

Opportunities and Challenges in Suicide Risk Assessment

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Received: June 07, 2019; **Published:** July 31, 2019

Abstract

Suicide is now understood as a multidimensional determined outcome, which results from a complex interaction of biological, genetic, psychological, sociological and environmental factors. According to the World Health Organization (WHO), suicide is globally among the top 10 causes of death worldwide. Good clinical care includes ongoing suicide risk assessment and management but this process can be challenging for clinicians.

Suicide risk assessment and suicide risk management are clinical competencies that are applied by mental health and health care providers throughout the period of patient care. There is a need for a clear and concise approach to suicide risk assessment and management and this article highlights some of the important challenges faced by clinicians in suicide risk assessment. It also points to opportunities in better patient care by providing on going suicide risk assessment and management in addition to creating more helpful instruments to be used in suicide risk assessment. A new tool has been suggested to help clinicians in this process.

Keywords: *Suicide; Risk Assessment; Tool; Instrument; Self-Harm*

Introduction and Background

Suicide is now understood as a multidimensional determined outcome, which results from a complex interaction of biological, genetic, psychological, sociological and environmental factors. Not all of these factors are present nor are they equally weighted in all suicides. Thus, the outcome of any one suicide may be the result of factors or weighting of factors that can be different from those related to any other suicide. The experience of suicide can touch almost every person, family and community. There exists a stigma related to suicide and this stigma may be a barrier to help-seeking for individuals who are contemplating suicide [1].

According to the World Health Organization (WHO), suicide is globally among the top 10 causes of death and the second leading cause of death in people aged 15 - 29 years. In 2012, about 804,000 people died by suicide globally, accounting for 1.4% of deaths worldwide with an average population rate of about 11.4/100,000.

The psychological and social impact of suicide on the family and society is immeasurable. On average, a single suicide intimately affects at least six other people. If a suicide occurs in a school or workplace it can have an impact on many of those who are present or on site in those locations. Some high profile suicides can have substantial impact on communities as well.

In the United States, suicide is the 10th leading cause of death for all ages. More than one person dies by suicide every 15 minutes in the United States (US Department of health and Human services-DHHS, 2012). In 2011, over 8 million adults reported having serious thoughts about suicide and over 1 million reported a suicide attempt (Substance Abuse and Mental Health Administration-SAMSHA, NSDUH Report, 2011) [2-7].

Method

The author reviewed the findings from the relevant literature in the past 10 years (2009 - 2019) regarding the suicide risk assessment and management. The following databases were searched: PubMed, Medline, Embase and the Cochrane library.

Only review articles were searched and screened for relevance and multiple filters were applied. A working group including 6 psychiatrists, one psychologist, one clinical social worker, 4 nurses and one occupational therapist examined the relevant suicide risk assessment and management tools and a new tool was created based on the relevant literature and clinical experience. The tool was sent to relevant stakeholders for comments and suggestions. The working group met again and finalized the tool. The working group suggested a window of a 2 year period to validate this new tool. The results include the clinical opinion of the author in addition to relevant literature findings.

Results and Discussion

Suicide risk assessment

Suicide risk assessment and suicide risk management are clinical competencies that are applied by mental health and health care providers throughout the period of patient care. Suicide risk assessment refers to the health provider's evaluation of suicide probability for a patient that occurs at every point of patient contact. This assessment can be applied with various degrees of intensity and can be assisted by the use of certain assessment tools that can be applied in specific situations. Not every point of patient contact requires the same degree of risk evaluation, but every point of patient contact requires a degree of risk evaluation. The degree of evaluation is based on clinical judgment, knowledge of the patient and knowledge of the patient's circumstances. It can include information obtained directly from the patient or from collateral sources.

Over the course of clinical contact with a patient, suicide risk may change. For example: the emergence of specific symptoms (such as command hallucinations telling the person to take his/her life or the emergence of hopelessness within the context of a Depressive episode); worsening of the clinical condition (such as increasing severity of a Depressive episode or increased substance use); emergence of significant life events (such as loss of a loved one or the suicide of a friend or admired person); changes in clinical care situations (such as discharge from hospital or post emergency room visit care) can all increase suicide risk during the time course of clinical care. Thus, suicide risk assessment is an ongoing process.

Good clinical care includes ongoing suicide risk assessment and management.

Suicide risk assessment and suicide risk management are both the individual responsibility of every health care provider and the collective responsibility of the entire health care team involved with any specific patient. Communication amongst members of the health care team about patient suicide risk is an important part of ongoing care.

The World Health Organization recommends that all people over the age of 10 years with a mental disorder or other risk factor should be asked about thoughts or plans of self-harm within the past month.

Most guidelines encourage the use of standardized process for SRA.

One observational UK study found that the process of assessment itself correlated with a lower likelihood of future suicidal Behavior (Olfson M 2013). This speaks to an often overlooked aspect in risk assessment: that Clinician-patient contact can provide an important therapeutic effect [8].

A suicide risk assessment will enable a trained health care provider to determine the probability of death by suicide in the short term (usually over a period of hours to a few days). Long-term predictions are not reliable, thus suicide risk assessment is a continuous process. For some patients, increased risk for suicide can be an acute phenomenon while for others it can be a chronic phenomenon. For some patients who are at chronically elevated risk for suicide, acute exacerbations of that risk can occur.

Difficulties and challenges in suicide risk assessment

Suicide risk assessment is an inexact activity. Many people who are considered to be at high risk for suicide, never die by suicide and some who are not so considered do. There are several challenges in conducting a suicide risk assessment:

- Clinicians commonly rely on subjectively reported information, which does not always provide a full picture of the risk. Collateral information can provide a more complete picture of risk.
- Suicide risk assessment scales do not accurately predict death by suicide. They may be useful as a clinical tool or as documentation of the type of suicide risk assessment that was done but cannot be used for suicide risk assessment by individuals not trained in suicide risk assessment.
- There is a lack of consistency in the education and training of health care providers in the competencies needed to conduct a suicide risk assessment. Suicide risk assessment requires training, a good understanding of the patient, their condition and their circumstances and clinician awareness that risk is not a static phenomenon and that risk can change over time. It is the responsibility of the health care provider to conduct the most appropriate degree of suicide risk assessment at every patient contact and if information on patient status is received in periods between patient contact points.
- Suicidal behaviour can produce intense emotional responses from clinicians. When these emotions are unrecognized, they can create negative reactions on the part of the clinician that limit their ability to work effectively with people who are acutely suicidal.
- A barrier to assessment is the belief held by some clinicians that asking about suicidal thoughts will induce such thoughts in patients. In the clinical setting, asking about suicide ideation or plans does not increase the risk of suicide. On the contrary, it decreases the risk of suicide as it identifies individuals who are at higher probability of imminent death by suicide and thus is part of ongoing suicide risk assessment. However, there is no substantial data available to provide the answer if outside of the clinical setting, asking people about suicide ideation or plans either decreases or increases risk of death by suicide. According to Bolton and his colleagues [8], A nonsystematic review published in 2014 examined 13 studies published between 2001 and 2013 that investigated this question and found that none reported a significant increase in suicidal ideation in patients who were asked about suicide.

Suicide risk assessment tools

The use of suicide assessment tools can assist a clinician in suicide risk assessment and when applied can also provide documentation of what the suicide risk assessment consisted of. This type of documentation may be preferred to clinical notes that make little or no mention of suicide risk assessment details. However, there are no suicide risk assessment tools that can accurately predict whether a person will or will not die by suicide and over what period of time.

Suicide risk assessment leads to suicide risk management. Suicide risk management is also a continuous process and is based on the clinician's determination of the probability of suicide as an outcome - both acute and chronic. It involves application of both general and specific interventions. For example, some general interventions include provision of evidence-based treatments to individuals who have a mental illness or collaborative care approaches to the ongoing treatment of individuals with chronic and persistent mental illness. Some specific interventions may include tailored frequent post hospital or emergency room discharge contact, the advice to limit access to lethal means (such as removing guns from the home), or hospitalization (voluntary or involuntary) as the location in which treatment is provided.

None of the available tools provide a section on communicating the risk with other providers nor the management plan all in one sheet [9-12].

Conclusion

A new tool has been created to capture the different areas in suicide risk assessment and management. The tool includes the relevant risk factors and protective factors or buffers. It also includes a communication plan to document sharing the risk with other clinicians involved in patient care and the circle of support of the patient. Finally, a small section allows clinicians to document their management plan with the patient and determine the risk level through their clinical judgement. There is a possible opportunity to improve the process of suicide risk assessment by using the new suggested tool below.

Mental Health and Addictions
Sadek Suicide Risk Assessment and Intervention Tool

Date	Time	Assessor	Diagnosis
Reason: <input type="checkbox"/> MH Assessment <input type="checkbox"/> Admission/Transfer/Discharge <input type="checkbox"/> Acute deterioration			
<p>Interview Risk Profile</p> <ul style="list-style-type: none"> <input type="checkbox"/> Suicidal thinking or Ideation <input type="checkbox"/> Access to lethal means <input type="checkbox"/> Suicide intent or lethal plan or plan for after death (note) <input type="checkbox"/> Hopelessness <input type="checkbox"/> Intense Emotions: rage, anger, agitation, humiliation, revenge, panic, severe anxiety <input type="checkbox"/> Current Alcohol or Substance intoxication /problematic use <input type="checkbox"/> Withdrawing from family, friends <input type="checkbox"/> Poor Reasoning/Judgment <input type="checkbox"/> Clinical Intuition: assessor concerned <input type="checkbox"/> Recent Dramatic Change in mood <input type="checkbox"/> Recent Crisis/Conflict/ Loss <p>Illness Management</p> <ul style="list-style-type: none"> <input type="checkbox"/> Lack of clinical support <input type="checkbox"/> Noncompliance or poor response to treatment 	<p>Individual Risk Profile</p> <ul style="list-style-type: none"> <input type="checkbox"/> Ethnic, cultural risk group or refugee <input type="checkbox"/> Family history of suicide <input type="checkbox"/> Trauma: as domestic violence / sexual abuse/neglect <input type="checkbox"/> Poor self-control: impulsive / violent/aggression <input type="checkbox"/> Recent suicide attempt <input type="checkbox"/> Other past suicide attempts, esp. with low rescue potential <input type="checkbox"/> Mental illness or addiction <input type="checkbox"/> Depression/ anhedonia <input type="checkbox"/> Psychotic <input type="checkbox"/> Command hallucinations <input type="checkbox"/> Recent admission / discharge / ED visits <input type="checkbox"/> Chronic medical illness/ pain <input type="checkbox"/> Disability or impairment <input type="checkbox"/> Collateral information supports suicide intent <p>Circle of support</p> <ul style="list-style-type: none"> <input type="checkbox"/> Lack of family/ friend's support <input type="checkbox"/> Caregiver unavailable <input type="checkbox"/> Frequent change of home 	<p>Risk Buffers – Not to be used to determine degree of risk.</p> <ul style="list-style-type: none"> <input type="checkbox"/> Has reason to live/hope <input type="checkbox"/> Social support <input type="checkbox"/> Responsibility for family/kids/pets <input type="checkbox"/> Capacity to cope/resilience <input type="checkbox"/> Religion/ faith <input type="checkbox"/> Strength for managing risk <p>Communication Plan</p> <p>Verbal (V) Written/fax (W)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Nurse: <input type="checkbox"/> Physician: <input type="checkbox"/> SDM/Family: <input type="checkbox"/> Mobile Crisis: <input type="checkbox"/> Others: <input type="checkbox"/> Documentation in chart <p>Management Plan</p> <ul style="list-style-type: none"> <input type="checkbox"/> Follow patient care plan for chronic risk <input type="checkbox"/> Regular outpatient follow-up <input type="checkbox"/> Removal of lethal means <input type="checkbox"/> Urgent outpatient follow-up <input type="checkbox"/> Admit to a psychiatric unit <ul style="list-style-type: none"> <input type="checkbox"/> Routine observation <input type="checkbox"/> Close observation q 15 m <input type="checkbox"/> Constant observation 	
<p>Suicide Risk Level: Risk assessment is based on clinical judgment and not based on number of items checked. The checklist is intended to guide the clinical decision only.</p>			
<p>RISK LEVEL: <input type="checkbox"/> High <input type="checkbox"/> Moderate <input type="checkbox"/> Low Signature: _____</p>			
<p>Analysis of Risk, Comments and Collateral Information: _____</p> <p>_____</p> <p>_____</p> <p>_____</p>			

Figure

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Volume 8 Issue 8 August 2019

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