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ASARI:

Assessment of Suicide and Risk Inventory

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Clinical Assistant Professor, UBC Department of Psychiatry

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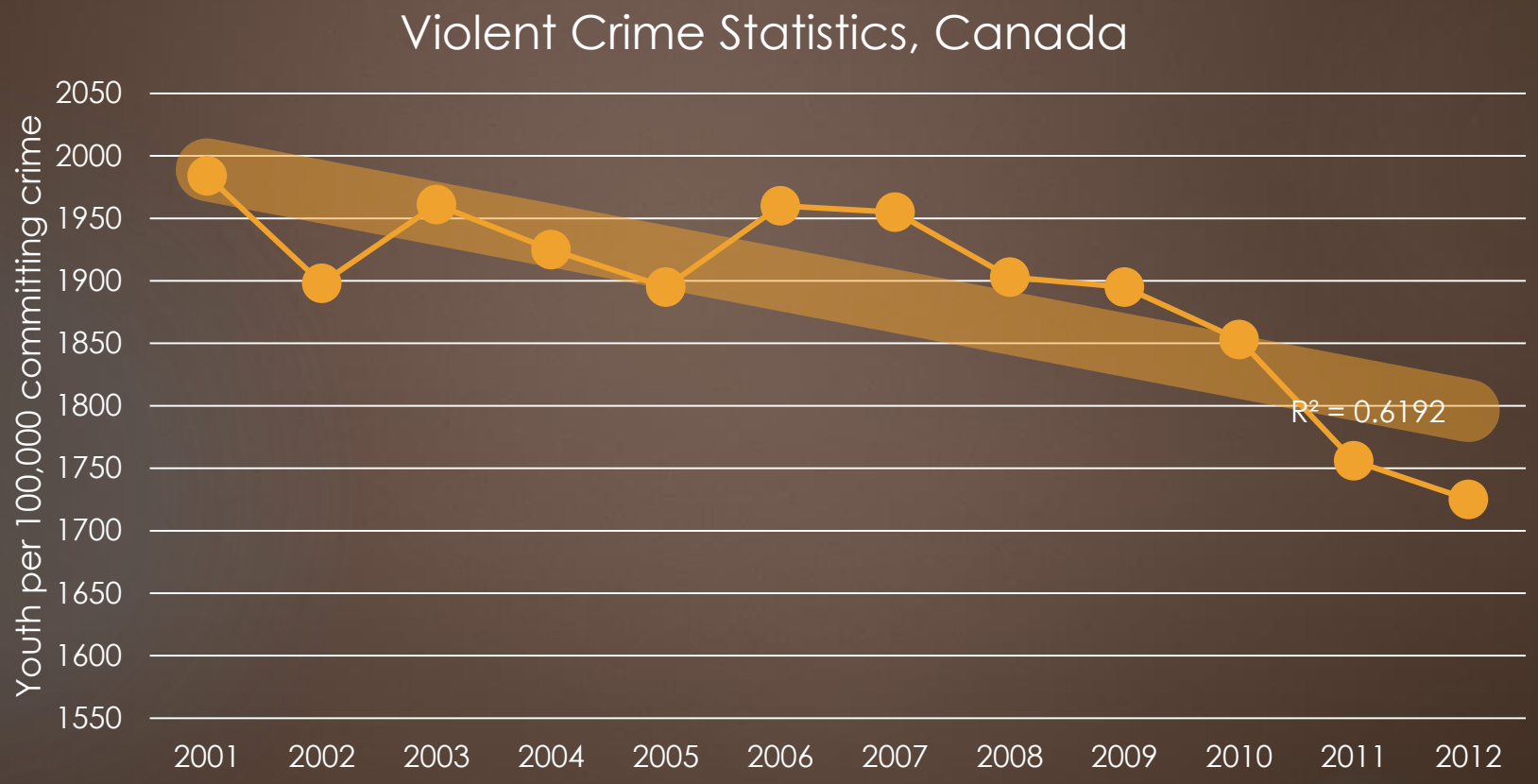
MY SOAPBOX

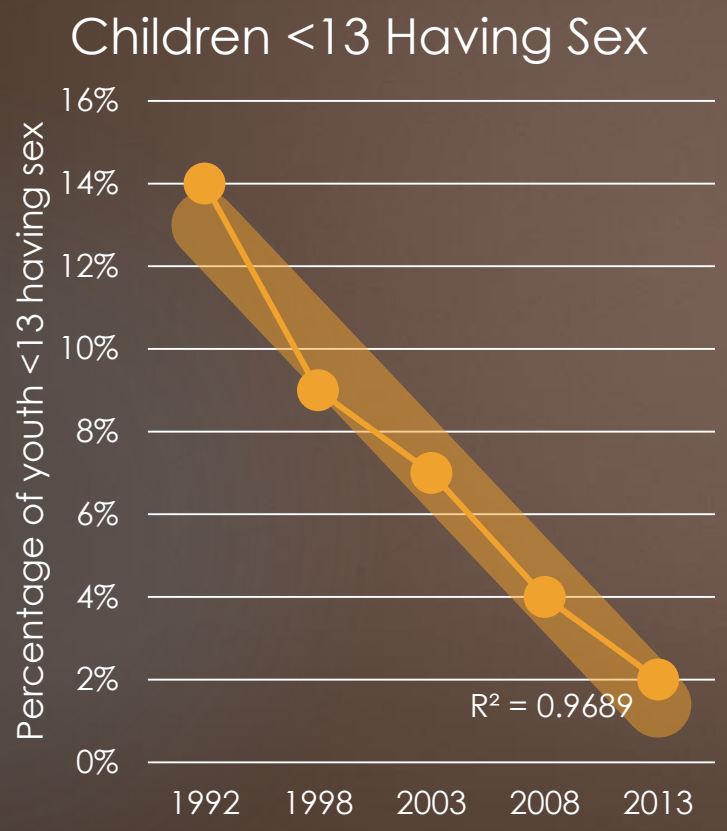
"KIDS TODAY…"

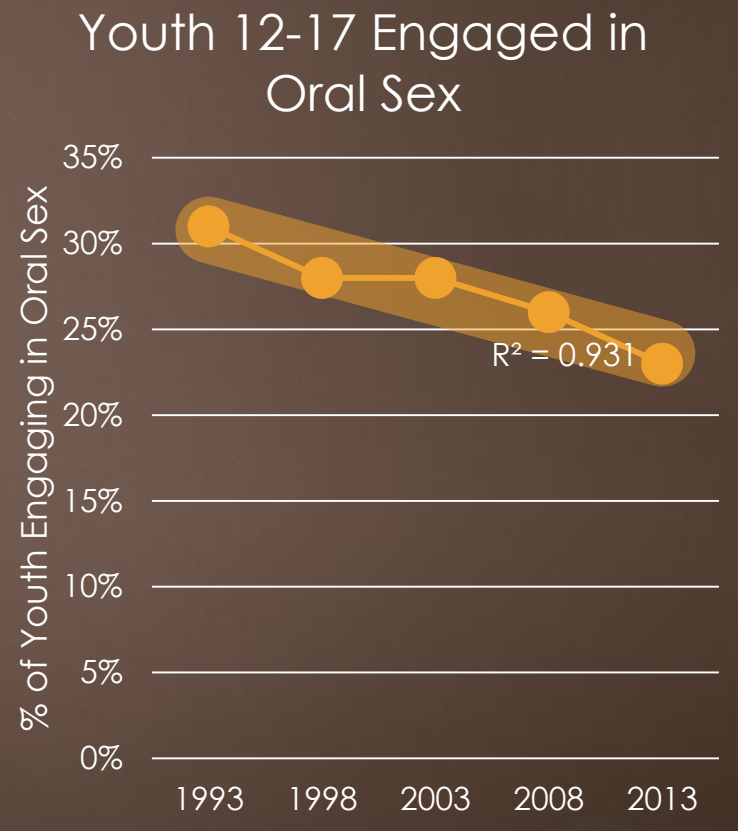
… are less violent



Source: Statistics Canada, Canadian Centre for Justice Statistics, Uniform Crime Reporting Survey.

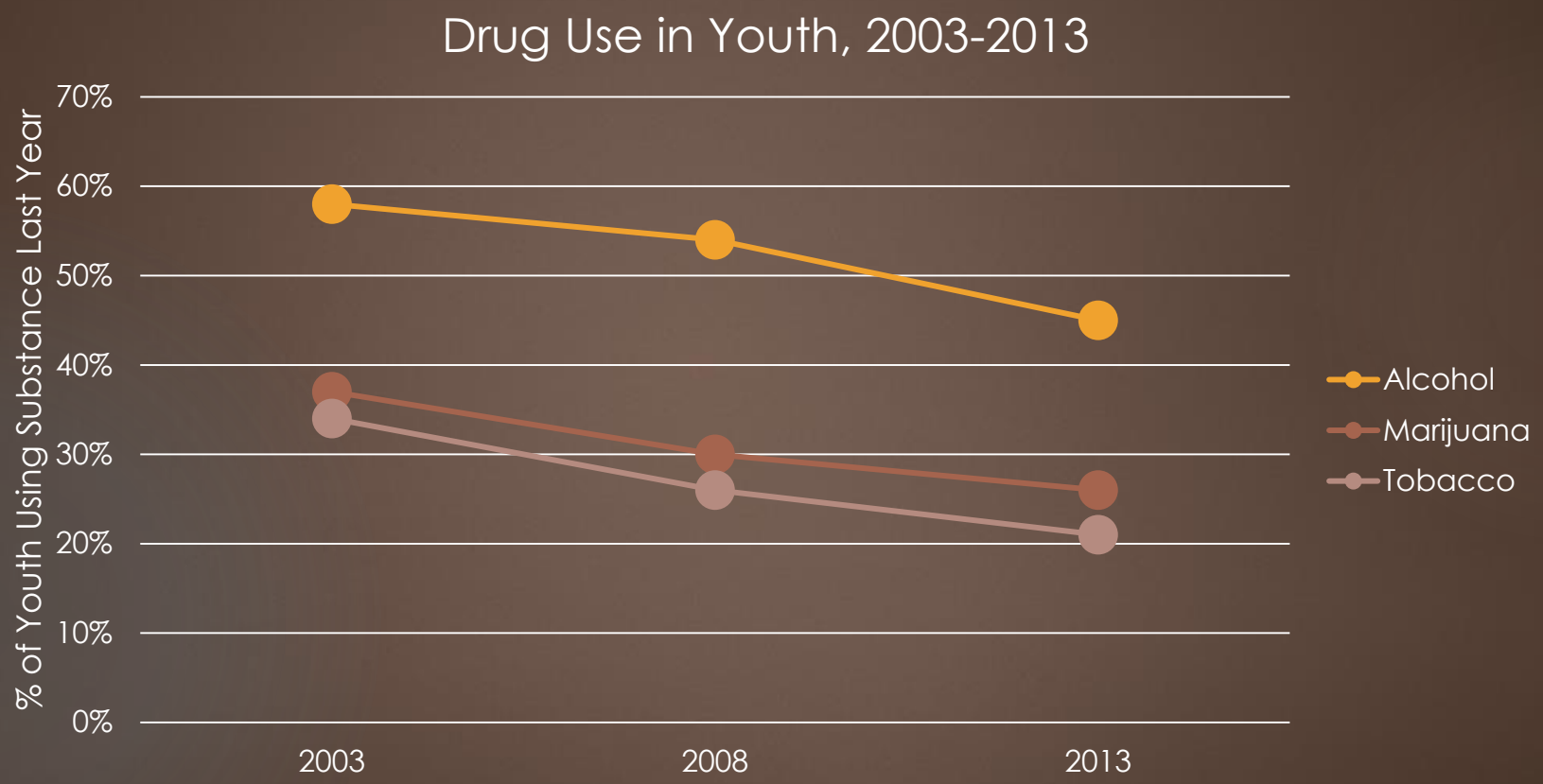
… are less SEXUAL





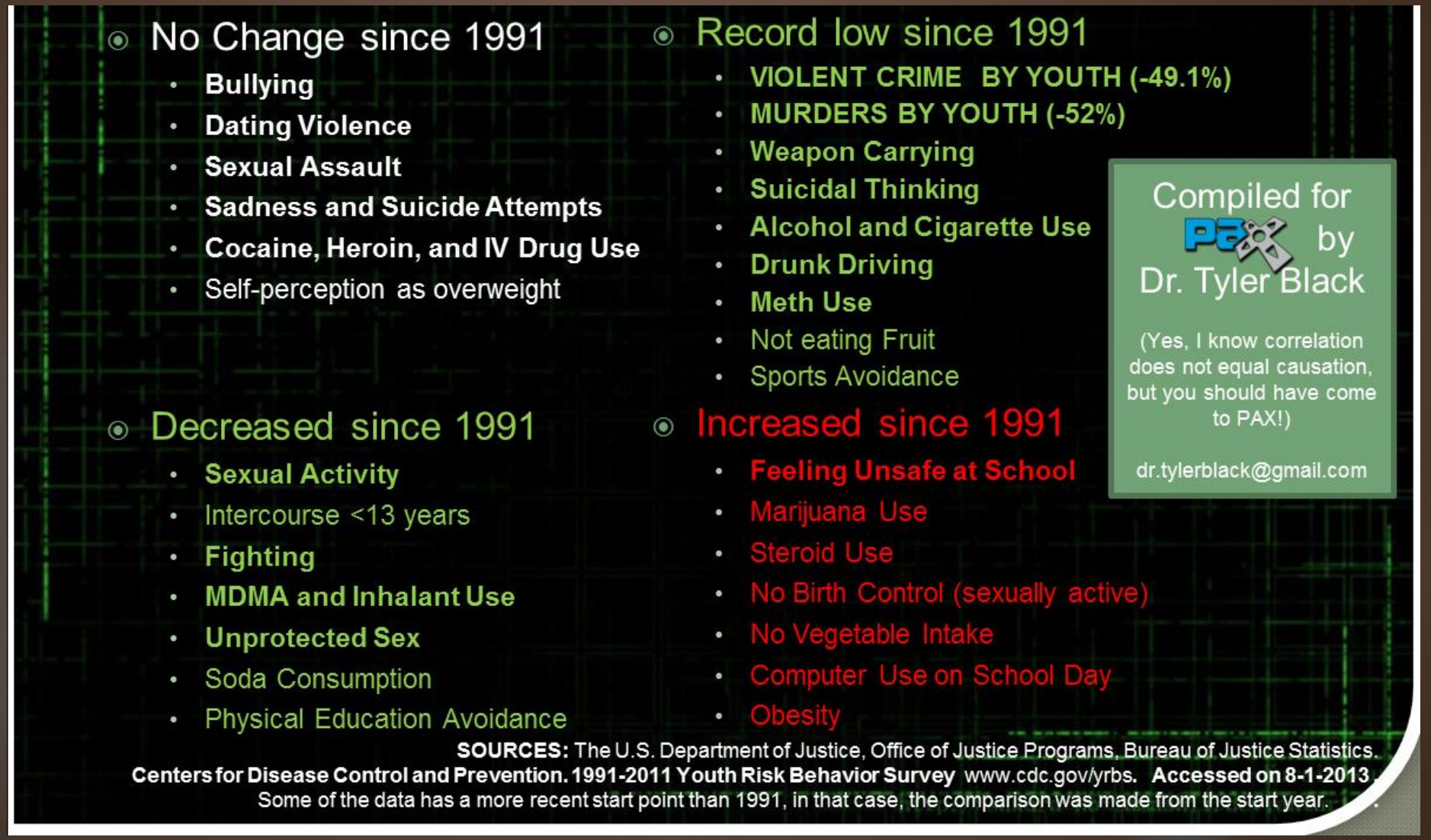
Source: McCreary Centre Adolescent Health Survey, 2003-2013 (prior to 2003 based upon two other Canadian Surveys - Rotermann, M. (2008). Trends in teen sexual behaviour and condom use. Health Reports, 19, (3), 1-5. and Saewyc, Taylor, Homma & Ogilvie. (2008). Trends in sexual health and risk behaviours among adolescent students in British Columbia. *The Canadian Journal of Human Sexuality*, 17 (1/2), 1-14.)

… USE LESS DRUGS



Source: Statistics Canada, Canadian Centre for Justice Statistics, Uniform Crime Reporting Survey.

… are better than we were



Learning Objectives

At the end of the presentation, the learner should be able to:

1) differentiate between perceived myths and the reality of suicide epidemiology
2) understand the motivations for suicide
3) understand the need for major systemic change in suicide risk assessment
4) have confidence in screening for suicidal thoughts or behaviours in children and adolescents.
5) approach suicide risk assessment with organization.
6) clearly and effectively document suicide risk.

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Suicide Risk Assessment

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Epidemiology

SUICIDE IN CHILDREN AND ADOLESCENTS

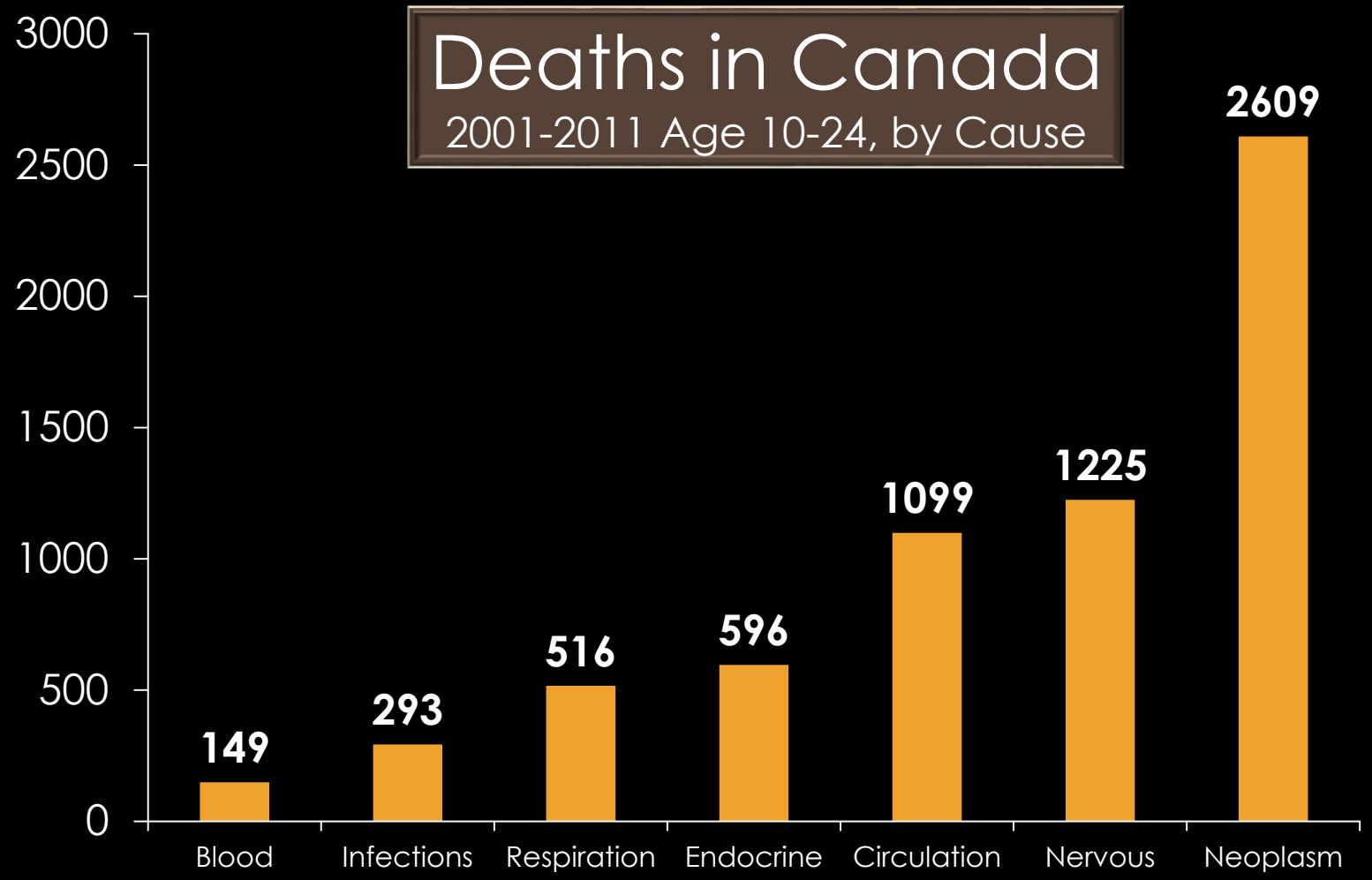
The Scope of Emotion-related Safety Behaviours

Behaviour	Percentage of Youth 12-17 per year
Sad or Hopeless every day x 2weeks	30%
Non-Suicidal Self Injury	13-46.5%
Seriously Considered Attempting Suicide	17%
Made a Plan Regarding Suicide	14%
Attempted Suicide	8%
Serious Suicide Attempt	1.2 - 2.7%
Death By Suicide	0.0056%*

Peterson, John, et al. "Nonsuicidal self injury in adolescents." *Psychiatry (Edgmont)* 5.11 (2008): 20-26.

Centers for Disease Control and Prevention (CDC). 1991-2013 High School Youth Risk Behavior Survey Data. Available at http://nccd.cdc.gov/youthonline/. Accessed on [2015-05-01].

Statistics Canada. Table 102-0551 - Deaths and mortality rate, by selected grouped causes, age group and sex, Canada, annual. Accessed: [2015-05-01]. *mathematical extrapolation

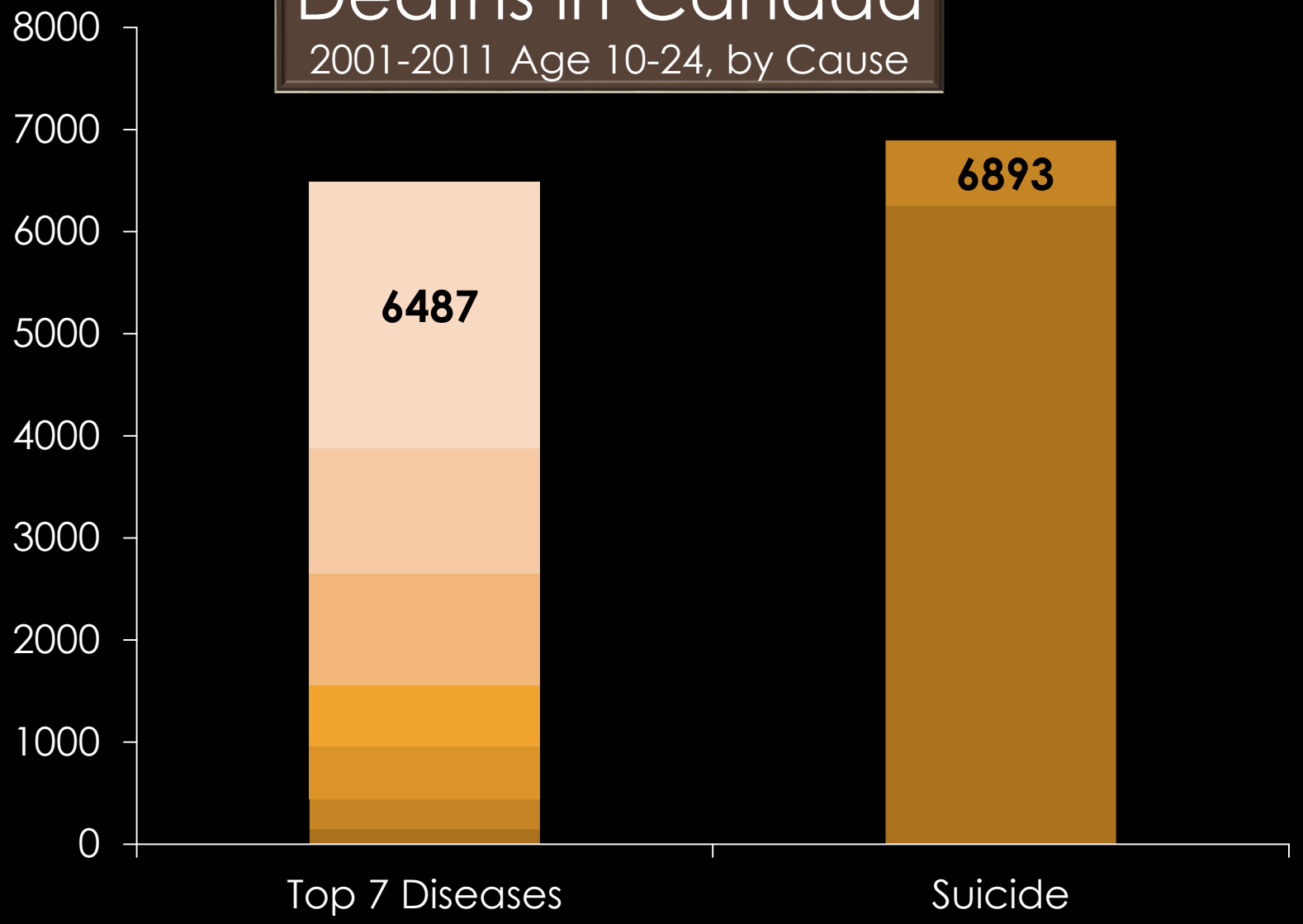


The Importance of Youth Suicide

Statistics Canada. Table 102-0551 - Deaths and mortality rate, by selected grouped causes, age group and sex, Canada, annual (accessed: February 23, 2014)

Deaths in Canada

2001-2011 Age 10-24, by Cause



Statistics Canada. Table 102-0551 - Deaths and mortality rate, by selected grouped causes, age group and sex, Canada, annual (accessed: February 23, 2014)

Culture

Substantially Increased Risk:

1. **First Nations / Metis / Inuit**
   - Much more for isolated / reserve populations (5-6x Canadian avg)
   - Metro-based populations similar to non-First Nations youth

2. **Street Youth / Street Culture**
   - Estimated at 10-15x the average youth rate of suicide

3. **Gay / Bisexual / Lesbian / Transgendered / QI2S**
   - 3x the average youth rate of suicide

4. **Bullies and the Bullied**
   - Unclear but estimated 2-5x the average youth rate of suicide

1. Government of Canada, 1995 2. Hwang et. al, 2001 3. UMN Press Release 2009

Bullying and Suicide Attempts

Study 1:

- Age 11-14:
  - Bullied: 1.7X more likely
  - Bullies: 2.1X more likely

Hinduja, Sameer, and Justin W. Patchin. "Bullying, cyberbullying, and suicide."*Archives of Suicide Research* 14.3 (2010): 206-221.

Study 2:

- Bullied: 2.9X more likely
- Bullies: 1.4X more likely
- Bully-victims: 9.3X more likely

Hepburn, Lisa, et al. "Bullying and suicidal behaviors among urban high school youth." *Journal of Adolescent Health* (2012).

Bullying and Suicide Attempts

- More complex studies may change these numbers
  - Control for sex, age, $$, family, psychiatric disorder
  - Bully victims 2-**14**X more likely to consider suicide
  - Bully perpetrators 2-4X more likely to consider suicide

Skapinakis, Petros, et al. "The association between bullying and early stages of suicidal ideation in late adolescents in Greece." *BMC psychiatry* 11.1 (2011): 22.

Bullying and Suicide

The largest study of children looking at actual suicide attempts and completions (5,400 children) was underpowered to detect completed suicide.

Though there was a difference in rate, it is important to note that more children in the study died of suicide with **no** bullying/bullied history (9) than who did with a bullying history (6).

Klomek, Anat Brunstein, et al. "Childhood bullying behaviors as a risk for suicide attempts and completed suicides: a population-based birth cohort study." *Journal of the American academy of child & adolescent*

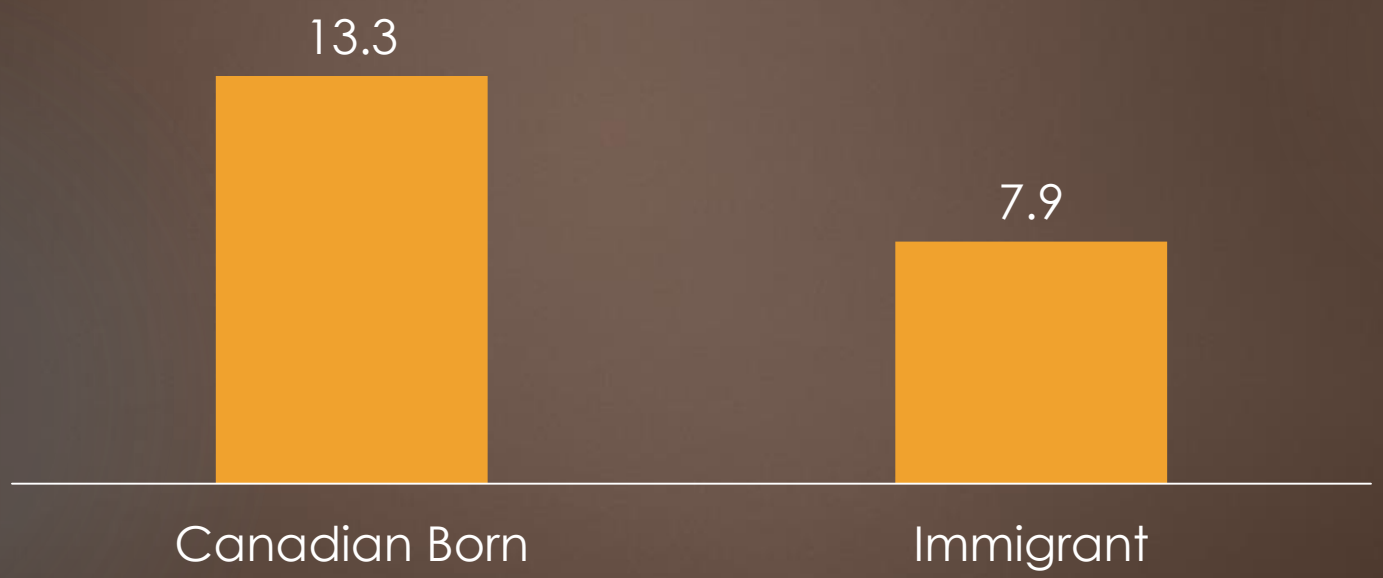
Suicide and Bullying

- Media attention has focused on bullying and suicide
- High profile suicides in the media

- **Most children who are bullied do not die by suicide**
- **Suicide is not *simple*.**
- **Bullying adds risk, but it is not the *sole risk*.**

Immigration Status

Suicides per 100,000 people
Canada, 1995-1997

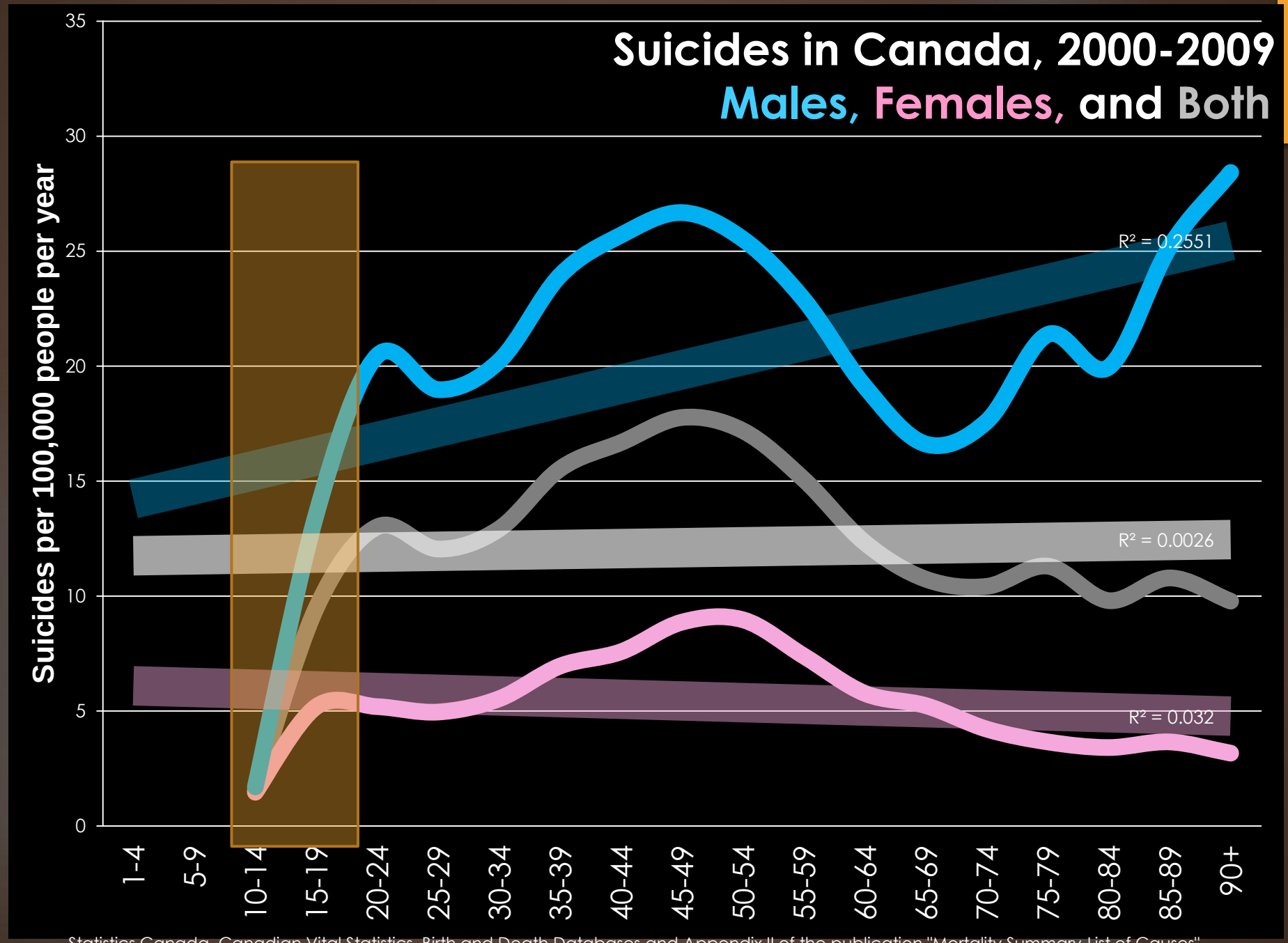


Source, "Suicide in Canadian Immigrants",
Statistics Canada, 2004

Race, Culture, and Immigration Status

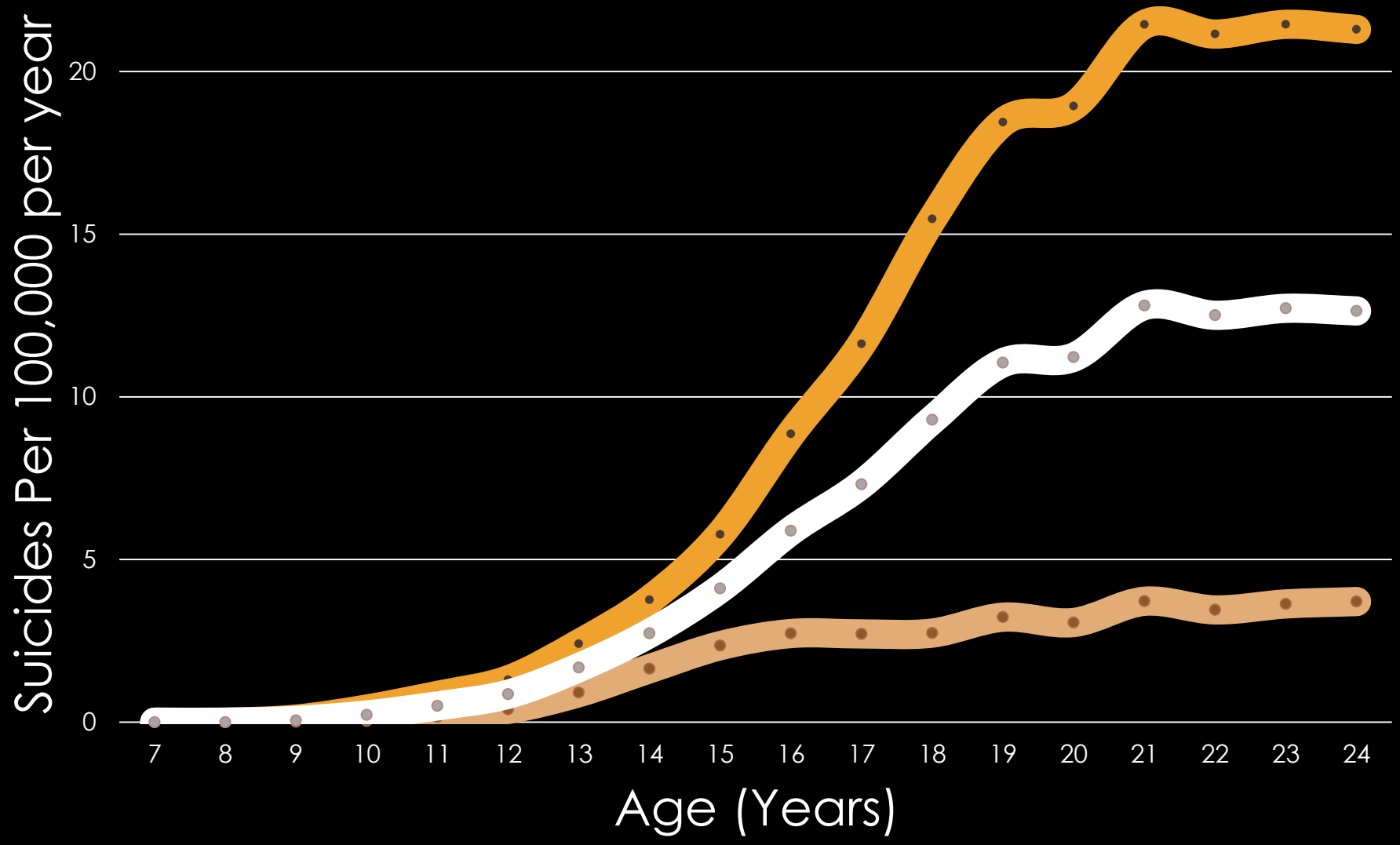
Myth: Suicides are more common in immigrant and visible minority populations.

The Evidence: While suicide is prevalent in all races, a native-born, Caucasian Canadian is in the highest risk group for lifetime suicide rates. Rates are increased for non-metropolitan First Nations populations, GBLT youth, and Street Youth.



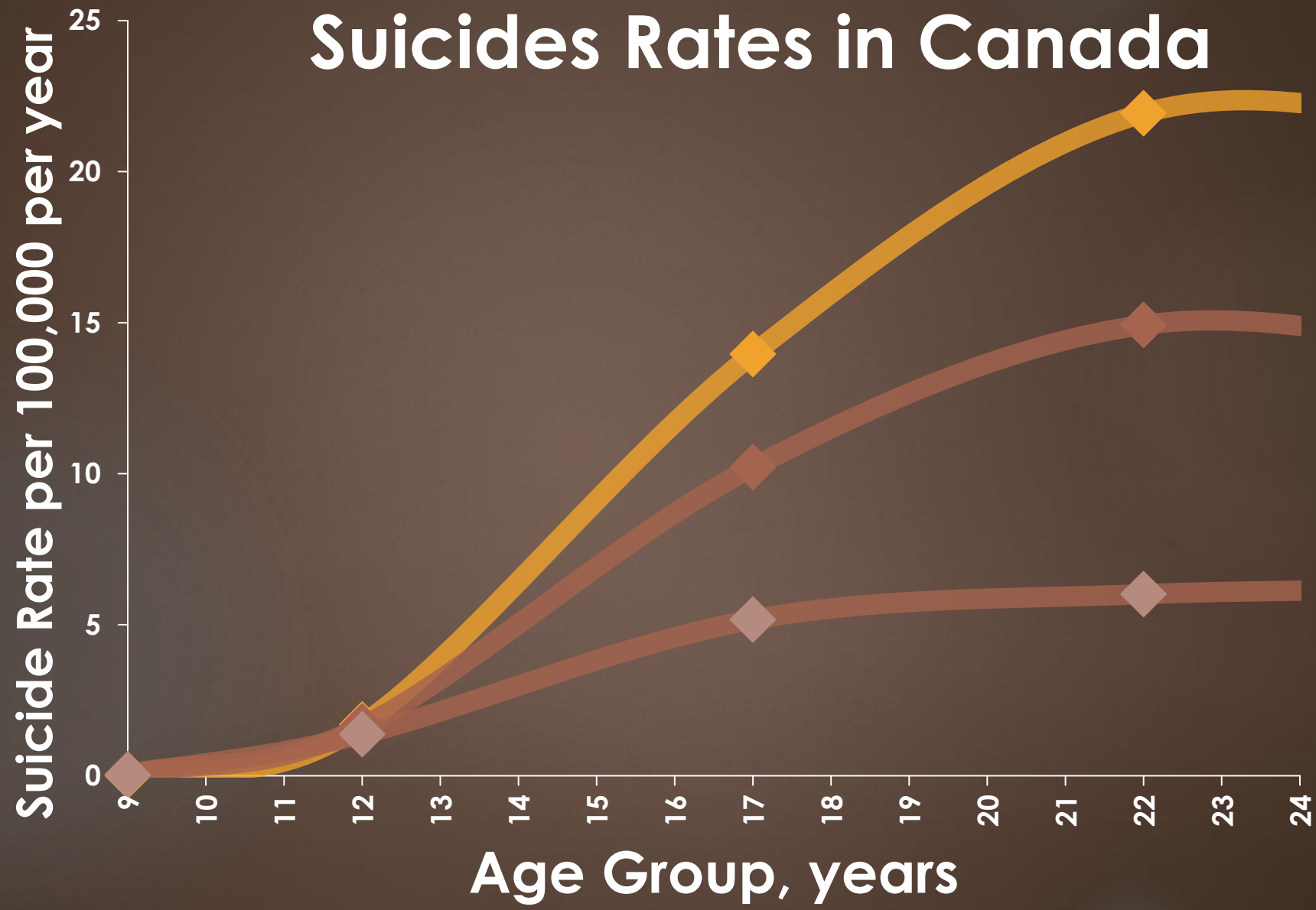
Statistics Canada, Canadian Vital Statistics, Birth and Death Databases and Appendix II of the publication "Mortality Summary List of Causes" (catalogue number 84F0209XIE). Compiled by author using CANSIM, 2012-2-14.

Suicides by Age, 1999-2007, United States

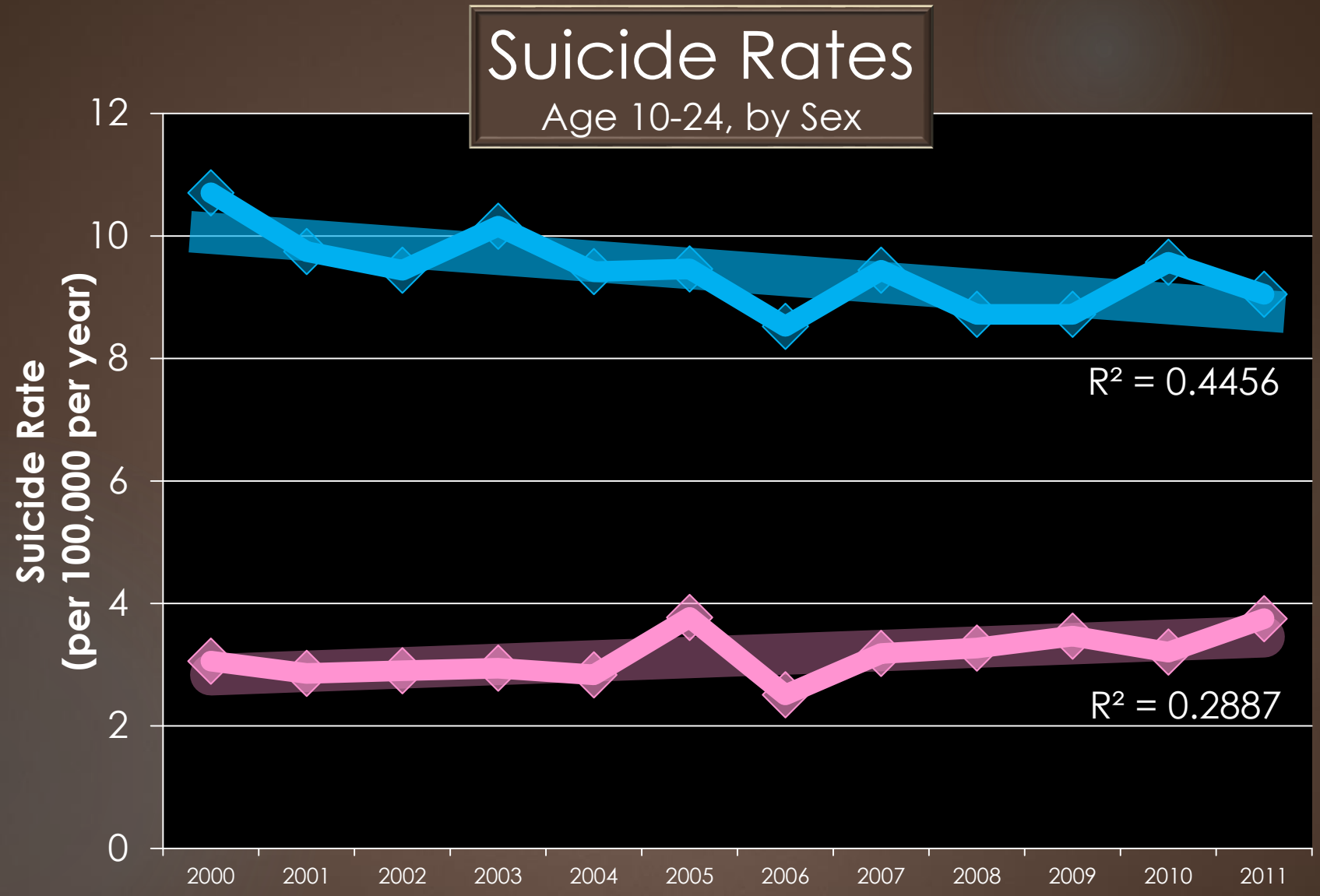


Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2014) [cited 2014 Jun 01]. Available

Suicides Rates in Canada



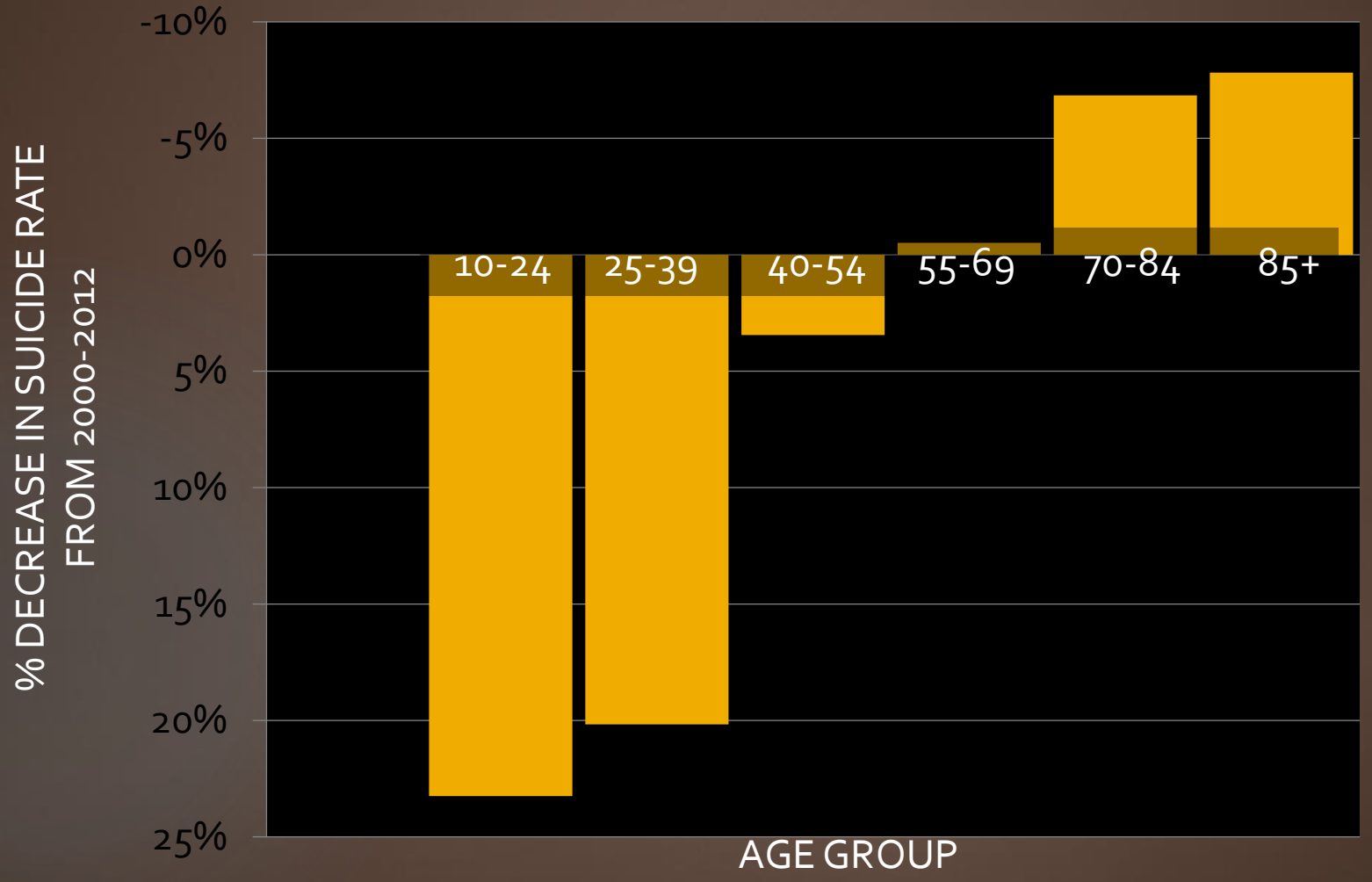
Statistics Canada. Table 102-0551 - Deaths and mortality rate, by selected grouped causes, age group and sex, Canada, annual (accessed: February 23, 2014)



Trends in Youth Suicide

Statistics Canada. Table 102-0551 - Deaths and mortality rate, by selected grouped causes, age group and sex, Canada, annual (accessed: February 23, 2014)

SUICIDE RATES IN CANADA
% DECREASE SINCE 2000



Statistics Canada, Canadian Vital Statistics, Birth and Death Databases and Appendix II of the publication "Mortality Summary List of Causes" (catalogue number 84F0209XIE). Compiled by author using CANSIM, 2012-2-14.

Age and Suicide

Myths: Increasing age is correlated with increased suicide risk, and adolescents are at higher risk than adults.

The Evidence:

- Starts at age 10
- Increases until age 24
- Remains high but peaks at age 50
- Decreases until age 70
  - Continues Decrease (Females)
    or
    Rebounds Severely (Males)

Mental Illness & Suicide

The Evidence:

Lifetime risk in all mood disorders	= 2.2%
Lifetime risk in **schizophrenia**	= 4.9%
Lifetime risk in addictions	= 8% +
Lifetime risk in eating disorders	= 8-10% (?)
Lifetime risk in bipolar disorder	= 8-19% **
Lifetime risk in borderline PD	= 5-10% (?)

Psychiatr Danub. 2014 Jun;26(2):108-14.
Arch Gen Psychiatry. 2005 Mar;62(3):247-53.
Am J Psychiatry 157:1925-1932, December 2000

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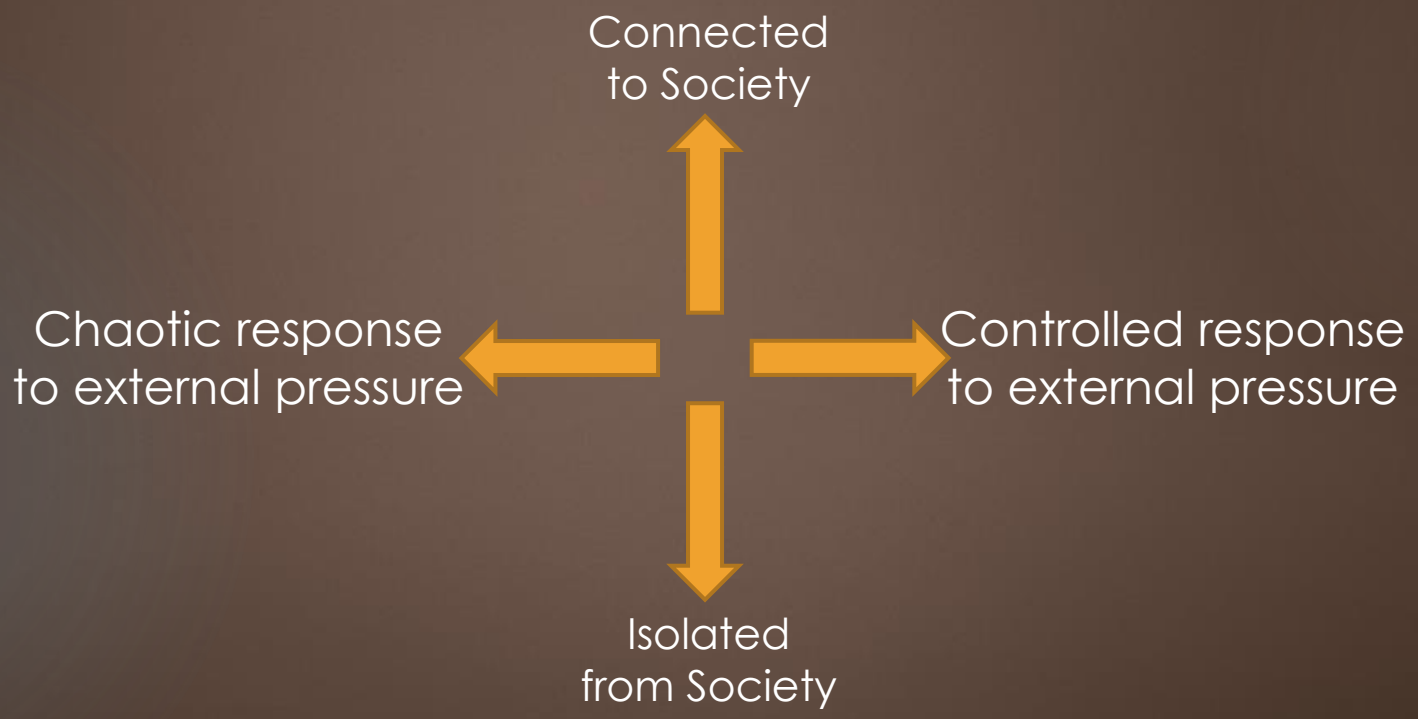
Motivations for Suicide

UNDERSTANDING MOTIVATION CAN DIRECT TREATMENT

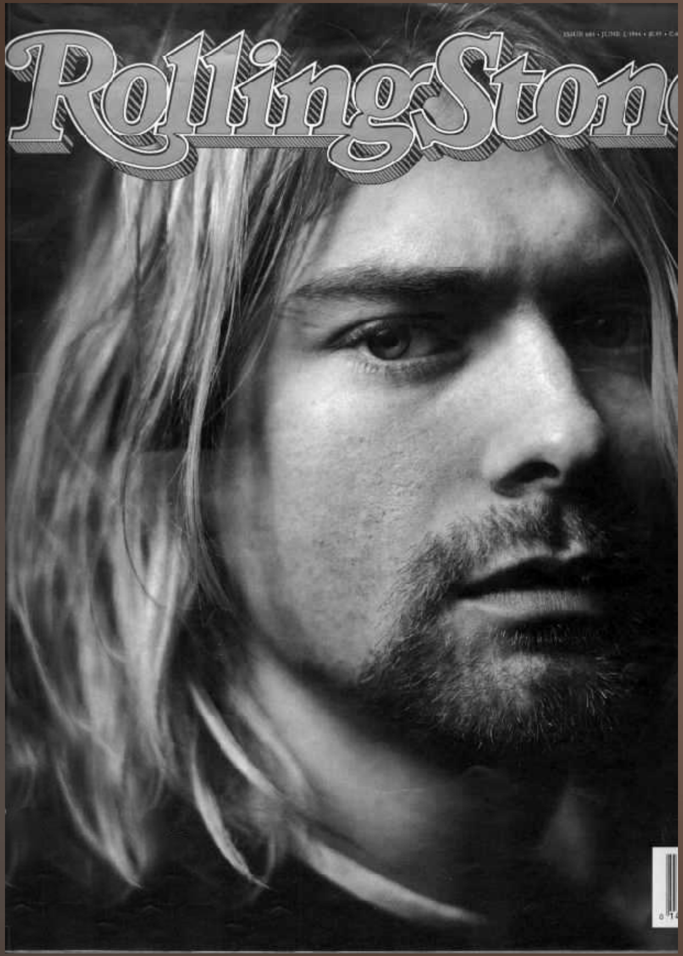
Motivations for Suicide



Motivations for Suicide

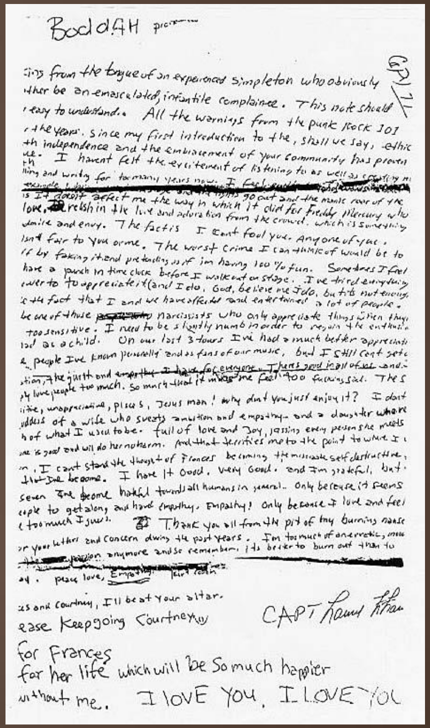
Chaotic response
to external pressure

Motivations – Pressure (Anomic)



"Sometimes I feel as if I should have a punch-in time clock before I walk out on stage"

"I can't stand the thought of Frances becoming the miserable, self-destructive, death rocker that I've become."


Boddah

Thank you all from the pit of my burning nause

your letters and concern during the past years. I'm too much of an erratic, mood

passion anymore and so remember, its better to burn out than to

peace love, Empathy. Kurt Cobain

Frances and Courtney, I'll be at your altar.

Please Keep going Courtney

for Frances

for her life which will be So much happier

without me. I LOVE YOU, I LOVE YOU

In Children & Adolescents

Anomic Suicidal Motivation

- school pressure
- shifting social pressures
- family losses/changes

Motivations for Suicide

Chaotic response to external pressure

Controlled response to external pressure

Motivations – Hopeless (Fatalistic)

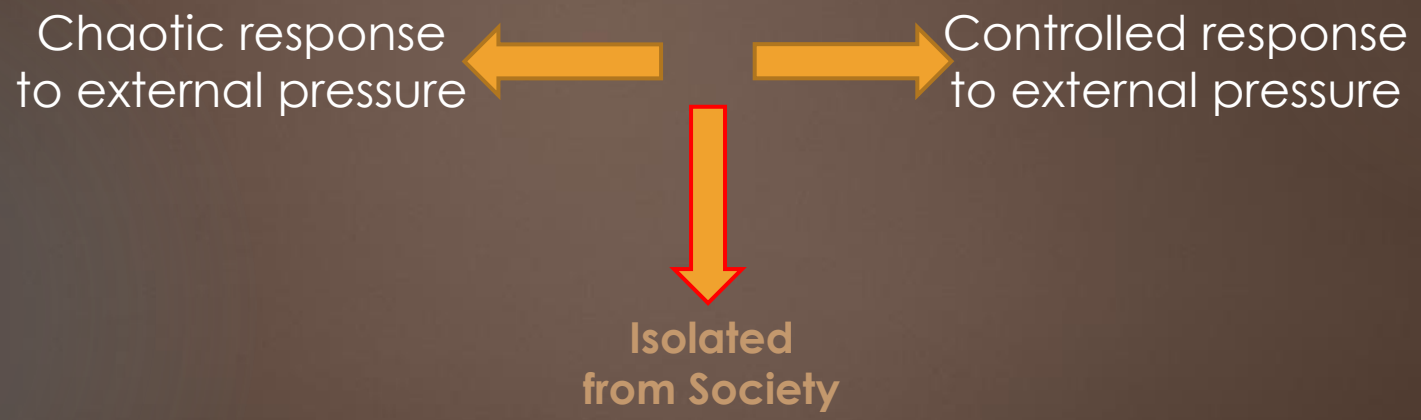
- Course of ALS (Lou Gehrig's Disease):
  - Reduced dexterity
  - Foot drop/wrist drop
  - Slurred speech
  - Muscle spasms
  - Loss of Mobility
  - Depression, anxiety
  - Muscle atrophy
  - Difficulties swallowing
  - Impaired breathing
  - Death

In Children & Adolescents

Fatalistic Suicidal Motivation

- Hopelessness about the future,
- Repeated disappointments
- Chronic illness

Motivations for Suicide



Motivations - Isolation

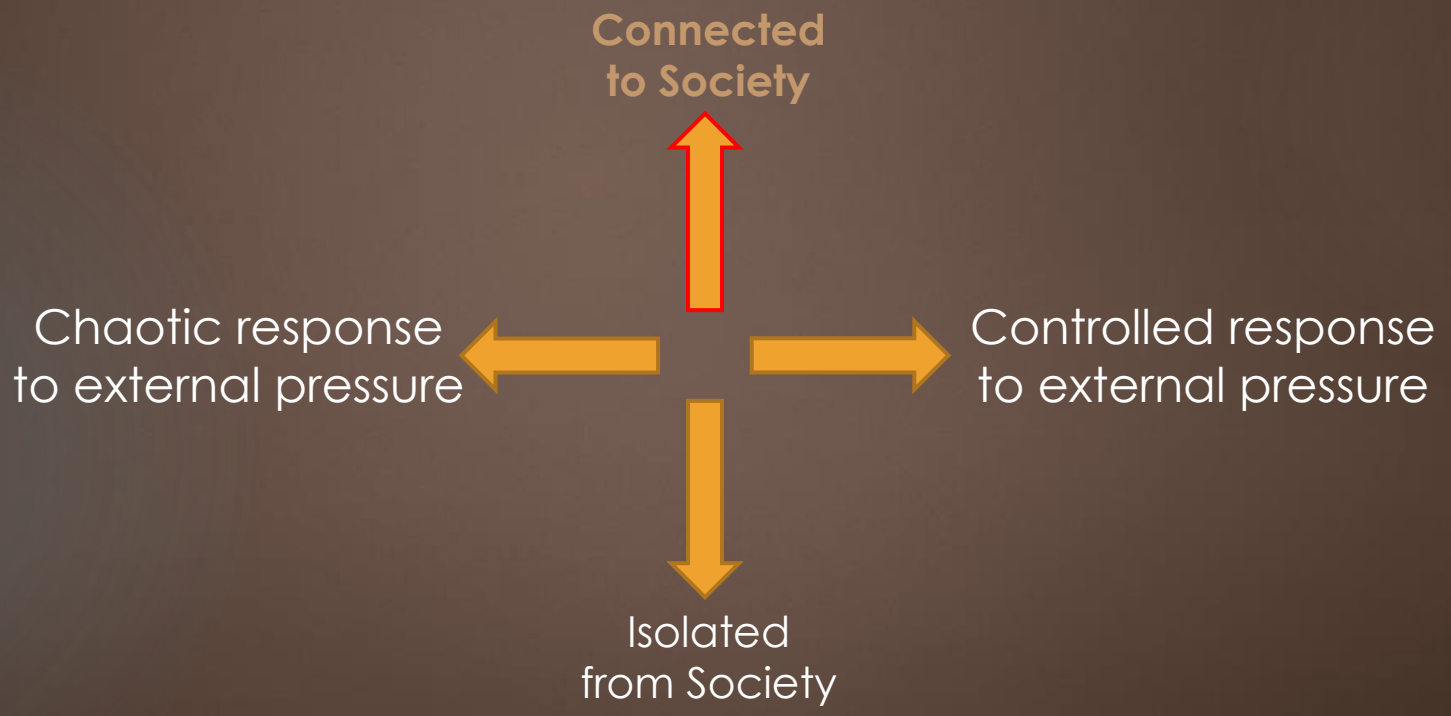
- (Egoistic suicide) – not connected to others or community

In Children & Adolescents

Egoistic Suicidal Motivation

- isolated communities
- LGBT youth
- victims of trauma

Motivations for Suicide



Motivations - Socioistic

- The opposite of Egoistic suicide, the individual is entirely focused on the effect on their community.

Hachiro Hosokawa - a member of Thunder Gods Kamikaze squadron.

In Children & Adolescents

Socioistic Suicidal Motivation

- protecting parents or friends
- remorse over perceived infraction
- revenge

Importance of Motivation

- Most suicide interventions done by therapists address *anomic* suicidal ideation
  - "Safety planning"; distraction, call someone…
- If you understand the motivation, you can target your intervention, or recognize when simple "safety planning" will not reduce risk

Therapeutic Approaches in Fatalistic Suicidal Motivation

- Cognitive Behavioural Therapy
- Problem Solving Therapy
- Supportive Therapy

Fatalistic Suicidal Ideation

Preventing suicide in fatalistic ideation involves **solving problems** and **providing hope**.

Supportive Therapy

Problem Solving Therapy
Cognitive Behavioural Therapy

Non-suicidal Self-Injury

Non-suicidal Self-Injury ("parasuicide") Behaviours or Attitudes that *appear* suicidal to an observer but are driven by another motive

Eg: therapeutic cutting, trying to get attention, proving a point, wanting to sleep, treating a mental illness

Trends in Youth Suicide

Therapeutic Cutting is on the rise.

- 1990 – 1 in 18 girls will have tried cutting by graduation of high school
- 2010 – 1 in 2-3 girls will have tried cutting by graduation of high school

Therapeutic cutting is not, has never been, and will never be a suicidal behaviour.

Non-lethal suicidal behaviour

- For every suicide, there are 25 "attempts"
- In youth, this may be even more (50-100)

- In young females, estimated to be upward of 1000 NSSIs per completed suicide
  - Risk of suicide in 10-18 ♀: 5 per 100,000 per year
    Risk of NSSI in 10-18 ♀: >5000 per 100,000 per year

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Self Injury

SELF INJURY IS A POORLY DEVELOPED THERAPEUTIC BEHAVIOUR

The Numbers of Self Injury

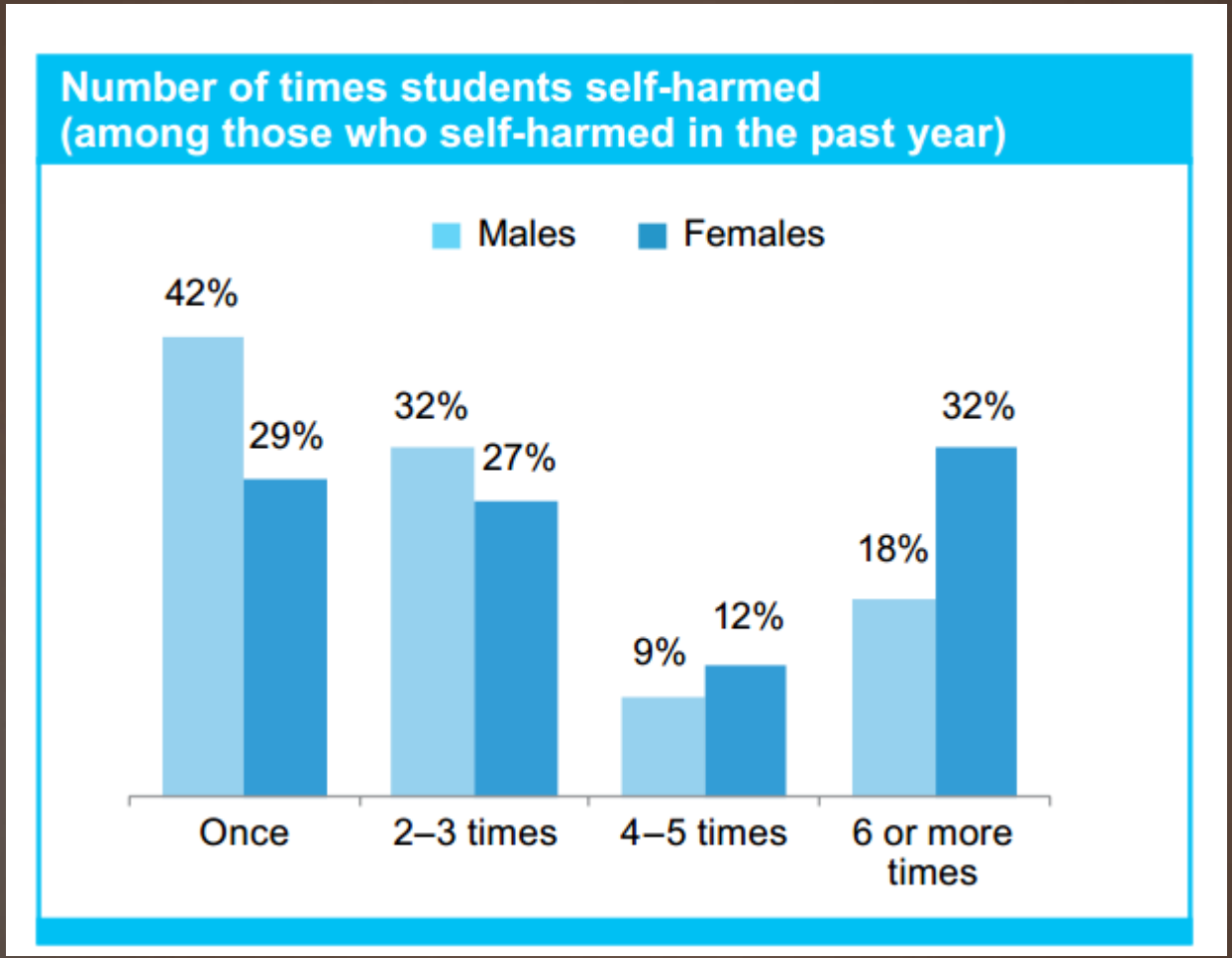
- Among adults, NSSI is rare:
  - 4-6% in early adulthood, decreasing to < 1%
- Among adolescents, likely much more common
  - Studies vary: general agreement between 15-30% in any year
  - "Have you ever tried?"
    - Numbers are definitely rising
    - Recent studies suggest 35.6% to 50% (!)

Giletta, Matteo, et al. "Adolescent non-suicidal self-injury: A cross-national study of community samples from Italy, the Netherlands and the United States." *Psychiatry Research* (2012).

Youth Distress

The following questions and discussion items are based on the McCreary Centre AHS

- BC Study! (5th one done, 2013)
- 29,000 BC Students Grade 7-12
  - 50 of BC's 59 School districts.


Number of times students self-harmed
(among those who self-harmed in the past year)
Males
Females
42%
29%
32%
27%
9%
12%
18%
32%
Once
2–3 times
4–5 times
6 or more times

The Numbers of Self Injury

	Grade 9	Grade 12
Perform NSSI	Females 2x	Females 4x
Threaten NSSI	Females 2x	Females 5x
Talk about NSSI	Females 4x	Females 4x

Plener et al. (2009) *An international comparison of adolescent non-suicidal self-injury and suicide attempts: Germany and the* USA, **Psychological Medicine,** 39: 1459 - 1558

The Numbers of Self Injury

- Age of Onset
  - Consistently found to be 12-14 years of age

Jacobson, CM et al. (2007) *The Epidemiology and Phenomenology of Non-Suicidal Self-Injurious Behavior Among Adolescents: A Critical Review of the Literature*, **Archives of Suicide Research**, 11: 2, 129 — 147

The Numbers of Self Injury

- The Course of NSSI:
  - Very few studies
  - McLean Study of Adult Development (18-35)
    - Borderline Personality Disorder
    - 81% engaged in NSSI at baseline
    - 26% engaged in NSSI at 6-year follow-up

- ?? Peaks in adolescence, declines thereafter ??

Jacobson, CM et al. (2007) *The Epidemiology and Phenomenology of Non-Suicidal Self-Injurious Behavior Among Adolescents: A Critical Review of the Literature*, **Archives of Suicide Research**, 11: 2, 129 — 147

The Numbers of Self Injury

- Risk factors for Self-Injury
  - Depressive Symptoms
  - Family Loneliness
  - Victimization

Giletta, Matteo, et al. "Adolescent non-suicidal self-injury: A cross-national study of community samples from Italy, the Netherlands and the United States." *Psychiatry Research* (2012).

The Numbers of Self Injury

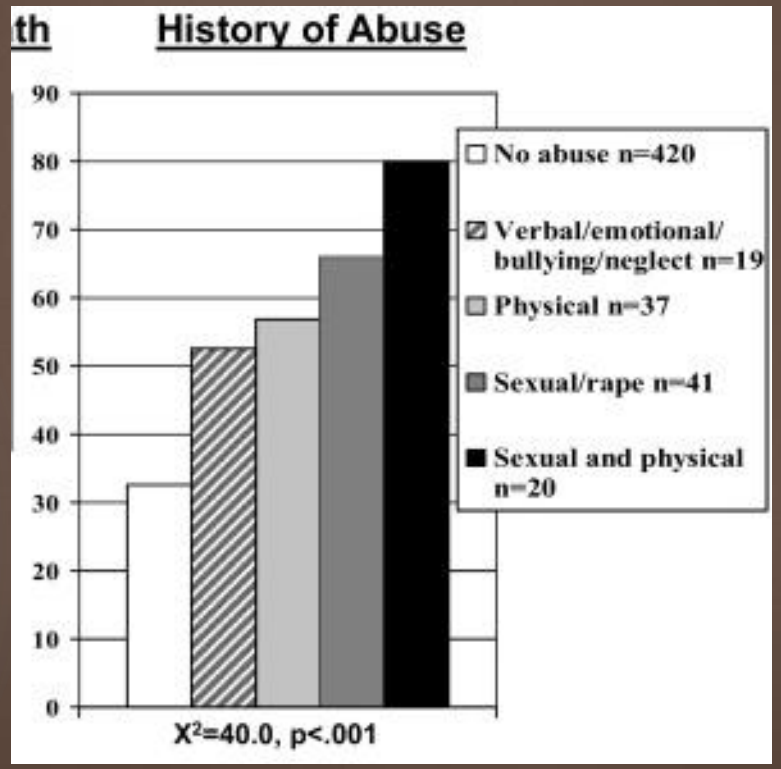
- Feelings and Experiences Associated with NSSI

- Before
  - anxiety and hostility > sadness > anxiety > hostility
- After
  - Relief
  - Guilt
  - Disappointment

Jacobson, CM et al. (2007) *The Epidemiology and Phenomenology of Non-Suicidal Self-Injurious Behavior Among Adolescents: A Critical Review of the Literature*, **Archives of Suicide Research**, 11: 2, 129 — 147

Abuse and NSSI

- Study of 1,432 Adolescents with ED (Stanford)
  - 40% engage in SIB regularly



Peebles, Rebecka, Jenny L. Wilson, and James D. Lock. "Self-injury in adolescents with eating disorders: Correlates and provider bias." *Journal of Adolescent Health* 48.3 (2011): 310-313.

The Science of Self-Injury

- Does NSSI come from biology?
  - Most repetitive self-injurers have impulsivity problems
    - Shoplifting
    - Drug and alcohol abuse
    - Bulemic eating disorders
    - Sexual Promiscuity
- Impulsivity is a highly genetic trait that relates to a known brain region (frontal lobe)

Sher, Leo and Stanley, Barbara H.(2008) 'The Role of Endogenous Opioids in the Pathophysiology of Self-Injurious and Suicidal Behavior', Archives of Suicide Research, 12: 4, 299 — 308

How can Self-Injurious Behaviours "Make you feel better?"

Pai
n

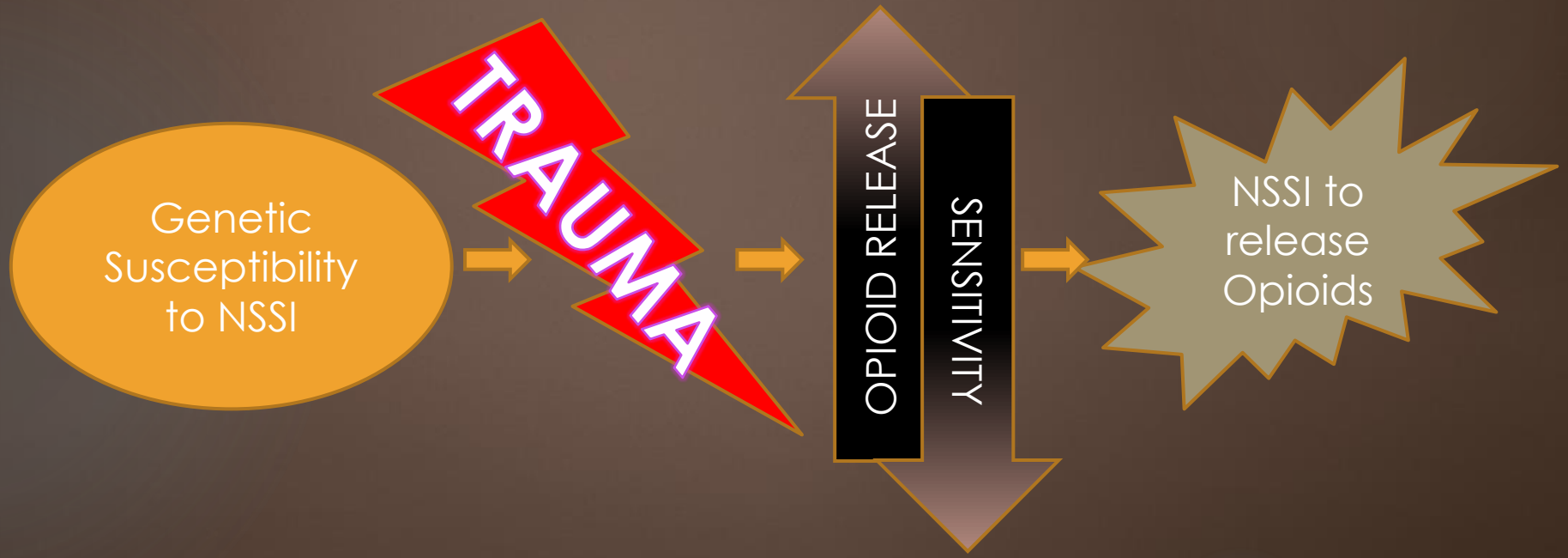
Endorphins

B-endorphin & met-enkephalin

Relief

The Science of Self-Injury

- Endorphins and NSSI



Sher, Leo and Stanley, Barbara H.(2008) 'The Role of Endogenous Opioids in the Pathophysiology of Self-Injurious and Suicidal Behavior', Archives of Suicide Research, 12: 4, 299 — 308

The Science of Self-Injury

- Those who have a *history of suicidality and self harm* have less endorphins in their spinal fluid than those who only have a history of suicidality.

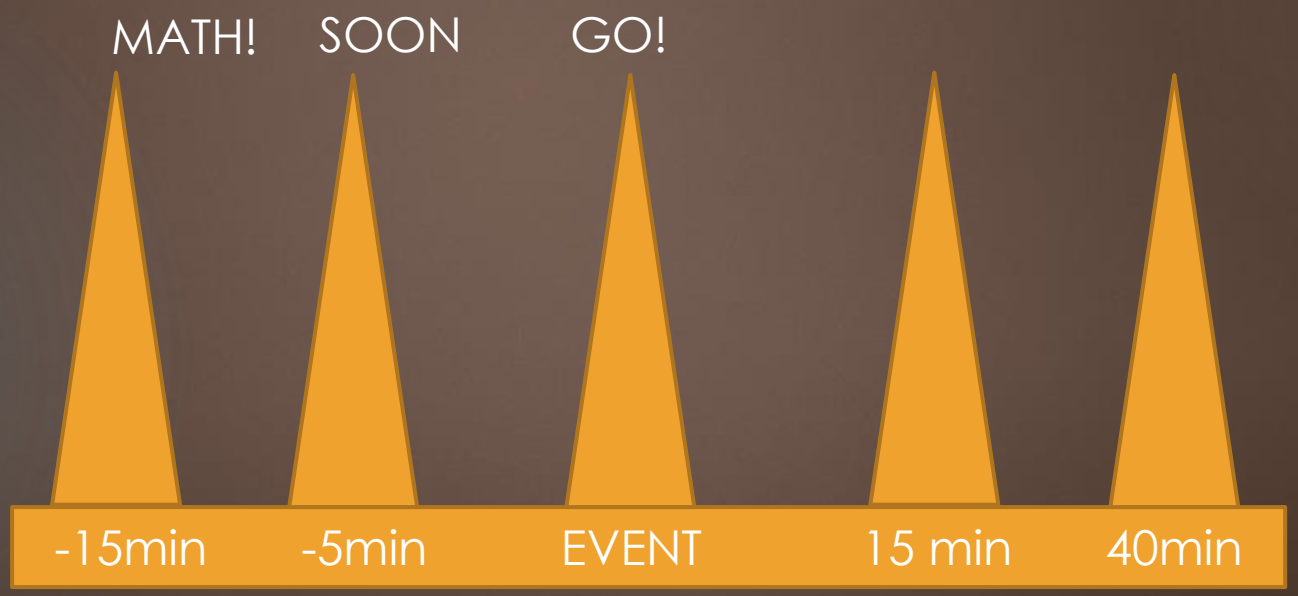
Stanley, B., et al., Non-suicidal self-injurious behavior, endogenous opioids and monoamine neurotransmitters, J. Affect. Disord. (2009), doi:10.1016/j.jad.2009.10.028

- People who self-injure report greater euphoria when given synthetic opioids than those who do not.

- Endorphins also trigger the dopamine reward pathway, suggesting a biological cause for "addictive patterns"

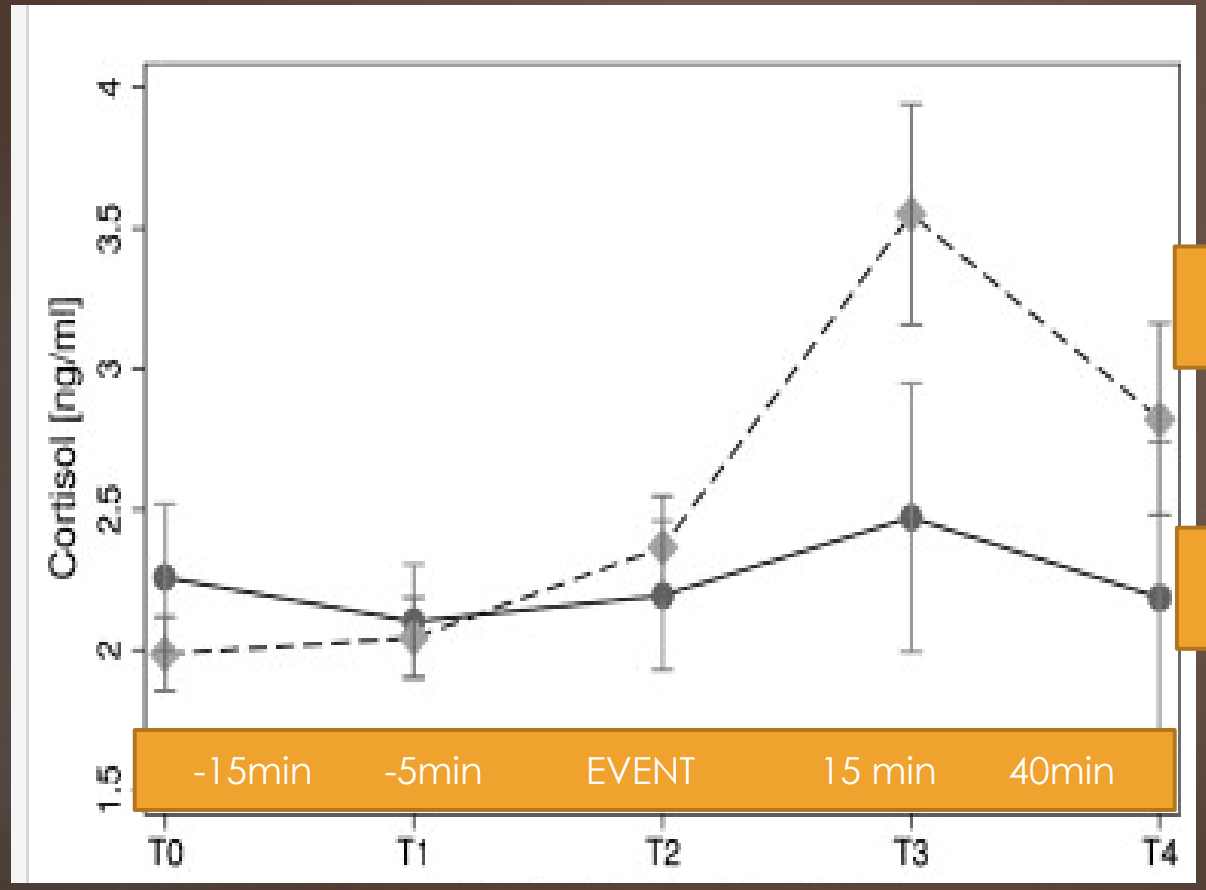
Sher, Leo and Stanley, Barbara H.(2008) 'The Role of Endogenous Opioids in the Pathophysiology of Self-Injurious and Suicidal Behavior', Archives of Suicide Research, 12: 4, 299 — 308

The Science of Self-Injury



Kaess, Michael, et al. "Alterations in the neuroendocrinological stress response to acute psychosocial stress in adolescents engaging in nonsuicidal self-injury." *Psychoneuroendocrinology* 37.1 (2012): 157-161.

The Science of Self-Injury



Controls

Self Harmers

Kaess, Michael, et al. "Alterations in the neuroendocrinological stress response to acute psychosocial stress in adolescents engaging in nonsuicidal self-injury." *Psychoneuroendocrinology* 37.1 (2012): 157-161.

Motivations Behind Self-Injurious Behaviour

"It puts a punctuation mark on what I'm feeling on the inside!"

"It's a way to have control over my body because I can't control anything else in my life"

"I usually feel like I have a black hole in the pit of my stomach, at least if I feel pain it's better than feeling nothing"

"I feel relieved and less anxious after I cut. The emotional pain slowly slips away into the physical pain"

Motivations Behind Self-Injurious Behaviour

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Back to Suicide: Opportunities for Intervention

Are those who commit suicide mentally ill?

- It is natural to assume most who commit suicide are *suffering* at least acutely

  (not always true)

- Does all such suffering equate to mental illness?

Opportunities for Intervention

- 90% of Suicide Victims had a mental health disorder when a psychological autopsy is performed
  - Actually, most had 2-3 (Axis I, substance disorder, Axis II) – only 12% had one Axis I condition.
  - These same studies find 30% disorder rate in the control population. (ie. high sensitivity)

Psychol. Med. 2003 Apr;33(3):395-405.

Opportunities for Intervention

What's wrong with "90% of people who died by suicide had mental illness?"

- Equates mental illness with suicide
- "mental illness" specificity is high using these stats (~0.9), but sensitivity is very low (~0.5)

Controlled, blinded psychological autopsies of youth show that only 25% of suicide victims met criteria for a psychiatric illness.

Freuchen et al. Child and Adolescent Psychiatry and Mental Health 2012, 6:1
Psychol. Med. 2003 Apr;33(3):395-405.

Opportunities for Intervention

- 1 month prior to suicide:
  - 40% contacted *any professional*
  - 20-25% contacted any *mental health professional*
- *In youth may be even less*

BMJ, 1999;318:1235=1239 AJP, 2002;159:909-916

Opportunities for Intervention

REMIX

If every mental health professional could *magically protect* every person they saw for an entire month…

… 75% of all suicides would still occur.

BMJ, 1999;318:1235=1239 AJP, 2002;159:909-916

Opportunities for Intervention

- Only 15% of youth who die by suicide have ever been hospitalized for psychiatric reasons
- 30-50% of youth who die by suicide have ever been identified as having psychiatric needs
- Mental illness likely adds 8-40X the risk
  - 10 / 100,000 per year →
    80-400 / 100,000 per year

BMJ 2002;325:74

Prevalence

"so much stress [they] could not function"

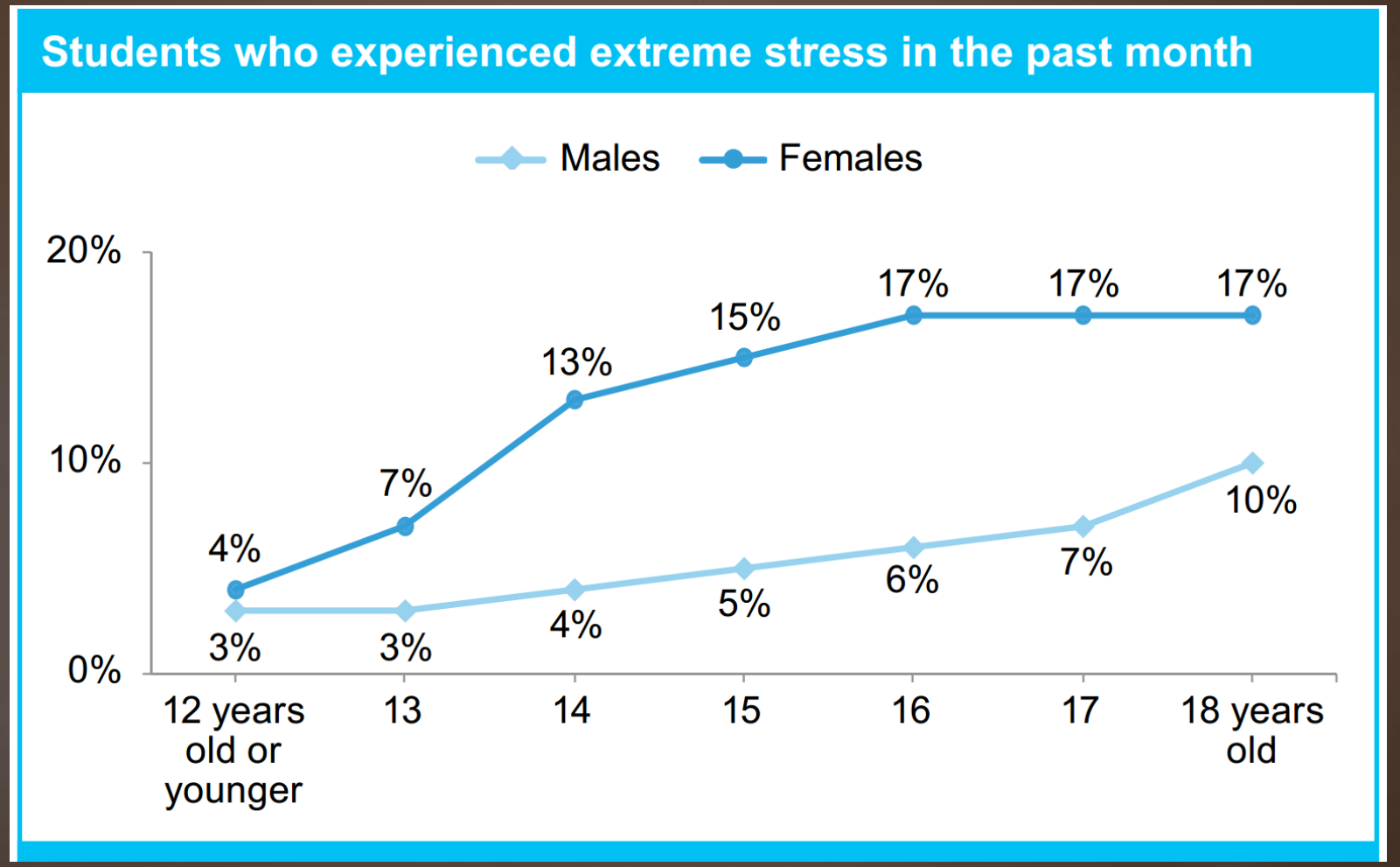
10% (1 in 10 adolescents)

"despair such that [they] wondered if anything was worthwhile"

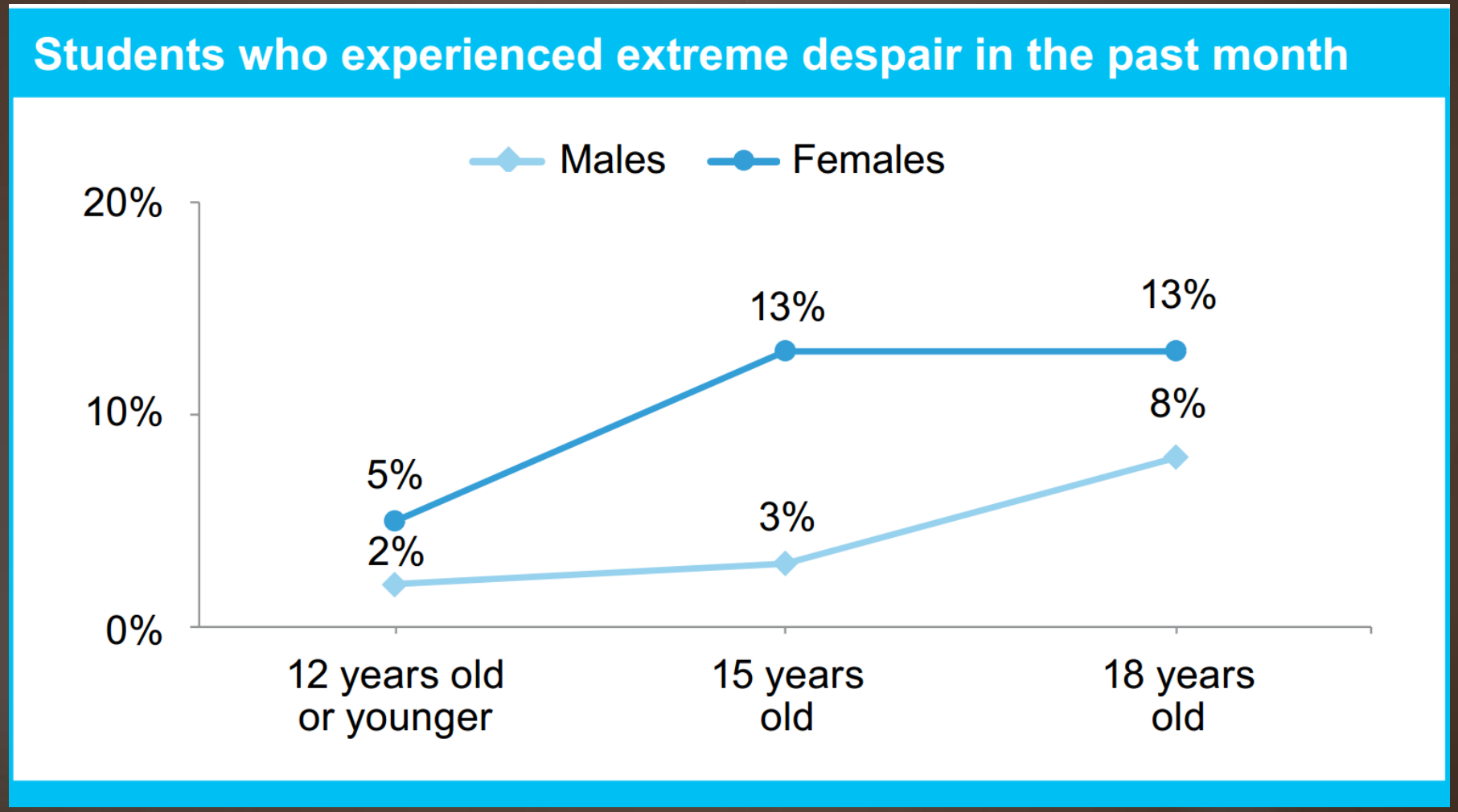
7% (1 in 14 adolescents)

Females 2x as likely to report the above

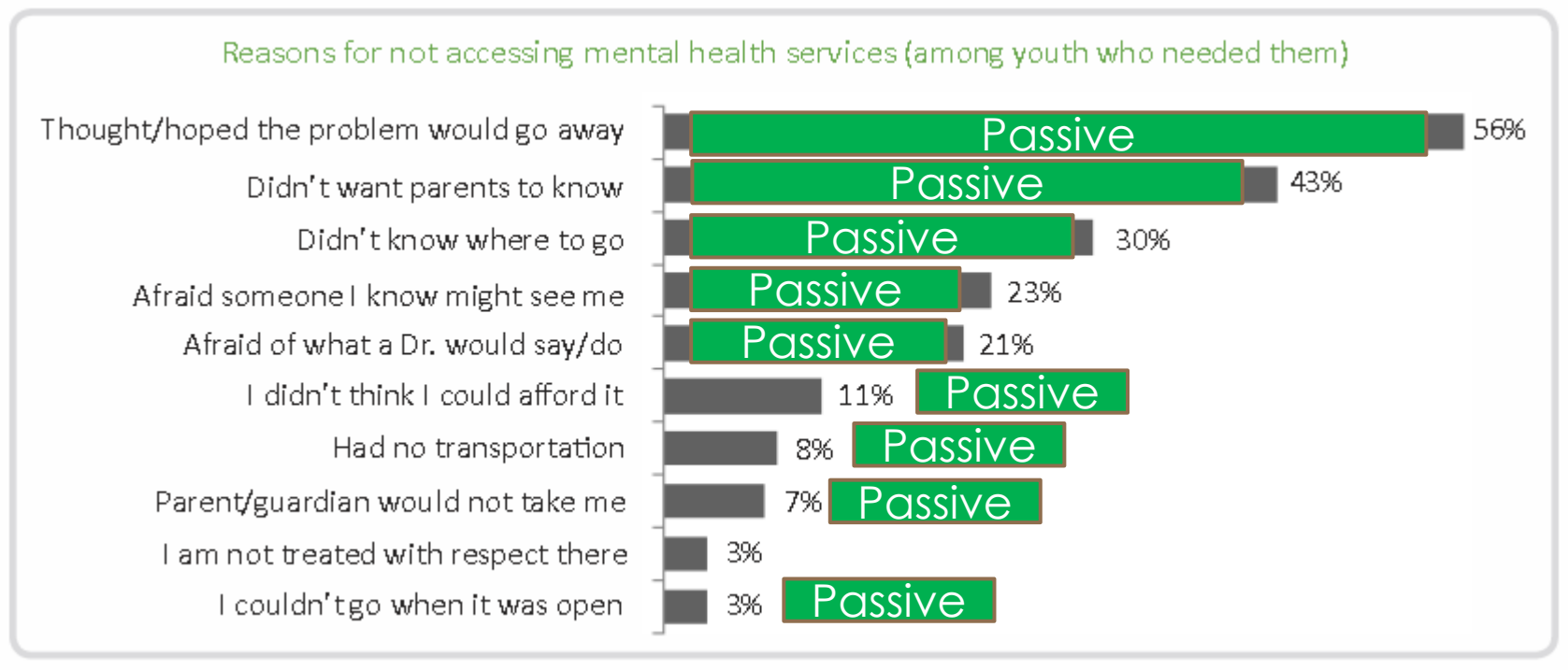
Prevalence


Students who experienced extreme stress in the past month
Males
Females
20%
10%
0%
4%
7%
13%
15%
17%
17%
17%
3%
3%
4%
5%
6%
7%
10%
12 years old or younger
13
14
15
16
17
18 years old

Prevalence


Students who experienced extreme despair in the past month
Males
Females
20%
10%
0%
13%
13%
8%
5%
3%
2%
12 years old or younger
15 years old
18 years old

Why don't these children see us in Mental Health?



Should we ask about suicide?

- Most studies tell us "yes"
- Screening vs. spontaneous report **7x more likely to discover suicidal thinking**
- Only **25% of completed suicides** occur in people who have recently accessed mental health services

We are missing the majority of truly at-risk kids!

AACAP. (2001). American Academy of Child and Adolescent Psychiatry Practice parameter for the assessment and treatment of children and adolescents with suicidal behavior. *J Am Acad Child Adolesc Psychiat*, 40:24S–51S.

How easy is it?

- It's normal to feel uncomfortable asking about mental health issues, **especially suicide**.
- In reality, anybody can do it.
- Many successful crisis programs use *youth volunteers* who are as young as 13!

Don't be intimidated.

Screening for Suicide

Age (or Equivalent Maturity Level)	Suicide Screening Script (the bolded question indicates the screening question)
12 years or older	"I'm going to ask you a few quick questions about how you are doing with respect to your mental health." 1. "Do you think that you have been under a lot of stress lately?" 2. "Have you ever felt like life is not worth living?" **3. "In the past month, have you felt so bad that you have considered harming or killing yourself?"**
10 to 12 years	"I'm going to ask you a few quick questions about how you think and feel." 1. "Sometimes people find that they have too much stress. Does this sound like you?" **2. "Sometimes when people are very upset, they think about hurting themselves. Has this happened for you?"**
If unable to communicate directly	To guardian: **"In the past month, have you had any concerns about your child with respect to safety or self-harm?"**

tylerblack.com/IWK

ASSESSING Suicide RISK

The 4 C's of Suicide Assessment

- Collateral
- Confidence
- Common Sense
- Changeability

Collateral History

- Collateral history essential to emergency suicide risk assessment
- "The more the merrier"
- In children, especially important
  - Child's perception of reality
  - Child's distortion of time
  - Child's reactionary nature

Confidence

- Patient well-known to you or new?
  - This works both ways!
- Does the patient feel confident in themselves? (NOT a "*safety contract*")
- Do you have collateral information?
- Poor Engagement / Rapport

Common Sense

Nothing astonishes people so much as common sense and plain dealing.

Ralph Waldo Emerson (1803-1882) U.S. poet, essayist and lecturer.

- Suicide is unpredictable
- Careful history taking
  - Consistency, plausibility
  - Chronological history of suicide attempt
  - **Active Ideation vs. Passive Ideation**
  - Assess affect before/during/after suicide attempt
  - Assess current view of suicide attempt

Changeability

Not Changeable

Age

Sex

Family History of Suicides

Family History of Mental Disorder

Prior Attempts of Suicide

Cultural Beliefs

Historical Diagnosis of Psychiatric DO

Historical use of Psychotropic Meds

Remote Loss

Changeable

Access to Lethality

Untreated Mental Health Disorder

Worsening Mental Health Disorder

Dealing with Recent Loss/Life Crisis

Lack of Social or Formal Support

No Access to Health Care

Non-response to Medication

Caregiver/Family Unavailable to care

Addictions

Changeability

- Changeability greatly influences the success of hospitalization
  - Can remove lethal methods
  - Can address untreated disorder
  - Can work with family
  - Can organize outpatient services
  - Can address coping strategies
- Without changeability, hospitalization has no goal, except to "protect."

Does Hospitalization Prevent Suicide?

- Every year, 100-400 inpatient deaths per 100,000 admissions

TABLE 3

IDENTIFIED RISK FACTORS FOR INPATIENT SUICIDE[3,6-14,16-25,30-32]

Chronic mental illness: affective and psychotic disorders[7,9,11-14,16,18,21,22,25,30]	Family psychiatric history[18,21]
Increased length of stay[3,11,18,23]	Depression[6,8,32]
Previous self-harm[3,8,9,11,17,21,22,24,25,31]	Multiple previous admits[10,18,25]
Previous SA[9,16-18,20-23]	More medications prescribed than controls[3]
Male gender[6-8,13,14,19]	AWOL during admit[8]
Planned SA[9]	Extrapyramidal side effects/ akathisia[8]
Suicidal behavior before admit[8]	Greater number of ward transfers[3]
SA during admit[3]	Part-time employed[23]
SI at time of and during admit[3,23]	Single[11]
Longer duration disorder[10,18]	Lives alone[22]
Recent bereavement[9]	Homeless[25]
History of suicide in first-degree relative[9]	

SA=suicide attempt; SI=suicidal ideation; AWOL=absent without leave.

Combs H, Romm S. *Primary Psychiatry.* Vol 14, No 12. 2007.

Dong JY, Ho TP, Kan CK. A case-control study of 92 cases of inpatient suicides. J Affect Disord. 2005;87(1):91-99

Powell J, Geddes J, Deeks J, Goldacre M, Hawton K. Suicide in psychiatric hospital inpatients. Risk factors and their predictive power. Br J Psychiatry. 2000;176:266-272

Deisenhammer EA, DeCol C, Honeder M, Hinterhuber H, Fleischhacker WW. Inpatient suicide in psychiatric hospitals. Acta Psychiatr Scand. 2000;102(4):290-294

Read DA, Thomas CS, Mellsop GW. Suicide among psychiatric inpatients in the Wellington region. Aust N Z J Psychiatry. 1993;27(3):392-398.

Does Hospitalization Prevent Suicide?

- Review of 76 inpatient suicides:
  - 78% denied suicidal ideation
  - 51% on q15 minute checks or 1:1 observation
  - 21% had no-suicide contract

Journal of Clinical Psychiatry, 2003:64(1)

Why Would Hospitalization Harm?

- **Fear response (anxiety and stress)**
  - Procedures and tests, meeting new people, family separation, worry about health
- **Feelings of isolation**
  - Not seeing friends, hard to see family
- **Decreased pro-social activity**
  - Playing sports, engaging with friends
- **Major life changes**
- **Parental upset / stress**

tylerblack.com/IWK

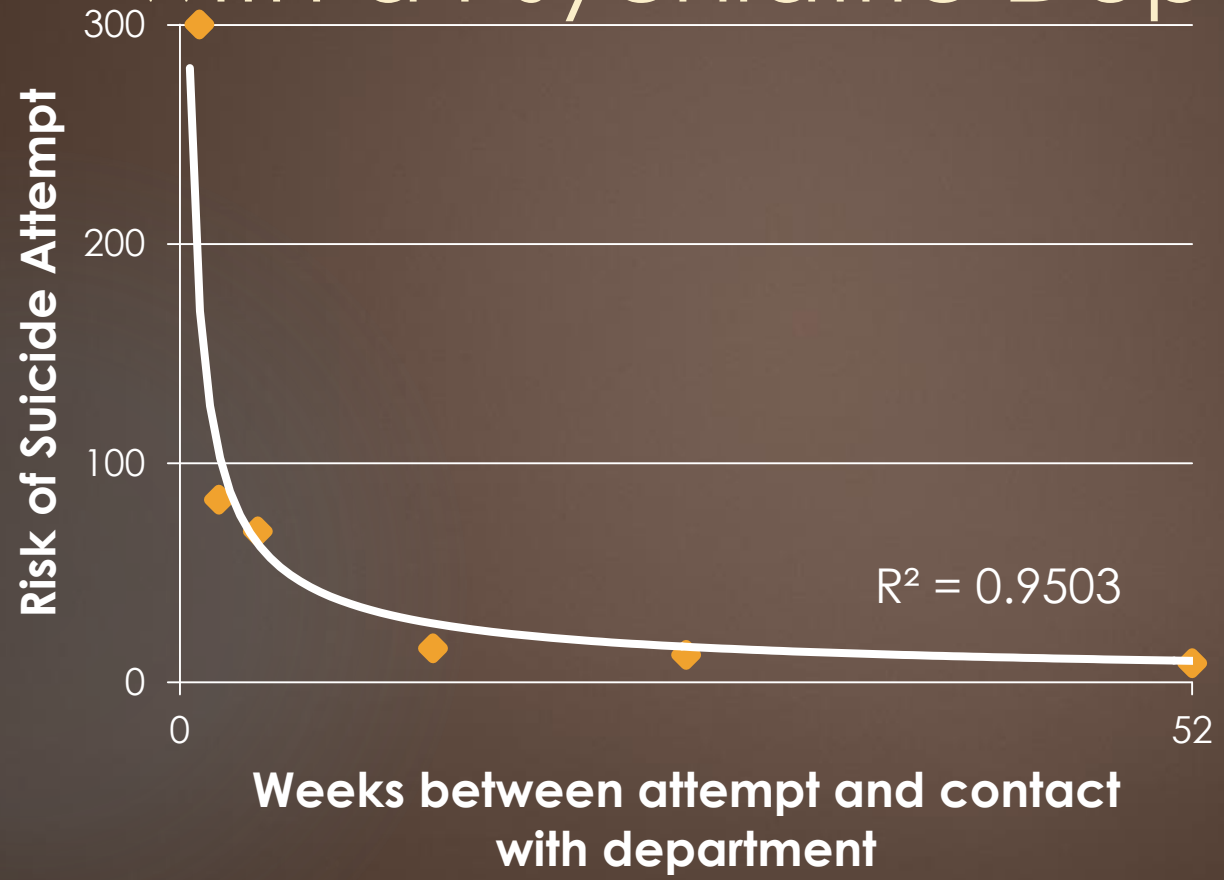
Suicide Risk Documentation

SAD PERSONS boooooooo!

1 - S: Male sex
1 - A: Age <19 or >45 years
2 - D: Depression or hopelessness
1 - P: Previous suicidal attempts or psychiatric care
1 - E: Excessive ethanol or drug use
2 - R: Rational thinking loss (psychotic or organic illness)
1 - S: Single, widowed or divorced
2 - O: Organized or serious attempt
1 - N: No social support
2 - S: Stated future intent

0–5: May be safe to discharge (depending upon circumstances)
6-8: Probably requires psychiatric consultation
>8: Probably requires hospital admission

Suicide Attempts after Contact with a Psychiatric Department



Time	Risk
1 week	300
2 weeks	83
4 weeks	68
3 months	16
6 months	13
1 year	9
2 years	6
3 years	5
5 years	4
5+ years	3

Journal of Child Psychology and Psychiatry
Volume 53, Issue 1, pages 16–25, January 2012

What does that tell us?

- Suicide risk is tremendously high AFTER we see our patients
- We need to consider suicide risk in all of our patients
- We need to ensure that follow-up teams are aware of the risk factors

THE REALITY OF WHAT WE DO

- We all:
  - ask about suicide
  - ask about suicidal behaviours and thinking
  - consider suicide risk in making follow-up appointments, referrals, and treatments
- **50% of full-time mental health professionals will have a person in care commit suicide**
- In a survey of psychiatrists, 38% experience "great distress" about suicide.

CURRENT PSYCHIATRY REPORTS Volume 14, Number 1, 79-85, DOI: 10.1007/s11920-011-0249-4

Documentation

- The problem is not in our individual approaches to suicide
- **Clinical decision-making** still remains the best-practice recommendation for suicide risk assessment

- Opportunities for improvement:
  - Having a standardized work flow
  - Organizational support and training around suicide risk assessment
  - **Documentation of our consideration of suicide risk**
  - Communicating risk to other staff, both internally and externally

APA Guidelines

TABLE 7. General Risk Management and Documentation Considerations in the Assessment and Management of Patients at Risk for Suicide

Good collaboration, communication, and alliance between clinician and patient

Careful and attentive documentation:

- **Risk assessments**
- **Record of decision-making processes**
- Descriptions of changes in treatment
- Record of communications with other clinicians
- Record of telephone calls from patients or family members
- Prescription log or copies of actual prescriptions
- Medical records of previous treatment (…)
  particularly treatment related to past suicide attempts

Critical junctures for documentation:

- **At first psychiatric assessment or admission**
- With occurrence of any suicidal behavior or ideation
- Whenever there is any **noteworthy clinical change**
- **For inpatients, before increasing privileges or giving passes and before discharge**

ASSESSING AND TREATING SUICIDAL BEHAVIORS: A Quick Reference Guide
DOI: 10.1176/appi.books.9780890423370.111619

The ASARI

Rationale of the ASARI

"The [suicide risk] assessment is comprehensive in scope, integrating knowledge of the patient's specific **risk factors**, **clinical history**, including psychopathological development and **interaction with the clinician**."

American Psychiatric Association. Practice guideline for the assessment and treatment of patients with suicidal behaviors [published correction appears in *Am J Psychiatry*. 2004;161:776]. *Am J Psychiatry*. 2003;160(11 suppl):1-60.

Important omissions occur when ***individual*** **risk and protective factors** are not assessed along with general risk factors.

Simon RI. Suicide risk: assessing the unpredictable. In: Simon RI, Hales RE, eds. *The American Psychiatric Publishing Textbook of Suicide Assessment and Management*. Washington, DC: American Psychiatric Publishing; 2006:1-32.

Rationale of the ASARI

… The documentation of the [assessment] should be **separately labeled in the psychiatric evaluation and in the progress notes** because of its singular importance …

… Identifying risk and protective factors that are scattered throughout the psychiatric evaluation **does not constitute an adequate assessment** …

… Risk and protective factors must be **pulled together into the process of analysis and synthesis** … to construct a clinical mosaic of the suicidal patient …

Simon RI. Psychiatric Times. Vol. 28 No. 11 December 1, 2011

The ASARI

- Goals of the document
  - Documentation & Communication of:
    - Suicide Risk Factors
    - Impressions and considerations
    - Treatments, and
    - Follow-Up
  - Easy to Fill Out (Goal is one page)

It is not intended to replace what you do, but to document what you do.

ASSESSMENT OF SUICIDE AND RISK INVENTORY

THIS INVENTORY IS FOR DOCUMENTATION PURPOSES ONLY

Suicide risk assessment may be performed by many methods, including patient & collateral interviews, review of documentation, and the use of standardized screening tools.

PATIENT IDENTIFICATION

SCREENING QUESTION O **DENIES SUICIDAL THINKING** O **ENDORSES SUICIDAL THINKING**

SEE REVERSE for an example of a screening pathway. An example screening question could be, "In the past month, have you considered suicide?"

Collateral Sources

CHRONIC RISK FACTORS	
Suicide Specific	
Prior Suicide Attempt	O
History of Suicidal Thinking or Behaviour	O
Patient Related	
History of Psychotic or Major Affective Disorder	O
Male Sex	O
History of Aggression	O
Ethnic or Cultural Risk Group	O
Chronic Illness Causing Severe Pain or Disability	O
System Related	
Family History of Mental Health Disorder	O
Family History of Suicide	O
History of Parental or Sibling Loss	O
History of Trauma, Abuse, Neglect	O
History of Frequent Change of Address	O

ACUTE RISK FACTORS	
Suicide Specific	
Recent Suicidal Thinking or Behaviour	O
Active Suicidal Ideation	O
Accessibility to Suicidal Means	O
Lethality of Suicidal Plan or Attempt	O
Patient Related	
High Anxiety / Agitation on Interview	O
Current Psychiatric Illness	O
Current Substance Misuse	O
No Compliance or Response to Treatment	O
Impulsivity	O
Hopelessness	O
System Related	
Recent Loss or Major Life Change	O
Lack of Social Supports	O
Lack of Professional Supports	O
Caregiver Unavailable or Inappropriate	O

Acuity Assessment of Suicide Risk

O **N/A** O **CHRONIC** O **CHRONIC with ACUTE Exacerbation** O **ACUTE**

Suicide Risk Assessment Rationale *(should also include protective or other factors used in assessing risk)*

Subjective assessment of Suicide Risk *(Based upon above and other sources, rate the subjective sense of suicide risk)*

O **LOW** O **MODERATE** O **HIGH**

Treatment/Interventions O No specific interventions recommended as risk felt to be baseline / low

O Admit to hospital unit:
O Consultation:
O Notification:
O Discussed safety planning
O Discussed removing lethal means

Follow-Up

Completed By **Signature** **Date** DD MM YY

Myths: Medicolegal Issues in Suicide Risk Assessment

1. **"Suicide Risk Assessment" is defined as "determining whether or not a person will kill themselves."**
   - No physician can predict suicide
   - SAD PERSONS, DIRT SLAP, etc, can often point to chronic risk factors that provide no sense of acuity
   - **The expectation is to assess suicide risk and to develop a plan for reducing the impact of identified risk factors.**

ASSESSING AND TREATING SUICIDAL BEHAVIORS: A Quick Reference Guide
DOI: 10.1176/appi.books.9780890423370.111619

Myths: Medicolegal Issues in Suicide Risk Assessment

2. **Documenting "denies suicidality" or "contracted for safety" is sufficient.**
   - In one study, 78% of inpatients who died by suicide reported "no suicidality" on their last interview. *Journal of Clinical Psychiatry, 2003:64(1)*
   - *The assessor is the enemy of suicide!*
   - "Contracting for safety" has **no** empirical support. (DBT contracting does)
   - **You must document your reasoning and judgment of risk**.

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Myths: Medicolegal Issues in Suicide Risk Assessment

3. **Documenting "high suicide risk" will force admissions or certifications.**
   - There is *no specific treatment for suicide risk*
   - A host of factors contribute to the decision to admit or certify
   - In general, higher acuity (not severity) necessitates certification or admission.
   - **You are obligated to establish a treatment plan that reduces or manages known risk factors.**

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EDITORIAL

Suicide Risk Assessment: What Is the Standard of Care?

Robert I. Simon, MD

J Am Acad Psychiatry Law 30:340–4, 2002

Documentation of suicide risk assessments … **can be done in a concise, time-efficient manner**. The failure to document suicide risk assessments [… will, upon review, suggest they …] were not performed.

EDITORIAL

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J Am Acad Psychiatry Law 30:340–4, 2002

Also, **when the clinician fails to describe her or his decisionmaking process** in the patient's record, [...there will be no evidence of ...] the complex issues involved in the assessment of the risk.

EDITORIAL

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Robert I. Simon, MD

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The lack of [this] documentation may allow the courts to focus narrowly on simpler aspects of the case, while overlooking the **clinical complexities and ambiguities** that exist with every patient who attempts or commits suicide.

The ASARI

- Free for any clinical or research use. (License is on document)
  - http://asari.ca for updates, documentation, and guides
  - Electronic version (tablet, laptop, echarting) coming soon
- Can be filled out by any discipline
  - (It may help inform risk assessment, but it guides the documentation of what you already do)
- Encourages communication

The ASARI

- Easy to Identify
  - Can be placed prominently in a chart, color allows for quick scanning
- Should not add unnecessary documentation
  - If you aren't separately discussing risk in its own paragraph, you SHOULD BE
  - If you are, you can now write "Please see ASARI"

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O Consultation:
O Notification:
O Discussed safety planning
O Discussed removing lethal means

Follow-Up

Completed By **Signature** **Date** DD MM YY

SCREENING AND COLLATERAL

ANALYSIS OF RISK FACTORS

DELIBERATION OF RISK ASSESSMENT

INTERVENTIONS FOR IDENTIFIED RISKS

ENSURING SPECIFIC FOLLOW-UP

ADOLESCENT SUICIDE - ASSESSMENT OF RISK INVENTORY
FOLLOW-UP WORKSHEET

PATIENT IDENTIFICATION

Treatment Outcomes

Subjective Assessment of Suicide Risk Direction

O IMPROVED O NO CHANGE O DETERIORATED
Recommended to update ASARI

Subjective Assessment of Suicide Risk

O LOW O MODERATE O HIGH

Acuity Assessment of Suicide Risk

O CHRONIC O CHRONIC with ACUTE Exacerbation O ACUTE

Treatment/Interventions

Follow-Up

Completed By **Signature** **Date** DD MM YY

Case Examples

Jessica White – 13 ♀ - OPD

Jessica White – 13 ♀ - OPD

- 16 y.o. brother died 6m ago in car accident
- Referred for depressive sypmtoms to OPD
- During Assessment:
  - Reports 5 DSM-IV-TR MDE symptoms
  - Moderate pathology, able to attend school with some difficulty
  - Attached to school counsellor
  - **Denies suicidal ideation, mother has no concerns. (screen negative and no MSE concerns)**
  - Family wondering about SSRI use as it's been 6 months

Jessica White – 13 ♀ - OPD

- DX: Though likely grief plays a large role, the impact on school and her worsening course suggest this may be:
  Major Depressive Disorder, Single Episode, Moderate
- TX:
  - Recommend IPT group to family
  - Gave advice re: SSRI (family and patient just want information at this time)
  - GP has good relationship and is glad to follow
  - Jessica wants to continue therapy with school counsellor.

James Monroe – 16 ♂ - UAC

James Monroe – 16 ♂ - UAC

- First Consultation – Front Desk pages you
  - “He’s here to see you but he looks very upset.”
- Arguing with MCFD SW upon approach, refuses to allow her to join meeting

James Monroe – 16 ♂ - UAC

- Review of file:
  - Previous hanging attempt 2y ago – serious attempt, closet hanger broke, led to CAPE stay + CART referral
  - Has had 2 recent alcohol poisoning ER stays and 1 recent cocaine intox. requiring ER stay
  - ++ aggressive during last ER stay, psychiatry consulted, sent to PLEA bed
  - Facing charges for assault of mother
  - Abusive father died by suicide 6 years ago, mother struggles financially with minimum-wage job / unemployment.

James Monroe – 16 ♂ - UAC

- On Interview:
  - Almost uninterviewable – tense, evasive, edgy, frequently slamming chair and threatening to run away
  - Mother + step father to attend today
    - Last night major fight regarding drug use
    - Assaulted mother, who wants to press charges
    - Mother refusing to answer phone, did not attend

James Monroe – 16 ♂ - UAC

- On Interview:
  - Frequent allusions to previous attempt
  - “I’ll do it proper this time”
  - Cannot get a hold of his girlfriend, “… doesn’t matter, she’ll leave me like everyone else anyway.”
  - ++ angry with suggestion to go to ER

James Monroe – 16 ♂ - UAC

- You elect to certify, notify CAPE and ER physician, and 9-1-1 is called to bring patient to ER. Security requested but not needed, James does go willingly.
- You cannot get a hold of mother, she is not answering her home phone or cellular phone

Sam Levine – 15 ♀ - ER (call)

Deviantart:
devBabsxStock

Sam Levine – 15 ♀ - ER (call)

- Multiple ER presentations / CAPE stays / P2
- Has presented to ER twice this week
  - 3d ago – fainting and “hearing voices” awake
  - 1d ago – fight with friend, took 15 tylenol RS
  - Today – cut self superficially after fight with another friend, called aunt. Aunt called foster parents (13+ years) and brought her to ER.

Sam Levine – 15 ♀ - ER (call)

- Current diagnosis is “bipolar II disorder”
  - On Quetiapine 300mg XR nightly,
    Fluoxetine 30mg daily
- Known severe history of neglect by biological parents (no longer in their care)
- Has DBT team (private), CYMH is on hold while DBT in place, also regularly sees school counsellor.
- ER CARE PLAN in place

Sam Levine – 15 ♀ - ER (call)

- She endorses suicidality, will “cut her self for real next time, you know, the right way.”
- Mitigating factors:
  - A known co-patient friend of hers is currently on CAPE. ++ suspicions on CAPE that they are colluding to be patients together
  - Seems ++ rehearsed. MSE inconsistent with her report. Witnessed “hallucination” – patently fabricated.
  - Previous hospitalization resulted in daily codes being called for factitious / rescue-able suicide attempts

Sam Levine – 15 ♀ - ER (call)

- Plan:
  - Reinforce care plan
  - Continue to present to hospital for emergency care
  - Recognizing hospitalization's toxicity, will not admit as poor coping strategies and chronic risk factors are unlikely to be changed by a CAPE stay
  - DBT Therapist contacted by phone, understands plan, able to see her tomorrow
  - Aunt will house her tonight, aware of reasons to activate emergency interventions