble concentrating on things, such as reading the newspaper or watching television ........................................... [ ] [ ] [ ] [ ]
- Moving or feeling so restless that other people could have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual ........................................... [ ] [ ] [ ] [ ]
- Thoughts that you would be better off dead or of hurting yourself in some way ........................................... [ ] [ ] [ ] [ ]
- Feeling nervous, anxious or on edge ........................................... [ ] [ ] [ ] [ ]
- Not being able to stop or control worrying ........................................... [ ] [ ] [ ] [ ]

A = Not at all B = Several days C = More than half the days D = Nearly every day

Score: 13

More... St...
Risk Factors for Suicidal Thoughts and Behaviors: A Meta-Analysis of 50 Years of Research

Joseph C. Franklin and Jessica D. Sobhsko
Vanderbilt University and Harvard University

Katherine M. Fox
Harvard University

Kate H. Bemley
Brown University

Xinyang Huang and Katherine M. Muscarella
Vanderbilt University

Bernard P. Chong
Columbia University Medical Center

Suicidal thoughts and behaviors (STBs) are major public health problems that have been a focus of research for several decades. One of the main points of controversy in the prevention and treatment of STBs is the relationship between familial risk factors and the likelihood of suicide. To provide a summary of current knowledge about risk factors, we conducted a meta-analysis of studies that have attempted to longitudinally predict a specific 13-year suicide outcome. This included 36 studies (1,055 total risk factor sets) from the past 30 years. The present meta-analysis demonstrated several consistent findings across studies, based on family history, and diagnostic accuracy analyses. Predictors were only slightly better than chance for all outcomes, with a broad category of studies considered to show limited evidence of predicative ability. The average study was nearly 10 years old, and there were some methodological differences among the studies included. The results of the meta-analysis highlight the need for more effective interventions to reduce suicide risk. In particular, these findings suggest that risk factors may be better measured using machine learning-based algorithms.

Keywords: meta-analysis, prediction, risk factors, suicidal behavior, suicide

This article was published Online First November 14, 2019. Joseph C. Franklin and Jessica D. Sobhsko, Department of Psychology, Vanderbilt University and Department of Psychology, Harvard University, Kathleen M. Fox, Department of Psychology, Harvard University, Kate H. Bemley, Department of Psychology, Brown University, Xinyang Huang, Department of Psychology, Vanderbilt University, and Katherine M. Muscarella, Department of Psychology, Vanderbilt University. Adam C. Jaccard, Department of Psychology, Harvard University, and Bernard P. Chong, Department of Emergency Medicine, Columbia University Medical Center, and Matthew E. Nock, Department of Psychology, Harvard University.

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“Our analyses showed that science could only predict future suicidal thoughts and behaviors about as well as random guessing.

“...In other words, a suicide expert who conducted an in-depth assessment of risk factors would predict a patient’s future suicidal thoughts and behaviors with the same degree of accuracy as someone with no knowledge of the patient who predicted based on a coin flip.”
General Approach to Testing

• Highly sensitive test
  – followed by
• Highly specific test(s)
  – for positive cases
Specific Approach to Testing

- Columbia–Suicide Severity Rating Scale (C–SSRS)
  - followed by
- Suicidal Affect-Behavior-Cognition Scale (SABCS); and
- Suicide Probability Scale (SPS); and
- Secondary Suicide Questions (SSQ)
  - for positive cases
# Columbia Suicide Severity Rating Scale

**Screen with Triage Points for Primary Care**

<table>
<thead>
<tr>
<th>Ask questions that are in bold and underlined.</th>
<th>Past month</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ask Questions 1 and 2</strong></td>
<td></td>
</tr>
<tr>
<td>1) <em>Have you wished you were dead or wished you could go to sleep and not wake up?</em></td>
<td>[ ] YES [ ] NO</td>
</tr>
<tr>
<td>2) <em>Have you had any actual thoughts of killing yourself?</em></td>
<td>[ ] YES [ ] NO</td>
</tr>
</tbody>
</table>

If **YES to 2**, ask questions 3, 4, 5, and 6. If **NO to 2**, go directly to question 6.

| 3) *Have you been thinking about how you might do this?*  
  e.g. "I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it...and I would never go through with it." | [ ] YES [ ] NO |
| 4) *Have you had these thoughts and had some intention of acting on them?*  
  as opposed to "I have the thoughts but I definitely will not do anything about them." | [ ] YES [ ] NO |
| 5) *Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?* | [ ] YES [ ] NO |
| 6) *Have you ever done anything, started to do anything, or prepared to do anything to end your life?*  
  Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. | [ ] YES [ ] NO |

If **YES**, ask: *Was this within the past 3 months?*

### Response Protocol to C-SSRS Screening

- Item 1: Behavioral Health Referral
- Item 2: Behavioral Health Referral
- Item 3: Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
- Item 4: Behavioral Health Consultation and Patient Safety Precautions
- Item 5: Behavioral Health Consultation and Patient Safety Precautions
- Item 6: Behavioral Health Consultation, Psychiatric Nurse/Social Worker, and consider Patient Safety Precautions
- Item 6: 3 months ago or less: Behavioral Health Consultation and Patient Safety Precautions
Strengths

• Theoretically sound
• Brief
• Triaging rubric
• Multiple versions for various administration settings
• In the public domain
Original Research

Prediction of Suicidal Behavior in Clinical Research by Lifetime Suicidal Ideation and Behavior Ascertained by the Electronic Columbia-Suicide Severity Rating Scale

James E. Mudd, PhD; John H. Greist, MD; James W. Jefferson, MD; Michael Fedorski, MS(c); John Morrin, MD; and Kelly Poenier, PhD

ABSTRACT

Objectives: To evaluate whether lifetime suicidal ideation with intent to act and/or suicidal behaviors reported at baseline predict risk of prospectively reporting suicidal behavior during subsequent study participation.

Methods: Data from studies using the electronic Columbia-Suicide Severity Rating Scale (e-CS-RS) to prospectively monitor suicidal ideation and behavior between September 2009 and June 2011 were analyzed. Studies included patients with major depressive disorder, delusional disorder, posttraumatic stress disorder, schizophrenia, bipolar disorder, and drug dependence. Dorsay et al's (2014) ASCO assessments were excluded, reemphasizing assessments and acute state records from patients who were not enrolled in the studies. Baseline assessment or enrollee's prospective follow-up assessments were included. Baseline lifetime e-CS-RS in-study reports were available for 144 participants (76.7% with lifetime ideation with intent to act, 73.0% with prior suicidal behavior or positive lifetime ideation with intent to act, 75.0% with prior suicidal behavior or suicide ideation with intent to act but not behavior, or both lifetime ideation with intent and prior behavior).

Results: 6/11 patients completed a baseline and 1 or more follow-up assessments. The mean follow-up period was 16.8y. Of patients with negative lifetime reports, 9.8% subsequently reported suicidal behavior during study participation; compared to 13.4% of patients with lifetime ideation with intent only (CIDI-CR-1/72, 936/96, 1/51-1/59, 9.9% of patients with lifetime ideation or CR-413, 936/96, 1/34-1/59, and 1.3% of patients with both CR-413, 936/96, 1/34-1/59, 9.9% of patients with lifetime ideation or CR-413, 936/96, 1/34-1/59). Sensitivity and specificity of positive reports for identifying suicidal behaviors were 16.7% and 96.8%, respectively.

Conclusions: Patients reporting lifetime suicidal ideation with intent to act and/or prior suicidal behavior at baseline are 4.87-10.85 times more likely to prospectively report suicidal behavior during study participation.

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The above is an abstract of the Original Research article Prediction of Suicidal Behavior in Clinical Research by Lifetime Suicidal Ideation and Behavior Ascertained by the Electronic Columbia-Suicide Severity Rating Scale. The full article is available for purchase from the publisher. The article has been peer-reviewed by the J Clin Psychiatry editorial board and is classified as an Original Research article. The article discusses the prediction of suicidal behavior in clinical research using the Electronic Columbia-Suicide Severity Rating Scale (e-CS-RS) and the potential for such research to improve the understanding and prevention of suicidal behavior.
## C–SSRS Psychometrics

<table>
<thead>
<tr>
<th></th>
<th>N = 3,776</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline assessments</td>
<td></td>
</tr>
<tr>
<td>Major depressive disorder</td>
<td>N = 3,440 (91%)</td>
</tr>
<tr>
<td>Positive cases</td>
<td>N = 984 (26%)</td>
</tr>
<tr>
<td>Follow-up assessments</td>
<td>N = 18,513</td>
</tr>
<tr>
<td>Positive cases</td>
<td>N = 414 (2.2%)</td>
</tr>
<tr>
<td>Positive baseline = future behavior</td>
<td>Sn = 0.67; Sp = 0.76</td>
</tr>
</tbody>
</table>

*J Clin Psychiatry 2013;74:887*
### C–SSRS Predictive Power

<table>
<thead>
<tr>
<th>Base Rate</th>
<th>NPP</th>
<th>PPP</th>
</tr>
</thead>
<tbody>
<tr>
<td>1%</td>
<td>0.996</td>
<td>0.027</td>
</tr>
<tr>
<td>5%</td>
<td>0.978</td>
<td>0.128</td>
</tr>
<tr>
<td>10%</td>
<td>0.954</td>
<td>0.237</td>
</tr>
<tr>
<td>20%</td>
<td>0.902</td>
<td>0.326</td>
</tr>
<tr>
<td>30%</td>
<td>0.843</td>
<td>0.545</td>
</tr>
</tbody>
</table>

Assessment 2009;16:215  | NNP = negative predictive power (value); PPP = positive predictive power (value)
C–SSRS Bottomline

• It’s much easier to rule out suicidal behavior than predict its future occurrence
• In my opinion, there are better instruments for short-term trending
  – Example: Daily assessment
The ABC’s of Suicide Risk Assessment: Applying a Tripartite Approach to Individual Evaluations

Keith M. Harris,*, Y. Jue Syu, Owen D. Lello, Y. L. Bieron Chew, Christopher H. Willke,†, Roger M. He,‡

1 School of Psychology, University of Queensland, St Lucia, QLD, Australia; 2 School of Public Health, University of Queensland, Herston, QLD, Australia; 3 School of Psychology, University of Newcastle, Newcastle, NSW, Australia; 4 Learning and Development Department, Bonita, Singapore, Singapore; 5 Hunter New England Mental Health, Newcastle, NSW, Australia; 6 Departmental Psychological Medicine, National University of Singapore, Singapore, Singapore

* bj.harris@uq.edu.au

Abstract

There is considerable need for accurate suicide risk assessment for clinical, screening, and research purposes. This study applied the tripartite affect-behavior-cognition theory, the suicidal behavior model, classical test theory, and item response theory (IRT), to develop a brief semi-structured measure of suicide risk that is theoretically-grounded, reliable and valid. An initial survey (n = 350) employed an iterative process to an item pool, resulting in the 19-item Suicide Affect-Beck Behavior-Cognition Scale (SABC-S). Three additional studies tested the SABC-S and a highly endorsed comparison measure. Studies included two online surveys (N = 1,017 and 710), and one prospective clinical survey (n = 72; Time 1, n = 44; Time 2, n = 64). Factor analyses demonstrated SABC-S construct validity through unidimensionality. Internal reliability was high (α = .90-93, split half = .90-94). The scale was predictive of future suicidal behaviors and suicidality (β = .68, 73, respectively), showed convergent validity, and the SABC-S demonstrated clinically relevant sensitivity to change. IRT analyses revealed the SABC-S captured more information than the comparison measure, and better defined participants at low, moderate, and high risk. The SABC-S is the first suicide risk measure to demonstrate equivalent item functioning by sex, age, or minority. In all comparisons, the SABC-S showed incremental improvements over a highly endorsed scale through stronger predictive ability, reliability, and other properties. The SABC-S is in the public domain, with this publication, and is suitable for clinical evaluations, public screening, and research.

Introduction

Suicide continues to be a leading cause of death, touching the lives of people from every corner of the globe, and ranks as the 16th leading cause of death. Despite the seriousness and universality of this problem, instruments that evaluate and predict suicidality have not received
Strengths

- Theoretically sound
- Brief
- Quantitative
- Scoring rubric ("barometer")
- Can trend numbers
  - Serial administration
- In the public domain
The suicidal affect-behavior-cognition scale

Give your patient the following instructions and questions, then total up their points using the associated scoring key. (Documents given to patients should not contain the scoring key.)

We would like to ask you some personal questions related to killing oneself. Please indicate the response that best applies to you by marking only one square.

1. Have you ever thought about or attempted to kill yourself?
   - Never
   - It was just a brief passing thought
   - I have had a plan at least once to kill myself but did not try to do it
   - I have attempted to kill myself, but did not want to die
   - I have had a plan at least once to kill myself and really wanted to die
   - I have attempted to kill myself, and really wanted to die

   Scoring key
   - 0
   - 1
   - 2
   - 3
   - 4
   - 5

2. How often have you thought about killing yourself in the past year?
   - Never
   - Scoring key
   - 0
   - 1
   - 2
   - 3
   - 4
   - 5

3. In the past year, have you had an internal debate/argument (in your head) about whether to live or die?
   - Never
   - Scoring key
   - 0
   - 1
   - 2
   - 3
   - 4
   - 5

4. Right now, how much do you wish to live?
   - Not at all
   - Scoring key
   - 0
   - 1
   - 2
   - 3
   - 4
   - 5

5. Right now, how much do you wish to die?
   - Not at all
   - Scoring key
   - 0
   - 1
   - 2
   - 3
   - 4
   - 5

6. How likely is it that you will attempt suicide someday?
   - Not at all
   - Scoring key
   - 0
   - 1
   - 2
   - 3
   - 4
   - 5
**High-Suicidal**
Very low WTL, very high WTD, high prediction of future suicide attempts, attempts with intent to die, frequent life/death debates.

**Moderate-Suicidal**
High WTD, low WTL, high prediction of future attempts, plans and attempts with intent to die, frequent life/death debates, very frequent suicidal thoughts.

**Low-Suicidal**
Moderate suicidal thoughts, low prediction of future attempts, infrequent life/death debate, moderately high WTL, very low WTD.

**Nonsuicidal**
No internal life/death debate, no thoughts of suicide, prediction of no future suicide attempts.

*Fig. 2. The suicidal barometer model with descriptions of suicidality levels based on item response theory analyses. WTL = wish to live, WTD = wish to die.*

doi:10.1371/journal.pone.0127442.g002
Suicide Probability Scale (SPS®)
Manual
John G. Cull, Ph.D. and Wayne S. Gill, Ph.D.

Western Psychological Services
Suicide Probability Scale

- 36-item psychological test
- Obvious (face valid) questions
  - Item 32: I think of suicide
- Subtle questions
  - Item 10: I feel people appreciate the real me
- Likert-type response options (n = 4)
  - None or a little of the time
  - Most or all of the time
Suicide Probability Scale

- Complex scoring
  - Weighted, non-linear item loading
  - Reverse scoring
  - Final estimate depends on base rate (presumptive risk)
“[T]he Probability Score does not refer to the probability that a particular individual will make a lethal suicide attempt.

Instead, it refers to the statistical likelihood that an individual belongs in the population of lethal suicide attempters.”
Scoring Procedure

- Calculate raw score
- Transform into T-score
- Transform into Probability score
  - Per base rate (presumptive risk)
- Make final classification
Probability Score

For three different base rates
## Classification

<table>
<thead>
<tr>
<th>Probability</th>
<th>Classification</th>
</tr>
</thead>
<tbody>
<tr>
<td>75–100</td>
<td>Severe</td>
</tr>
<tr>
<td>50–74</td>
<td>Moderate</td>
</tr>
<tr>
<td>25–49</td>
<td>Mild</td>
</tr>
<tr>
<td>0–24</td>
<td>Subclinical</td>
</tr>
</tbody>
</table>

Test manual, p. 15
Secondary Suicide Questions

1. Do you **intend** to kill or hurt yourself?
2. Do you have a **plan** for how you might kill or harm yourself?
   – If yes, delineate
3. Would you reach out for help (**seek safety**) if you had strong thoughts or urges to kill or harm yourself?
   – If yes, delineate

David A. Frenz, M.D.
# Response Sets

<table>
<thead>
<tr>
<th>Q1: No</th>
<th>Q1: No</th>
<th>Q1: Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q2: No</td>
<td>Q2: No</td>
<td>Q2: Moot</td>
</tr>
<tr>
<td>Q3: Yes</td>
<td>Q3: No</td>
<td>Q3: Moot</td>
</tr>
<tr>
<td>Reassuring</td>
<td>Worrisome</td>
<td>Emergency</td>
</tr>
</tbody>
</table>

David A. Frenz, M.D.
Case Example

- Psychotherapy client
- Major depressive disorder
- Endorsed suicidal ideation on C–SSRS
<table>
<thead>
<tr>
<th>Ask questions that are in bold and underlined.</th>
<th>Past month</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Have you wished you were dead or wished you could go to sleep and not wake up?</td>
<td>YES NO</td>
</tr>
<tr>
<td>2) Have you had any actual thoughts of killing yourself?</td>
<td>X</td>
</tr>
<tr>
<td>If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.</td>
<td></td>
</tr>
<tr>
<td>3) Have you been thinking about how you might do this?</td>
<td>X</td>
</tr>
<tr>
<td>e.g. &quot;I thought about taking an overdose but I never made a specific plan as to when or how I would actually do it... and I would never go through with it.&quot;</td>
<td></td>
</tr>
<tr>
<td>4) Have you had these thoughts and had some intention of acting on them?</td>
<td>X</td>
</tr>
<tr>
<td>as opposed to &quot;I have the thoughts but I definitely will not do anything about them.&quot;</td>
<td></td>
</tr>
<tr>
<td>5) Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</td>
<td>X</td>
</tr>
<tr>
<td>6) Have you ever done anything, started to do anything, or prepared to do anything to end your life?</td>
<td>Lifetime</td>
</tr>
<tr>
<td>Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.</td>
<td></td>
</tr>
<tr>
<td>If YES, ask: Was this within the past 3 months?</td>
<td>Past 3 Months</td>
</tr>
</tbody>
</table>

**Response Protocol to C-SSRS Screening**

- Item 1: Behavioral Health History
- Item 2: Physical Health History
- Item 3: History of Suicide Attempts
- Item 4: History of Suicide Attempts
- Item 5: History of Suicide Attempts
- Item 6: History of Suicide Attempts
- Item 7: History of Suicide Attempts
- Item 8: History of Suicide Attempts
- Item 9: History of Suicide Attempts
- Item 10: History of Suicide Attempts

Example created by DAF; does not contain PHI
CONFIDENTIAL MEDICAL REPORT

Stearns County Jail
107 Courthouse Square
St. Cloud, MN 56303
T: 320-269-3767
F: 320-266-6117

Inmate's Name
DOB
MRN

Example
In the past year, how often have you felt that you would be better off dead?
Never 0 0 0 0 0 0 Very Often

1. Have you ever thought about or attempted to kill yourself?
   Never:
   ○ 0 0 0 0 0 0 0
   ● 0 0 0 0 0 0 0 It was just a brief passing thought
   ○ 0 0 0 0 0 0 0 I have had a plan at least once to kill myself but did not try to do it
   ○ 0 0 0 0 0 0 0 I have attempted to kill myself, but did not want to die
   ○ 0 0 0 0 0 0 0 I have had a plan at least once to kill myself and really wanted to die
   ○ 0 0 0 0 0 0 0 I have attempted to kill myself and really wanted to die

2. How often have you thought about killing yourself in the past year?
   Never 0 0 0 0 0 0 0 Very Often

3. In the past year, have you had an internal dialogue/argument (in your head) about whether to live or die?
   Never 0 0 0 0 0 0 0 Frequently

4. Right now, how much do you wish to live?
   Not at All 0 0 0 0 0 0 0 Very Much

5. Right now, how much do you wish to die?
   Not at All 0 0 0 0 0 0 0 Very Much

6. How likely is it that you will attempt suicide someday?
   Not at All 0 0 0 0 0 0 0 Very Likely

Your Signature: 
Today's Date: 

Publ Opt 2015;10(6):e0127442

Version: 03/06/2018

Example created by DAF; does not contain PHI
Example created by DAF; does not contain PHI
CONFIDENTIAL MEDICAL REPORT

Secondary Suicide Questions

We would like to ask you some personal questions related to killing oneself. Please indicate the response that best applies to you by marking one choice.

1. Do you intend to harm or kill yourself here in jail?
   - No
   - Yes

2. Do you have a plan for how you might harm or kill yourself here in jail?
   - No
   - Yes
   (Please fill out the box below before answering Question 3)

   If you answered YES, please describe how you would try to harm or kill yourself here in jail.

   [Signature]

3. Would you reach out for help if you had strong thoughts or urges to harm or kill yourself here in jail?
   - No
   - Yes
   (Please fill out the box below)

   If you answered YES, please describe how you would reach out for help here in jail.

   Tell Someone

Your Signature: ___________________________ Today's Date: ___________________________

David A. Frenz, M.D. (author/owner) Version: 03/05/2018
Patient is not actively suicidal and multiple indicators suggest that he/she is at low risk for suicide

Ensure that a safety plan exists

Repeat SABCS and SSQ at next session
Violence Assessment
The Broset Violence Checklist (BVC) assesses confusion, irritability, bizarreness, verbalisha, physical signs, and attacks on objects as either present or absent. It is hypothesized that an individual displaying two or more of these behaviors is more likely to be violent in the next 24-hour period. All 109 consecutive referrals to four psychiatric inpatient acute units during a 2-month period were included in the study. Ratings were performed by at the time of admission and were made by each patient—once for each working day. Inturater reliability was adequate. Thirty-four separate incidences of violence occurred. Comparisons between ratings performed in the 24-hour interval before the incident and all other ratings suggested moderate sensitivity and poor specificity of the instrument. It is concluded that the BVC is a useful instrument in predicting violence within the next 24-hour period and that the psychometric properties of the instrument are satisfactory.

The Broset Violence Checklist

Sensitivity, Specificity, and Interrater Reliability

ROGER ALMVIK
Norwegian University of Science & Technology

PHIL WOODS
University of Manchester

KIRSTEN RASMUSSEN
Norwegian University of Science & Technology

Management of violent behavior among psychiatric patients constitutes a major challenge in psychiatric hospital units because it destroys the therapeutic climate, upsets fellow patients, demoralizes staff, and sometimes results in fatal damage. The need for predictive methods of identification of violent individuals to the part of those who may be subjected to the violence is reflected in the growing number of prediction studies over the past few decades. Violence is common in mainstream psychiatric settings, that is, acute and short-term wards, with injuries, stress, anxiety, and even psychotic illness being reported as the result of exposure to violent inpatients (Berg, Olsen, Sveipe, & Hey, 1994). Benjamin and Kjærbo (1997) found that more than 90% of doctors and nurses working in psychiatric hospitals have been subjected to violence from patients at some time during their career. Furthermore, it has also been reported that violent behavior among
**The Brøset Violence Checklist**

The patient is assessed for either the presence or absence of each item. One point is awarded when the definition is met and zero points are awarded when the definition is not met. The points for all of the items are then summed, with total scores ranging from 0 to 6. If a behavior is normal for a patient, the definition is met only if there is a change from baseline (e.g., patient with dementia, more confused than usual).

<table>
<thead>
<tr>
<th>Item</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confused</td>
<td>Appears obviously confused and disoriented. May be unaware of time, place or person.</td>
</tr>
<tr>
<td>Irritable</td>
<td>Easily annoyed or angered. Unable to tolerate the presence of others.</td>
</tr>
<tr>
<td>Boisterous</td>
<td>Behavior is overtly “loud” or noisy. For example, slams doors, shouts out when talking, etc.</td>
</tr>
<tr>
<td>Physically Threatening</td>
<td>Definite intent to physically threaten another person. For example, the taking of an aggressive stance; the grabbing of another person’s clothing; the raising of an arm, leg, making of a fist or modelling of a head-butt directed at another.</td>
</tr>
<tr>
<td>Verbally Threatening</td>
<td>Verbal outburst which is more than just a raised voice and where there is a definite intent to intimidate or threaten another person. For example, verbal attacks, abuse, name-calling, verbally neutral comments uttered in a snarling aggressive manner.</td>
</tr>
<tr>
<td>Attacking Objects</td>
<td>Attack directed at an object and not an individual. For example, the indiscriminate throwing of an object; banging or smashing windows; kicking, banging or head-butting an object; or the smashing of furniture.</td>
</tr>
</tbody>
</table>

**Source:** Roger Almvik (reprinted with his permission). The BVC is available at www.riskassessment.no and www.frenz.md.
# Classification

<table>
<thead>
<tr>
<th>Score</th>
<th>Classification</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Small</td>
</tr>
<tr>
<td>1–2</td>
<td>Moderate</td>
</tr>
<tr>
<td>&gt; 2</td>
<td>Very high</td>
</tr>
</tbody>
</table>

**Psychometrics**

\[ Sn = 0.50; Sp = 0.97 \]
### BVC Predictive Power

<table>
<thead>
<tr>
<th>Base Rate</th>
<th>NPP</th>
<th>PPP</th>
</tr>
</thead>
<tbody>
<tr>
<td>1%</td>
<td>0.995</td>
<td>0.144</td>
</tr>
<tr>
<td>5%</td>
<td>0.974</td>
<td>0.467</td>
</tr>
<tr>
<td>10%</td>
<td>0.946</td>
<td>0.649</td>
</tr>
<tr>
<td>20%</td>
<td>0.886</td>
<td>0.806</td>
</tr>
<tr>
<td>30%</td>
<td>0.819</td>
<td>0.877</td>
</tr>
</tbody>
</table>

Assessment 2009;16:215  |  NNP = negative predictive power (value); PPP = positive predictive power (value)
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