Updated: May 31, 2012

Suicide Risk Assessment in Children & Adolescents

Using the Evidence

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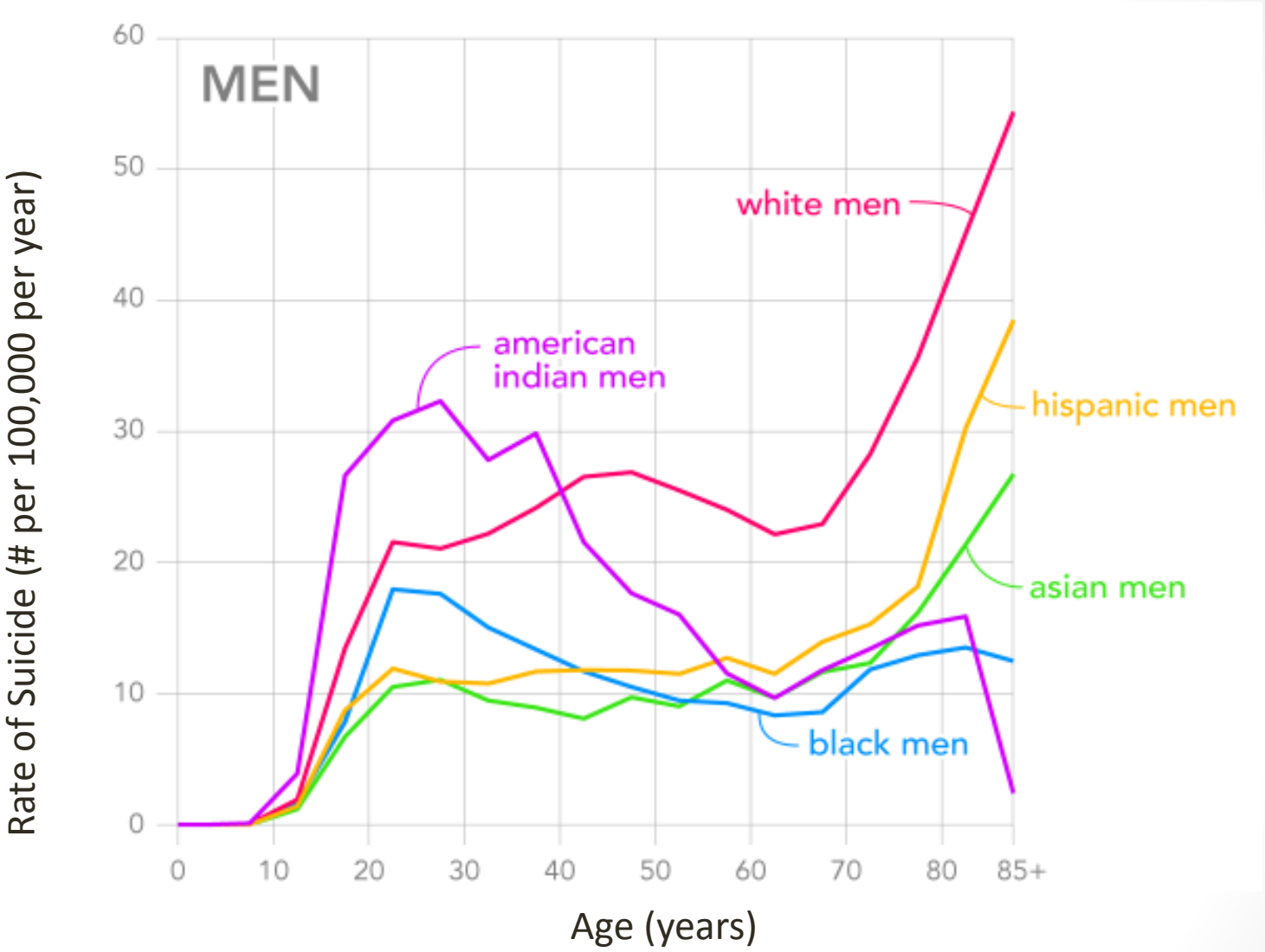
Learning Objectives

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.

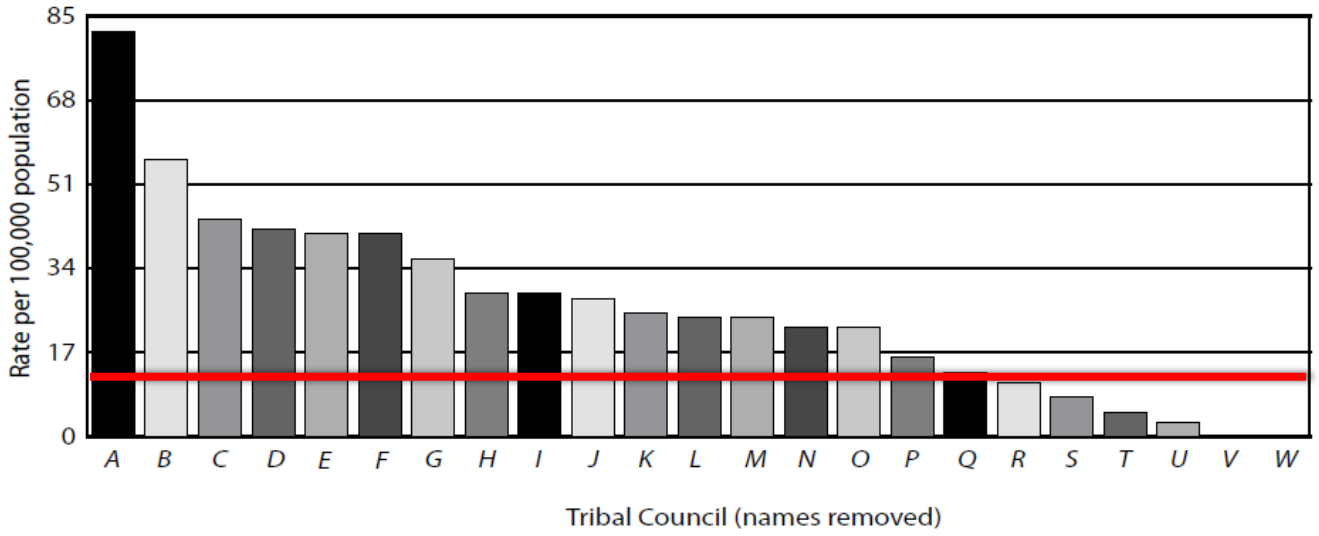
Race



U.S. Data (2006), census.gov

Caution: “Aboriginal”

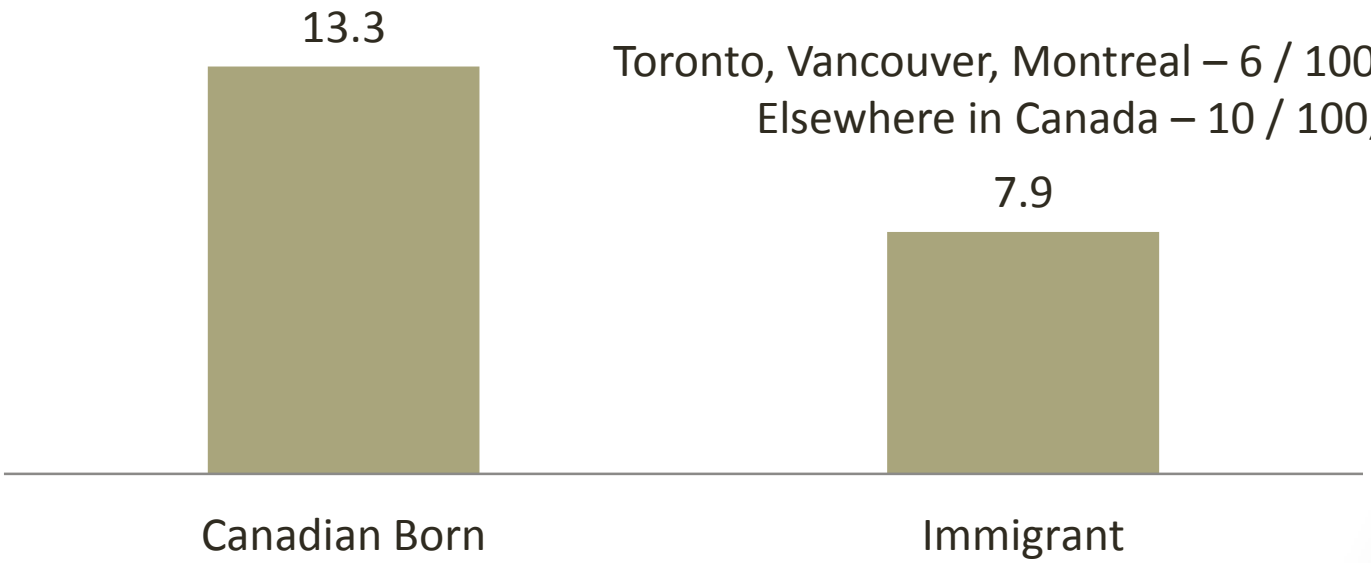
Figure 2-6) Average Annual Suicide Rate in British Columbia First Nations by Tribal Council, 1993–2000



Source: Lalonde, 2001.

Immigration Status

Suicides per 100,000 people
Canada, 1995-1997



Toronto, Vancouver, Montreal – 6 / 100,000
Elsewhere in Canada – 10 / 100,000

Source, “Suicide in Canadian Immigrants”, Statistics Canada, 2004

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

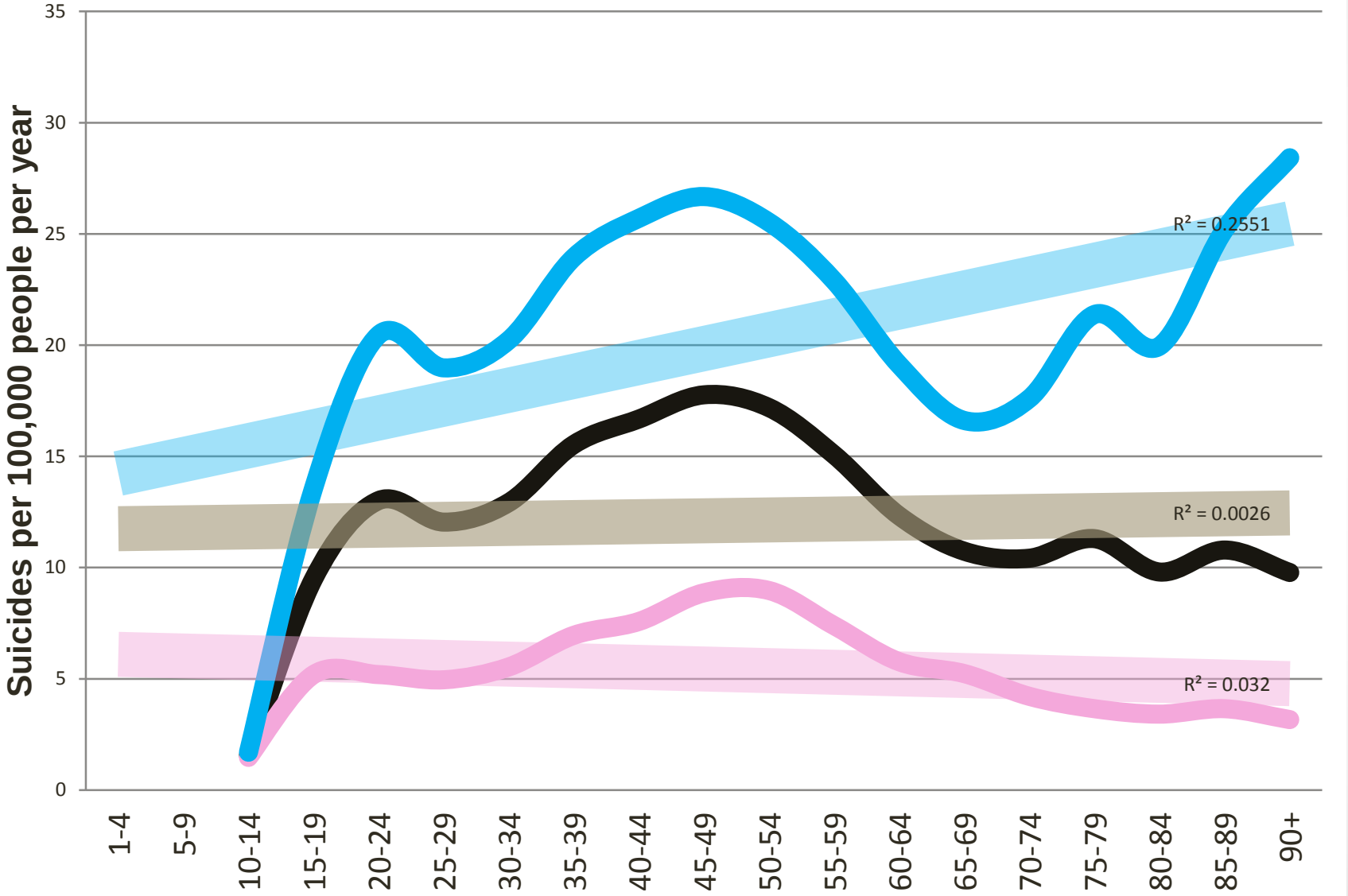
Race, Culture, and Immigration Status

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.

Age

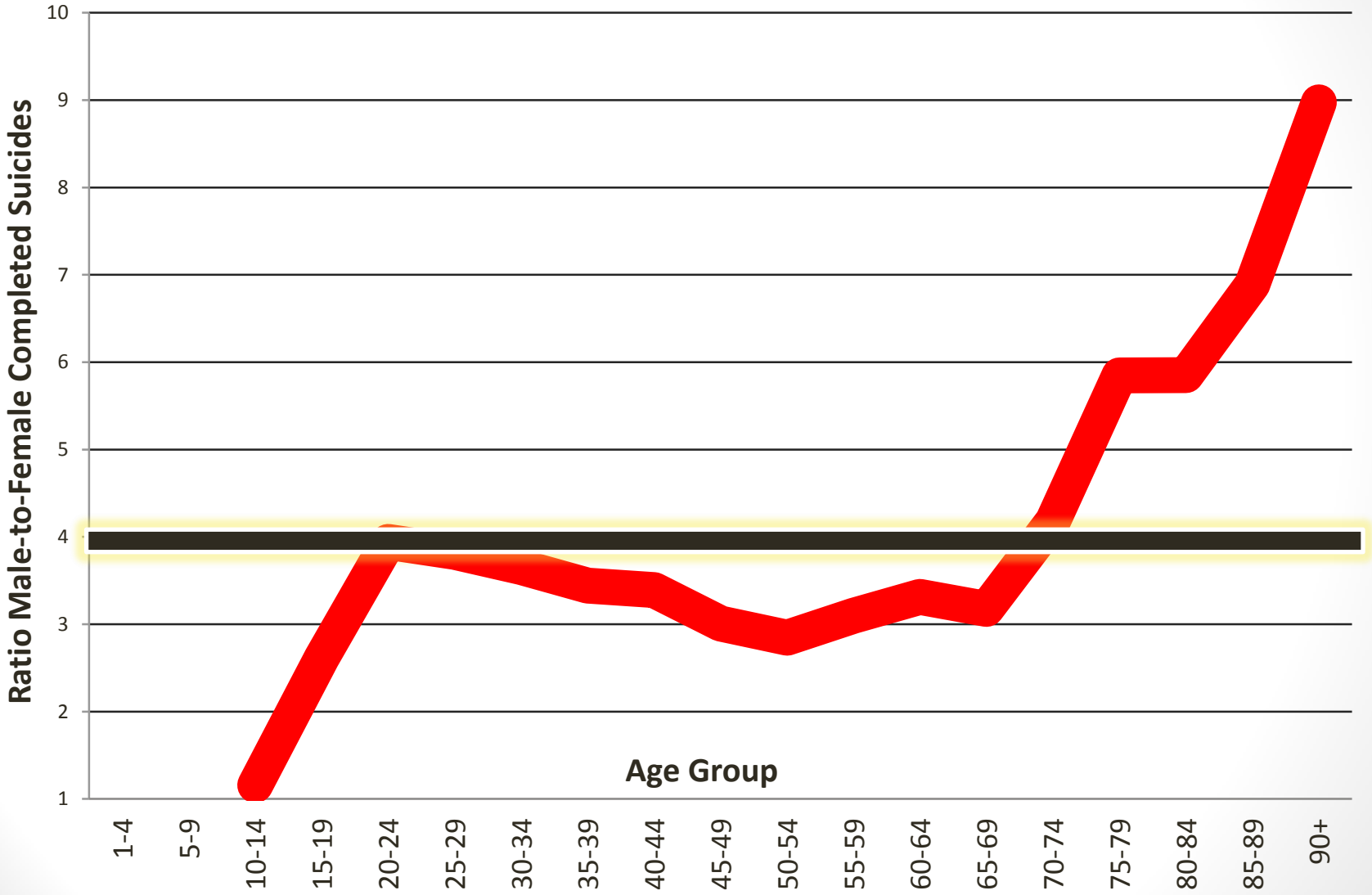
Suicides in Canada, 2000-2008
Males, Females, and Both



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

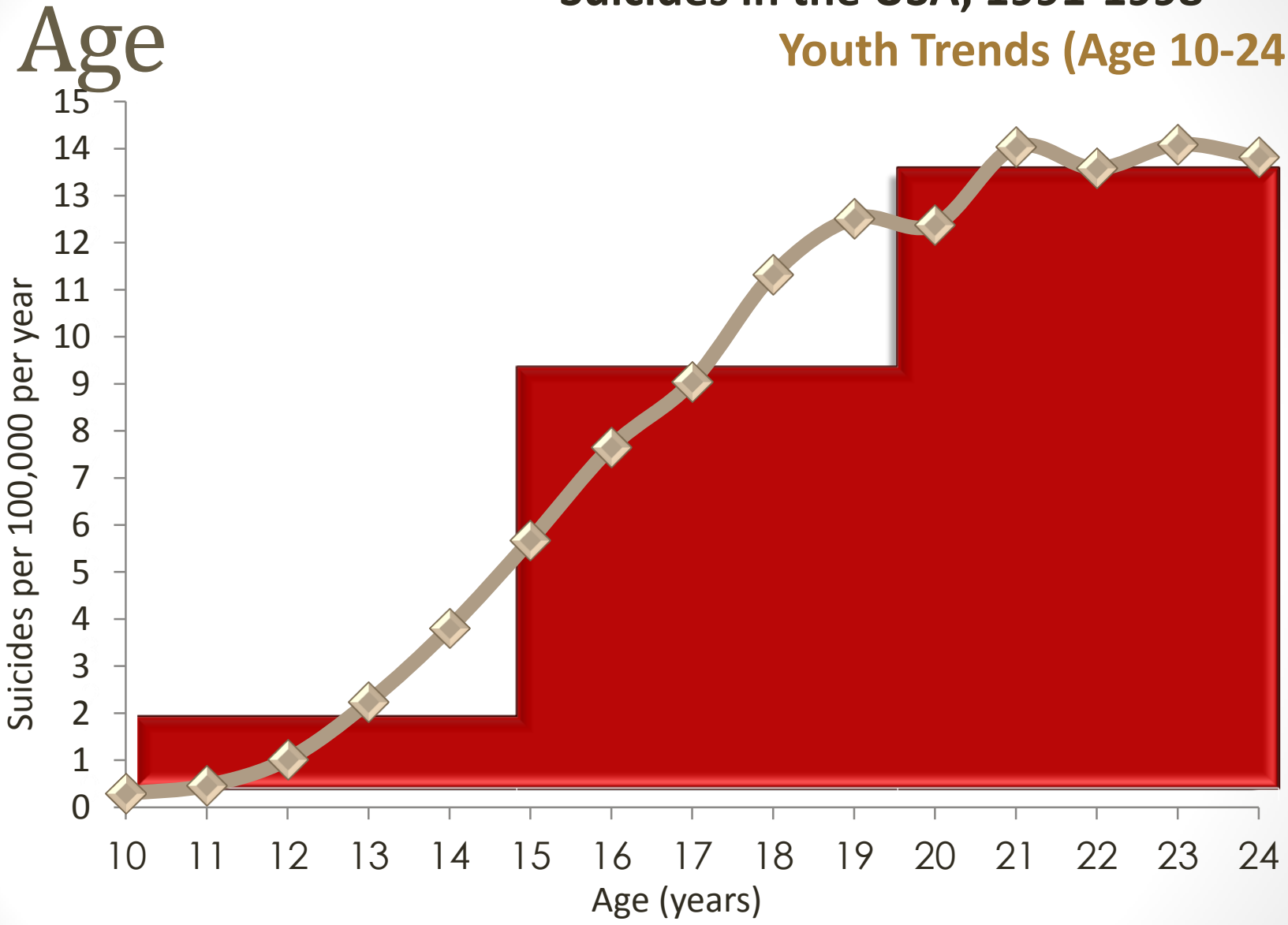
Suicides in Canada, 2000-2008
Male to Female Ratio



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.

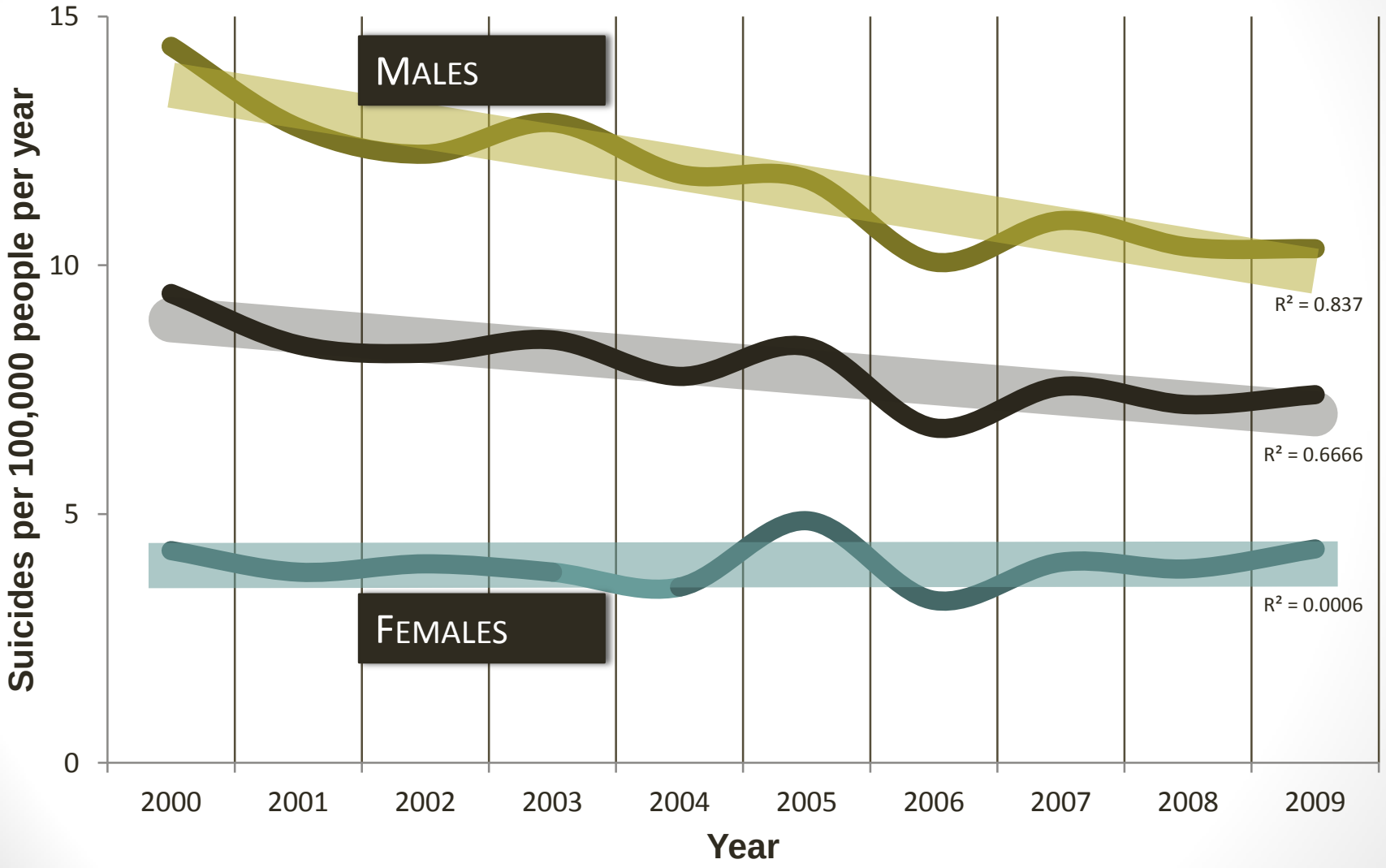
Suicides in the USA, 1991-1998

Youth Trends (Age 10-24)



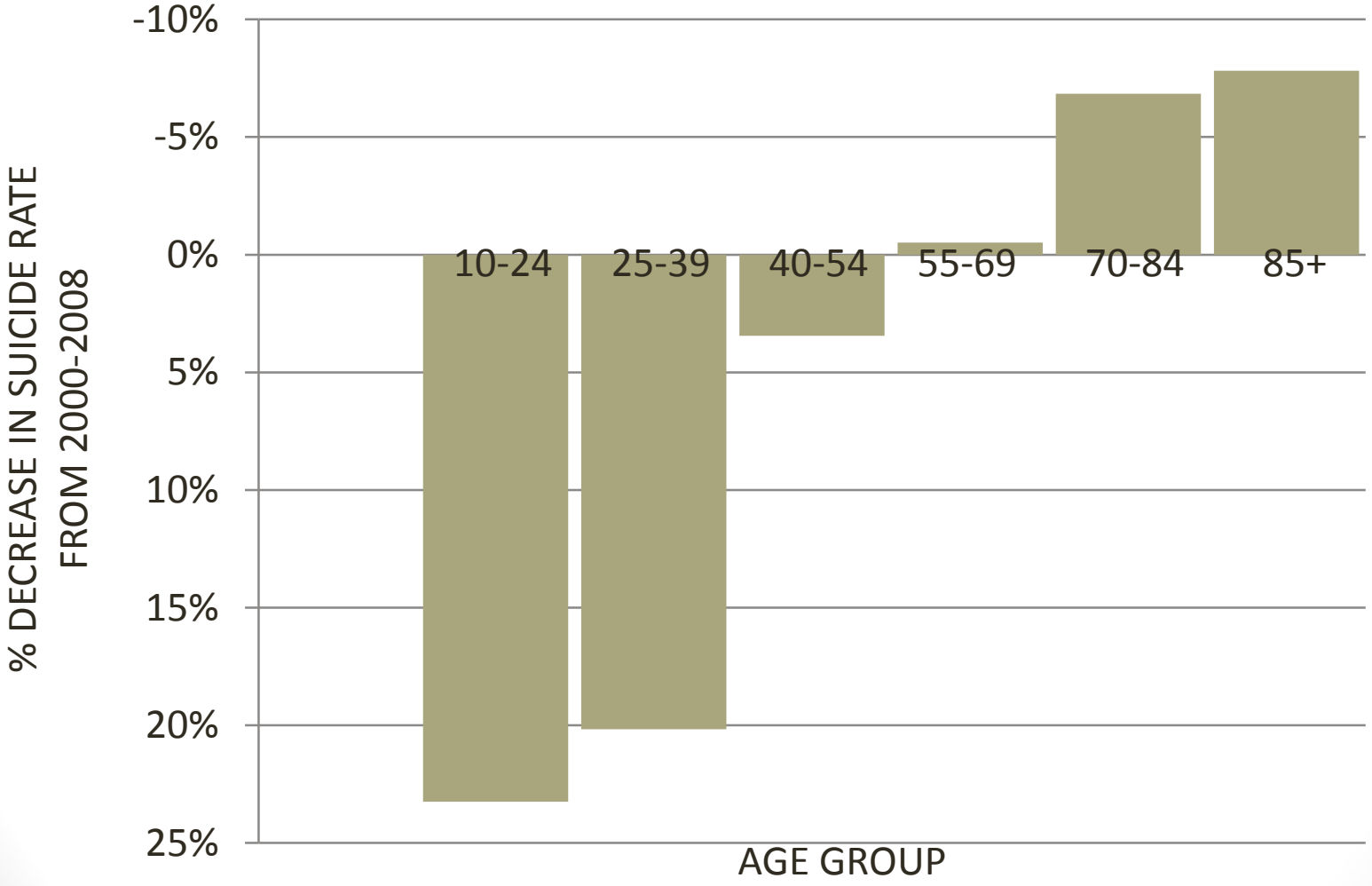
1991-1998 Data, Web-based Injury Statistics Query and Reporting System compiled by presenter (2010)

Trends of Youth Suicide



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, 2012-5-31.

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)

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

Mental Illness & Suicide

Lifetime Prevalence of Suicide in Mood Disorders:

Hospitalized for mood disorder + suicidal	8.6%
Hospitalized for mood disorder	4.0%
Treated for depression as outpatient	***1.8%***
Non-mood disorder	0.3-0.5%

Am J Psychiatry 157:1925-1932, December 2000

Mental Illness & Suicide

Lifetime Prevalence of Suicide in Schizophrenia:

- Cited by over 270 journals & major texts as 10%
  - 1977 Review of 34 articles

    Miles CP. Conditions predisposing to suicide: a review. *J Nerv Ment Dis.* 1977;164:231-246
  - 1990 Follow-up longitudinal studies

    Tsuang MT. Suicide in schizophrenics, manics, depressives, and surgical controls: a comparison with general population suicide mortality. *Arch Gen Psychiatry.* 1978;35:153-155.
- Flawed statistics!

- Reanalysis: (multiple confirmations)
  - At time of first diagnosis
  - Lifetime risk = 4.9% (4.3%-5.6%)

Arch Gen Psychiatry. 2005 Mar;62(3):247-53.

Mental Illness & Suicide

The Evidence:

- Lifetime risk in all mood disorders = 2.2%
- Lifetime risk in **schizophrenia** = 4.9%
- Lifetime risk in bipolar disorder = 6%
- Lifetime risk in addictions = 8% +
- Lifetime risk in eating disorders = 8-10% (?)
- Lifetime risk in borderline PD = 5-10% (?)

Arch Gen Psychiatry. 2005 Mar;62(3):247-53.
Am J Psychiatry 157:1925-1932, December 2000

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.

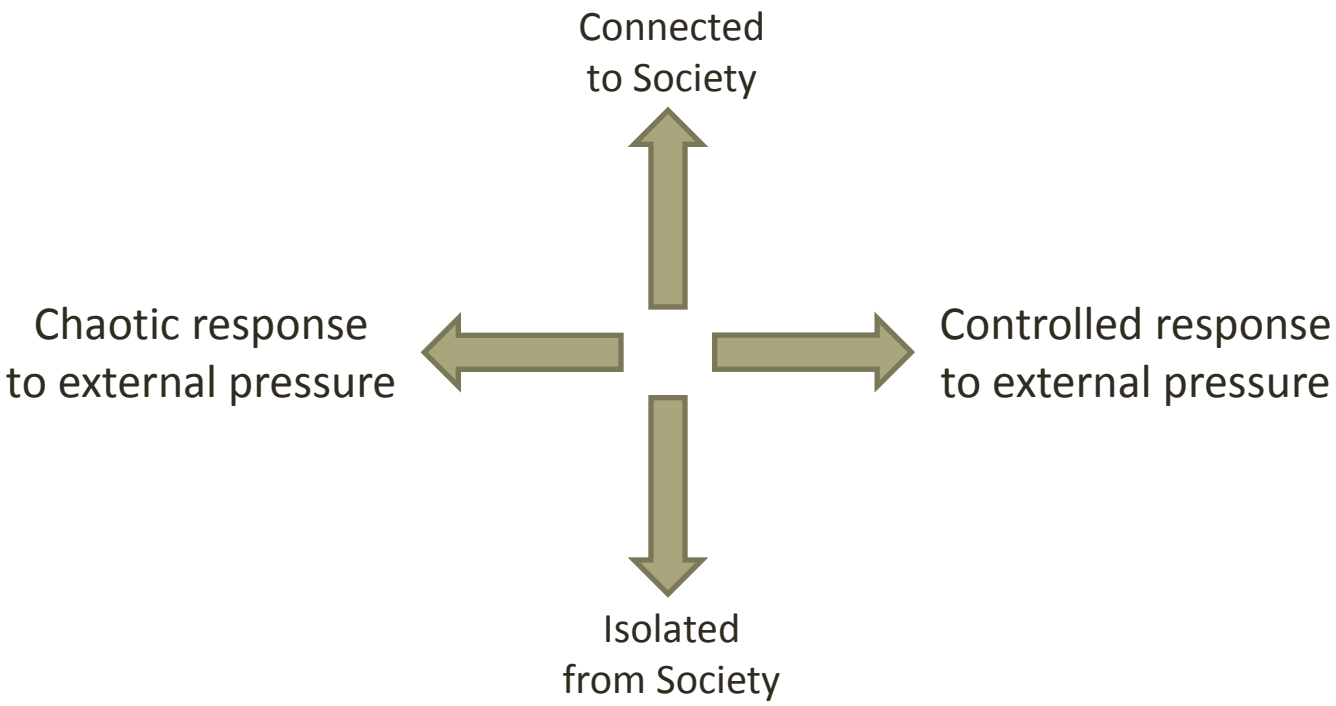
Freuchen et al. Child and Adolescent Psychiatry and Mental Health 2012, 6:1
Psychol. Med. 2003 Apr;33(3):395-405.

Opportunities for Intervention

- Only 15% of youth who die by suicide have ever been hospitalized for psychiatric reasons
- <30% 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

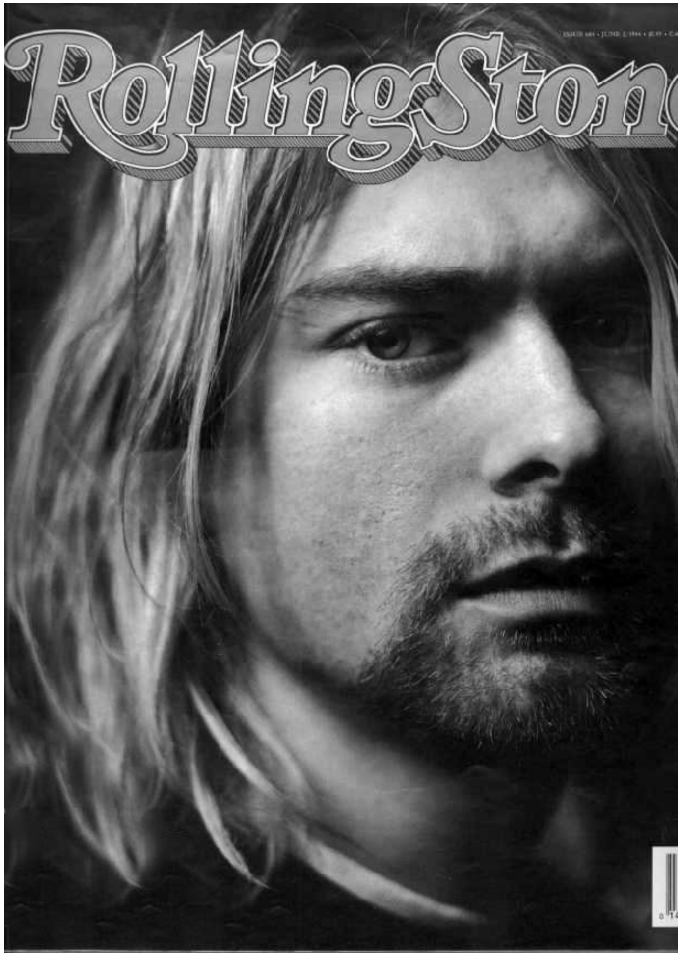
Motivations for Suicide



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

please Keep going Courtney

CAPT

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 – Escape (Fatalistic)

April 22, 1945 – Russia in Berlin, "Germany is Lost"

April 28, 1945 – Mussolini executed, "I will not have that happen to me"

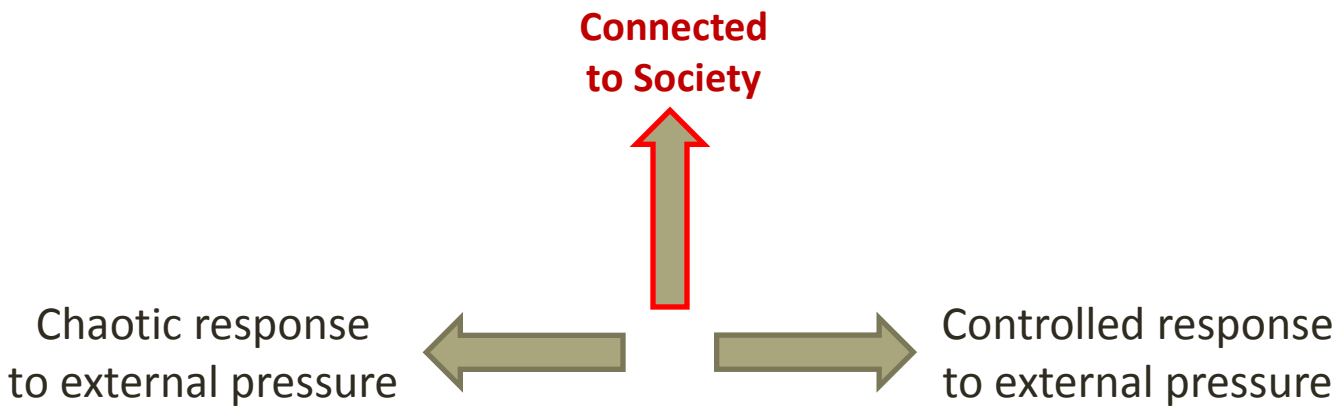
April 30, 1945 – Suicide by cyanide ingestion and gunshot to head

In Children & Adolescents

Fatalistic Suicidal Motivation

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

Motivations for Suicide



Motivations - Isolation

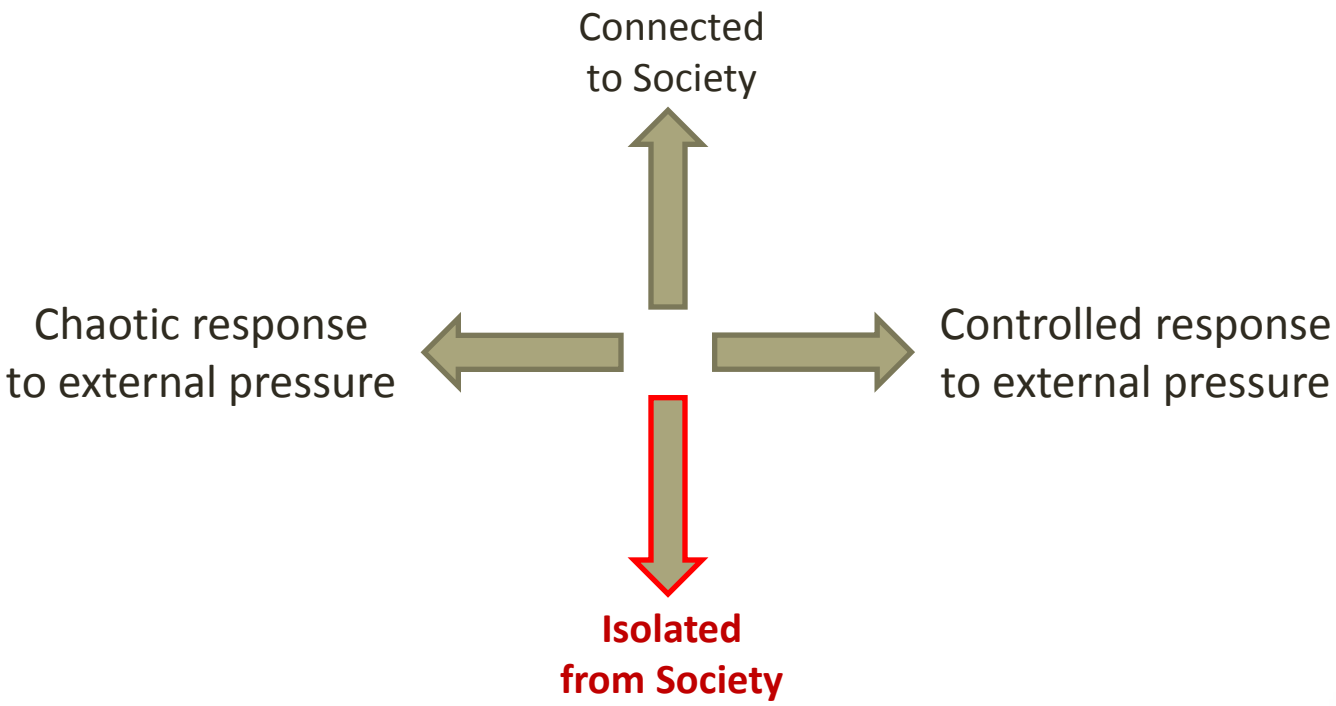
- (Egoistic suicide) – not connected to others or community

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

Egoistic 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

One other motivation…

- … No motivation to actually die.

Motivations for Suicide

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 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

Suicide in Children and Adolescents

THE CASE FOR SUICIDE SCREENING EXPANSION

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

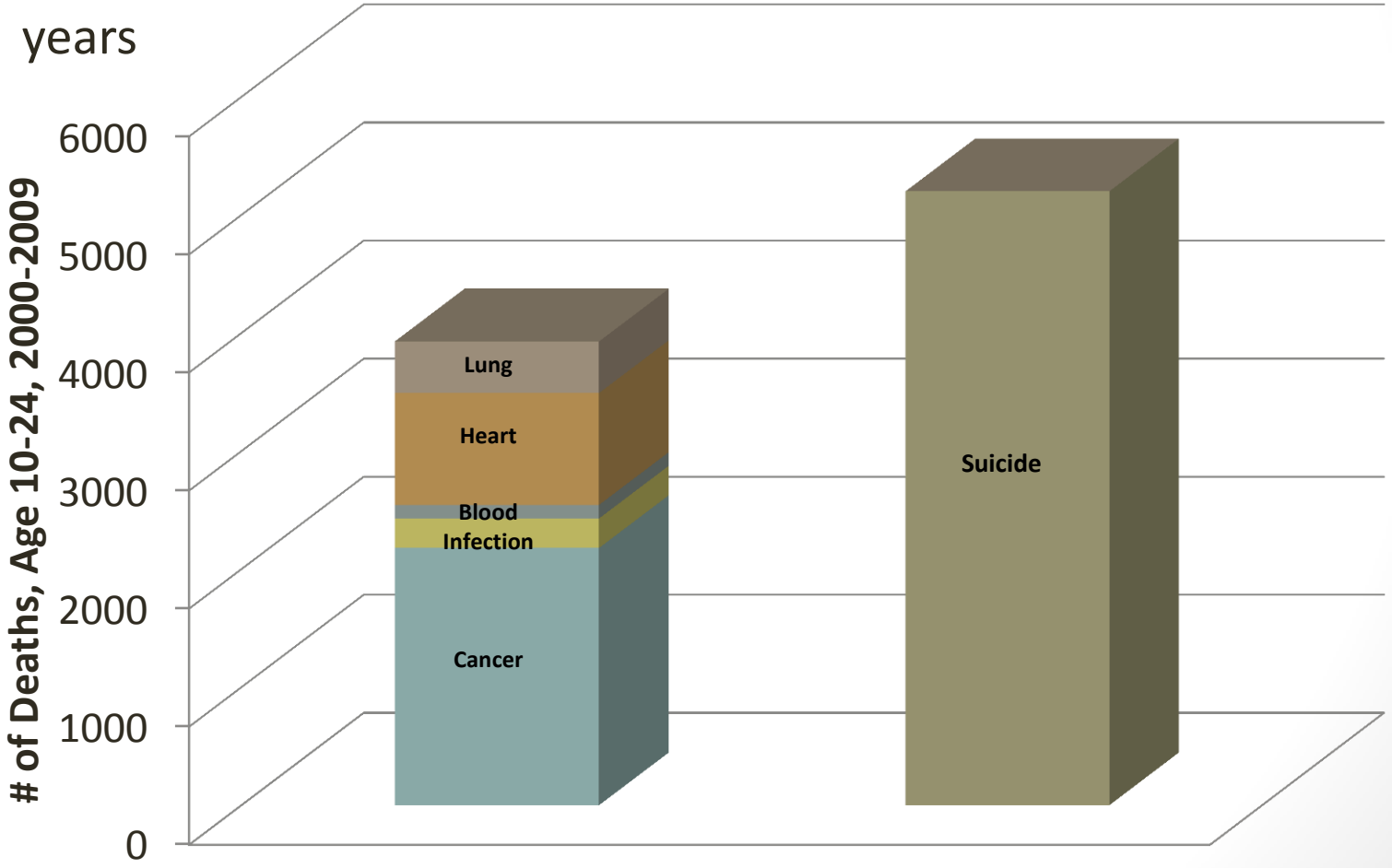
If every mental health professional could *magically protect* every person they saw for an entire month…

… 75% of all suicides would still occur.

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

Child and Adolescent Suicide

- Suicide is the 2nd leading cause of death in people aged 10-24 years



Statistics Canada, 2009 data, compiled via CANSIM by presenter

Youth Distress

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

- BC Study! (4th one done, 2008)
- 29,000 BC Students Grade 7-12
  - 50 of BC's 59 School districts.

Prevalence

“so much stress [they] could not function”

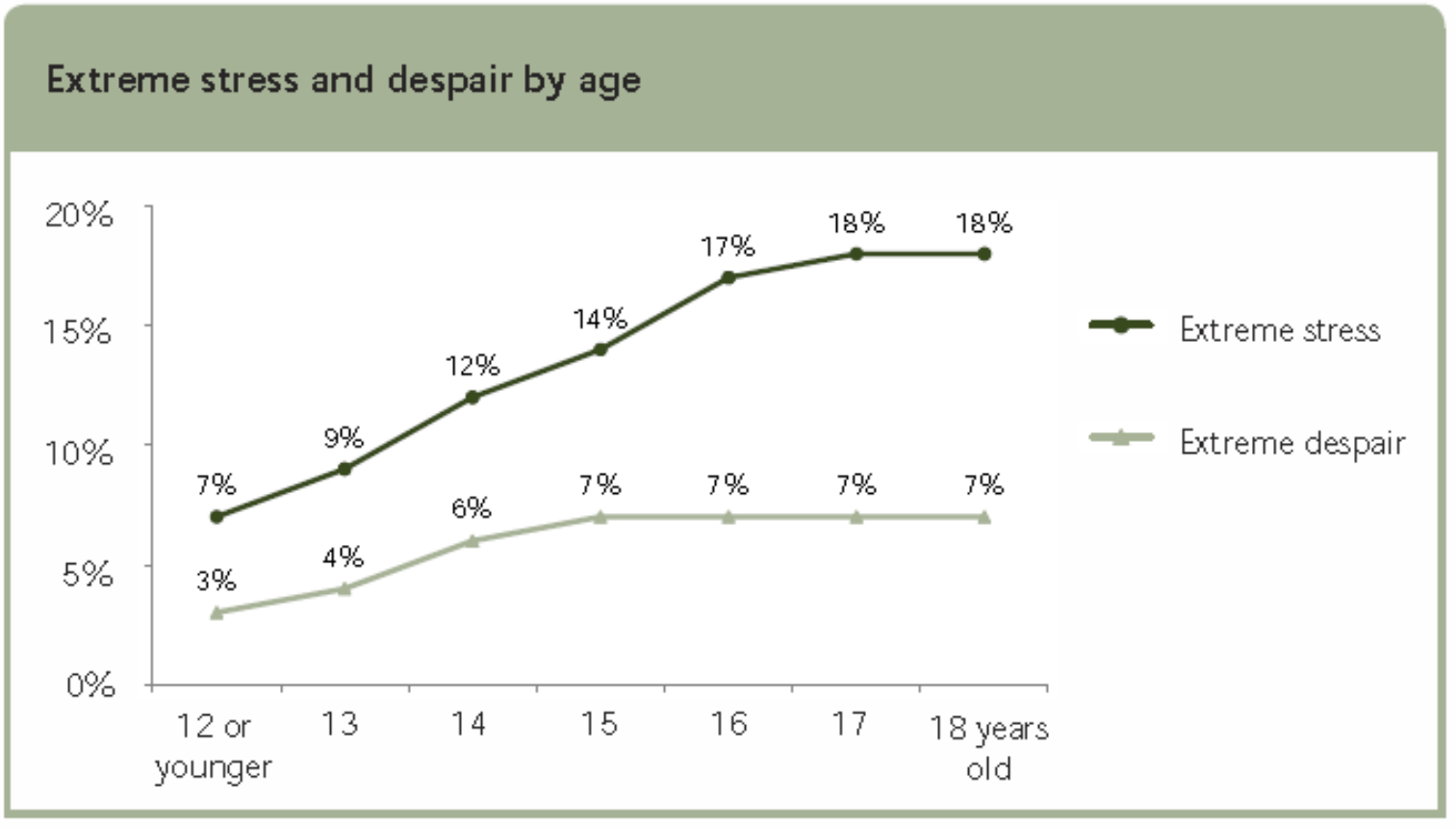
14% (1 in 7 adolescents)

“despair such that [they] wondered if anything was worthwhile”

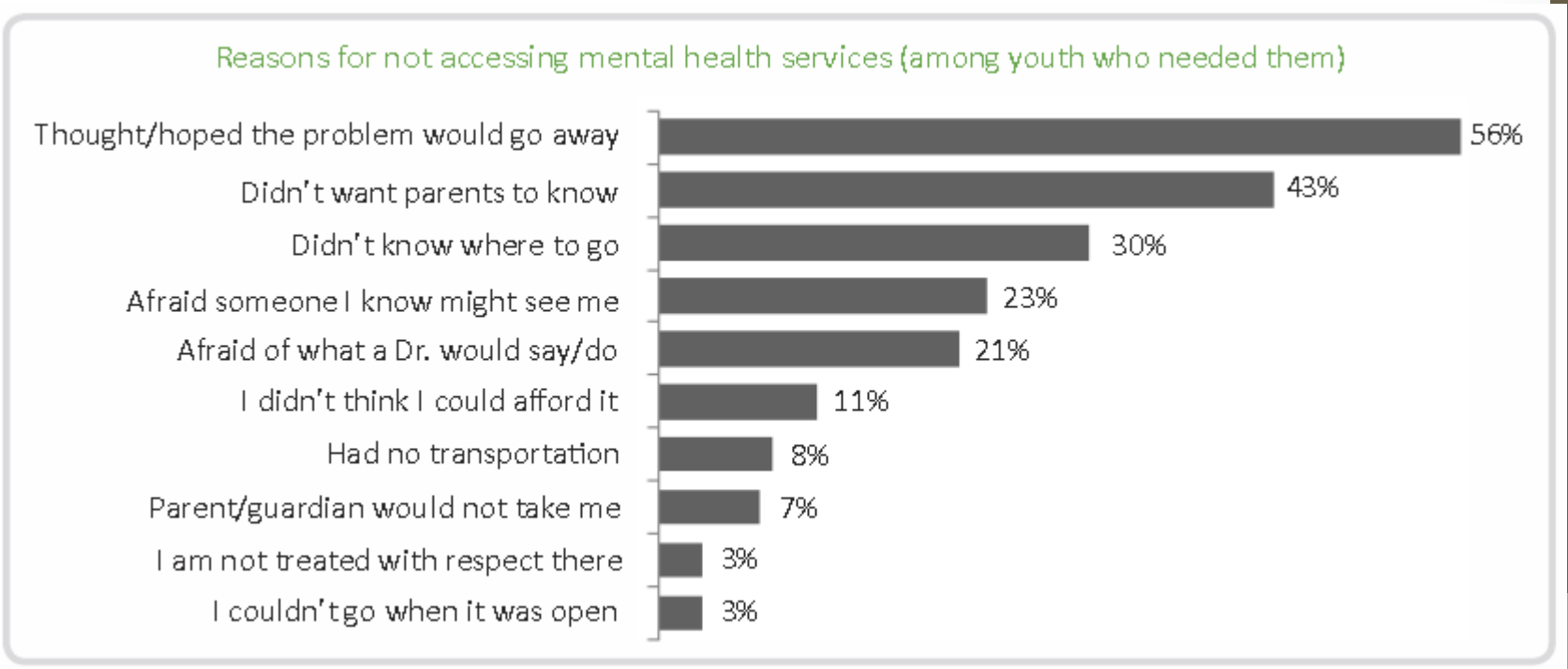
6% (1 in 17 adolescents)

Females 2x as likely to report the above

Prevalence


Extreme stress and despair by age
20%
15%
10%
5%
0%
7%
9%
12%
14%
17%
18%
18%
3%
4%
6%
7%
7%
7%
7%
12 or younger
13
14
15
16
17
18 years old
Extreme stress
Extreme despair

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



Suicide in Children and Adolescents

SCREENING FOR SUICIDE

Age-appropriate considerations

- Risk of completed suicide <10y is **very** low

  Therefore, asking about suicidal thinking should likely start after age 10

- Rate of **significant stress** <10y is ~3-5%
- Rate of **despair** <10y is 2-4%

  Therefore, it makes sense to consider asking about stress and feeling hopeless at any age!

Can I harm youth by asking about suicide?

- Studies tell us “no”
- The best study (n=2500) in 2005 showed:
  - No distress at the time of asking
  - No distress 3 days or 3 weeks after asking
  - **Children who were depressed or suicidal felt better after being asked this question even in a survey**.

Gould MS, M. F. (2005). Evaluating iatrogenic risk of youth suicide screening programs: a randomized controlled trial. *Journal of the American Medical Association*, 293:1635-1643.

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?"**

Suicide in Children and Adolescents

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	Changeable
Age	Access to Lethality
Sex	Untreated Mental Health Disorder
Family History of Suicides	Worsening Mental Health Disorder
Family History of Mental Disorder	Dealing with Recent Loss/Life Crisis
Prior Attempts of Suicide	Lack of Social or Formal Support
Cultural Beliefs	No Access to Health Care
Historical Diagnosis of Psychiatric DO	Non-response to Medication
Historical use of Psychotropic Meds	Caregiver/Family Unavailable to care
Remote Loss	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?

- 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)

Myth

- Hospitalization of suicidal patients protects them. (*hospitalization treats suicidality)*

- The Evidence:
  - Inpatient, close-observation suicides account for ~1,800 deaths in North America per year.

Journal of Clinical Psychiatry, 2003:64(1)

Suicide in Children and Adolescents

DOCUMENTING WHAT YOU DO

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

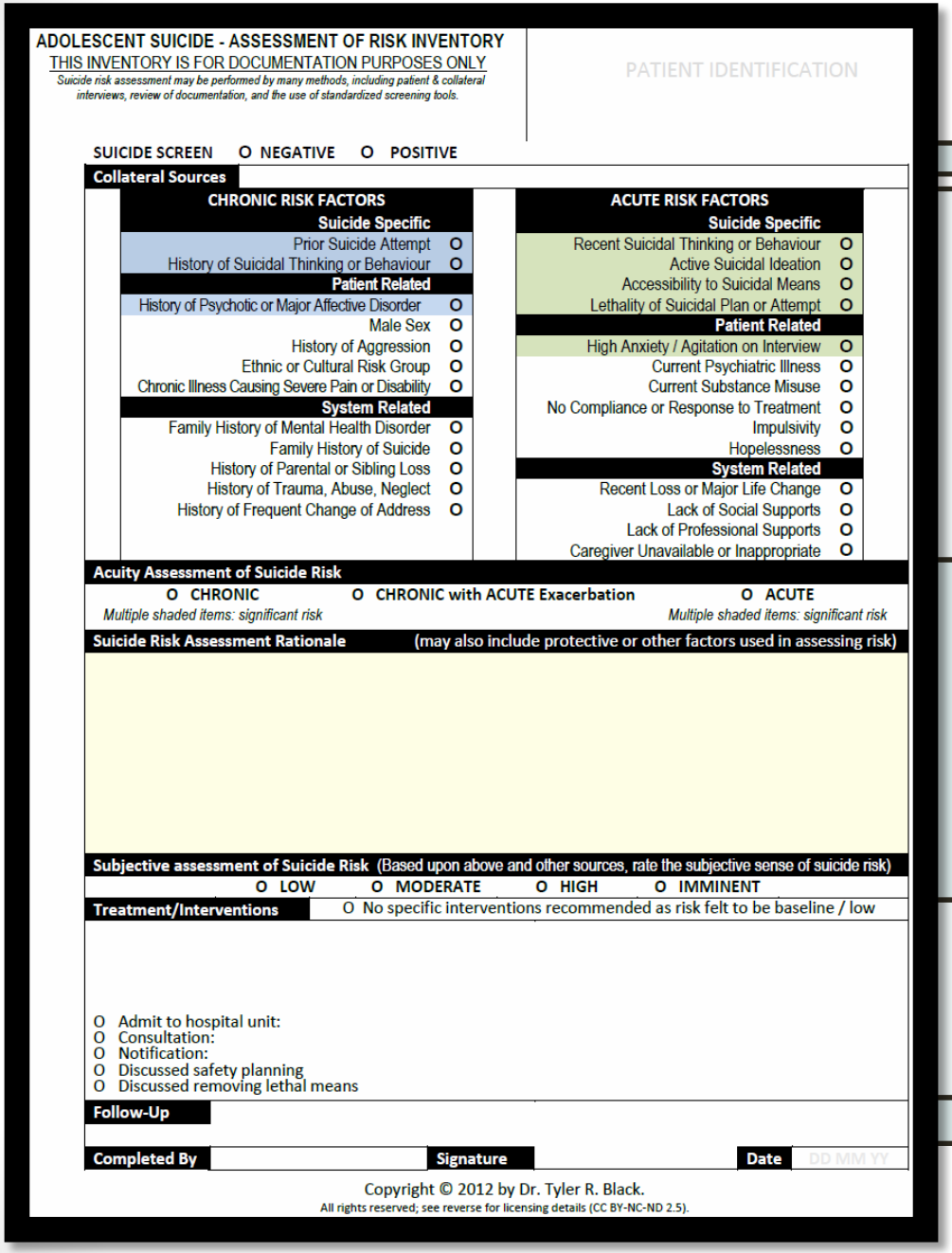
Assessment of Suicide and Risk Inventory

INTRODUCTION TO THE ASARI

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.



ADOLESCENT SUICIDE - ASSESSMENT OF 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

SUICIDE SCREEN O NEGATIVE O POSITIVE

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 CHRONIC — *Multiple shaded items: significant risk*

O CHRONIC with ACUTE Exacerbation

O ACUTE — *Multiple shaded items: significant risk*

Suicide Risk Assessment Rationale (may 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 O IMMINENT

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

SCREEN

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

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

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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WHAT RISK FACTORS DO HOSPITALIZATIONS ADD TO?

- **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**

RATIONALE OF ASARI – LEGAL?

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.

RATIONALE OF ASARI – LEGAL?

EDITORIAL

Suicide Risk Assessment: What Is the Standard of Care?

Robert I. Simon, MD

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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.

RATIONALE OF ASARI – LEGAL?

EDITORIAL

Suicide Risk Assessment: What Is the Standard of Care?

Robert I. Simon, MD

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

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)
  - Q4 2012 – 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
- 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"

Conclusion

- Epidemiology
  - Age 10-24 increasing risk, at-risk populations identified
  - Caucasians greatest lifetime risk, but all races at risk
  - Hopefully many “myths” busted
- Motivations for Suicide
- The Case for Screening Expansion
- Screening for Suicide
- Assessing Suicide Risk
- Documenting Suicide Risk

Conclusion

- Epidemiology
- Motivations for Suicide
  - Response to external pressure – Connection to Community
  - Target treatment based upon identified motivation
  - No motivation to actually die represents most “suicidal” presentations
- The Case for Screening Expansion
- Screening for Suicide
- Assessing Suicide Risk
- Documenting Suicide Risk

Conclusion

- Epidemiology
- Motivations for Suicide
- The Case for Screening Expansion
  - 2nd leading cause of death (10-24)
  - More deaths by suicide than most medical illnesses combined
  - Current “detection” (send identified kids to hospital) ineffective
- Screening for Suicide
- Assessing Suicide Risk
- Documenting Suicide Risk

Conclusion

- Epidemiology
- Motivations for Suicide
- The Case for Screening Expansion
- Screening for Suicide
  - <10: ask about stress, >10, ask about harm or despair, >12 suicide
  - Should be done throughout the community
  - More research needed in identifying pre-”suicidal” youth
- Assessing Suicide Risk
- Documenting Suicide Risk

Conclusion

- Epidemiology
- Motivations for Suicide
- The Case for Screening Expansion
- Screening for Suicide
- Assessing Suicide Risk
  - Collateral, Confidence, Common Sense, Changeability
  - Identify Chronic vs. Acute Risk Factors to help guide treatment
- Documenting Suicide Risk

Conclusion

- Epidemiology
- Motivations for Suicide
- The Case for Screening Expansion
- Screening for Suicide
- Assessing Suicide Risk
- Documenting Suicide Risk
  - ASARI highly recommended
  - Complete risk assessment includes identification of risk and synthesis of risk considerations