The ASARI

The **A**ssessment of **S**uicide **A**nd **R**isk **I**nventory

User's Guide

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Child and Adolescent Psychiatrist

2013 Edition

Users Guide

- Introduction to the ASARI
- Using the ASARI
- Frequently Asked Questions about the ASARI

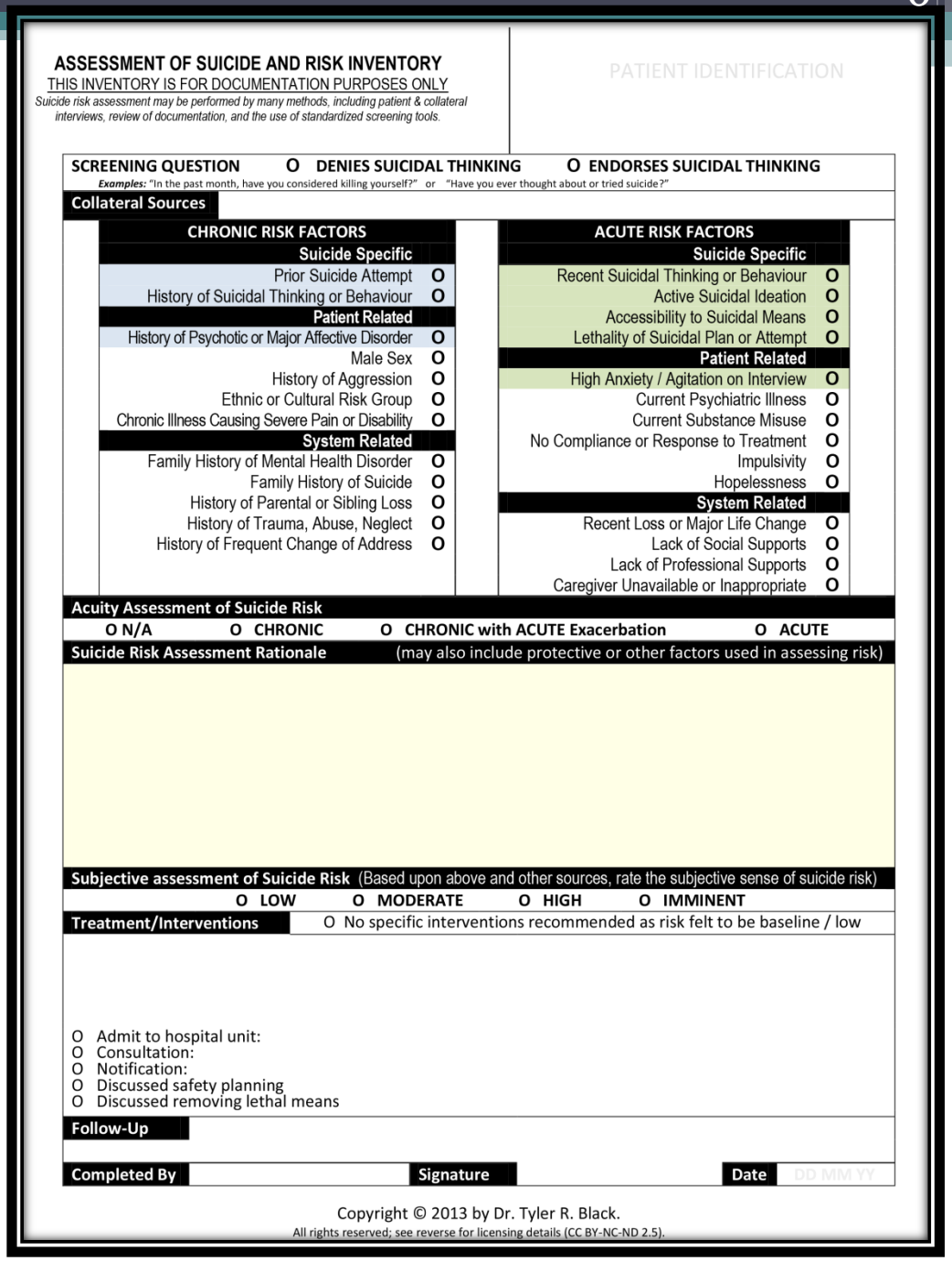
Introduction to the ASARI

What is the ASARI?

- The ASARI is a clinical documentation tool that is intended to accomplish the following:
  - Reinforce and standardize the structure of a complete suicide risk assessment within a system
  - Guide the user through **documenting** a complete suicide risk assessment
  - Allow for the rapid communication and easy comprehension of identified suicide risk between parties

The ASARI

- Fits on one page
- Formatted for easy viewing and completion
- Free for clinical use
- **By using the structure of a complete suicide risk assessment, provides an opportunity to document suicide risk effectively**



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**

Examples: "In the past month, have you considered killing yourself?" or "Have you ever thought about or tried suicide?"

Collateral Sources

CHRONIC RISK FACTORS		ACUTE RISK FACTORS	
Suicide Specific		**Suicide Specific**	
Prior Suicide Attempt	O	Recent Suicidal Thinking or Behaviour	O
History of Suicidal Thinking or Behaviour	O	Active Suicidal Ideation	O
		Accessibility to Suicidal Means	O
		Lethality of Suicidal Plan or Attempt	O
Patient Related		**Patient Related**	
History of Psychotic or Major Affective Disorder	O	High Anxiety / Agitation on Interview	O
Male Sex	O	Current Psychiatric Illness	O
History of Aggression	O	Current Substance Misuse	O
Ethnic or Cultural Risk Group	O	No Compliance or Response to Treatment	O
Chronic Illness Causing Severe Pain or Disability	O	Impulsivity	O
		Hopelessness	O
System Related		**System Related**	
Family History of Mental Health Disorder	O	Recent Loss or Major Life Change	O
Family History of Suicide	O	Lack of Social Supports	O
History of Parental or Sibling Loss	O	Lack of Professional Supports	O
History of Trauma, Abuse, Neglect	O	Caregiver Unavailable or Inappropriate	O
History of Frequent Change of Address	O		

Acuity Assessment of Suicide Risk

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

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

Why is the ASARI necessary?

- Most mental health assessments demonstrate incomplete documentation of suicide risk.
- Suicide risk is one of the primary concerns for mental health workers.
- Many legal myths exist regarding the assessment of suicide risk.
- Comprehensive suicide risk assessment is, or will be, an accreditation requirement for any organization working in mental health.

Remember…

… Suicide risk assessment is one of the most **important functions** of a mental health assessment; it should be treated as such in your documentation!

The Scope of Suicide

- For youth 10-24 years of age, suicide is the 2nd-leading cause of death, accounting for more deaths than **cancer, lung, heart, blood, and infectious diseases <u>combined</u>.**

- There are approximately **3,800 suicides every year** in Canada, or approximately **11 every day**. In the United States, the numbers become **38,000 suicides every year,** approximately **105 every day.**

Statistics Canada, compiled by author, 2001-2010 data set, run using the CANSIM database
CDC Suicide Facts at a Glance, accessed January 2013 at: http://www.cdc.gov/violenceprevention/pdf/Suicide_DataSheet-a.pdf

IMPORTANT

- The ASARI itself is NOT a suicide risk screening tool; instead, it is intended to document the suicide risk assessment already completed.
- There are many questionnaires, tools, or instruments designed to quantify suicide risk, however **none** are predictive of suicide.
- The current (2013) gold-standard for suicide risk assessment is **clinical judgment**.

Clinical Judgment

- A proper suicide risk assessment includes:
  - Identification of risk and protective factors
    - Interviewing the person
    - Using scoring instruments/tools
    - Collateral history
    - Review of previous documentation
  - **Synthesis of identified risk factors** with the qualities of the clinical interview
    - Clinical history
    - Psychopathological development
    - 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.
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.

Using the ASARI

- In the next slides, the ASARI will be broken down section-by-section to explain the key concepts.

Using the ASARI

- Overall, keep this in mind:
  - The ASARI is a documentation tool, meant to help the user express and record their thoughts about suicide risk assessment. Selecting a checkbox is the same as writing that item as a complete sentence.
- IE: Under **Chronic Risk Factors**
  checking "History of suicidal thinking" is the same as writing:
  "In terms of chronic risk factors, Jane Doe has had a history of suicidal thinking."

ASARI General Tips

- Familiarity with the ASARI will make it a simple document to fill out; for uncomplicated cases it is possible to complete in less than one minute.

- An ASARI should be completed:
  - Upon initial assessment
  - At regular intervals to be determined by clinical needs.
  - Upon any significant change in clinical status
  - Upon transfer of care to another clinician / hospital
  - Upon discharge from any program

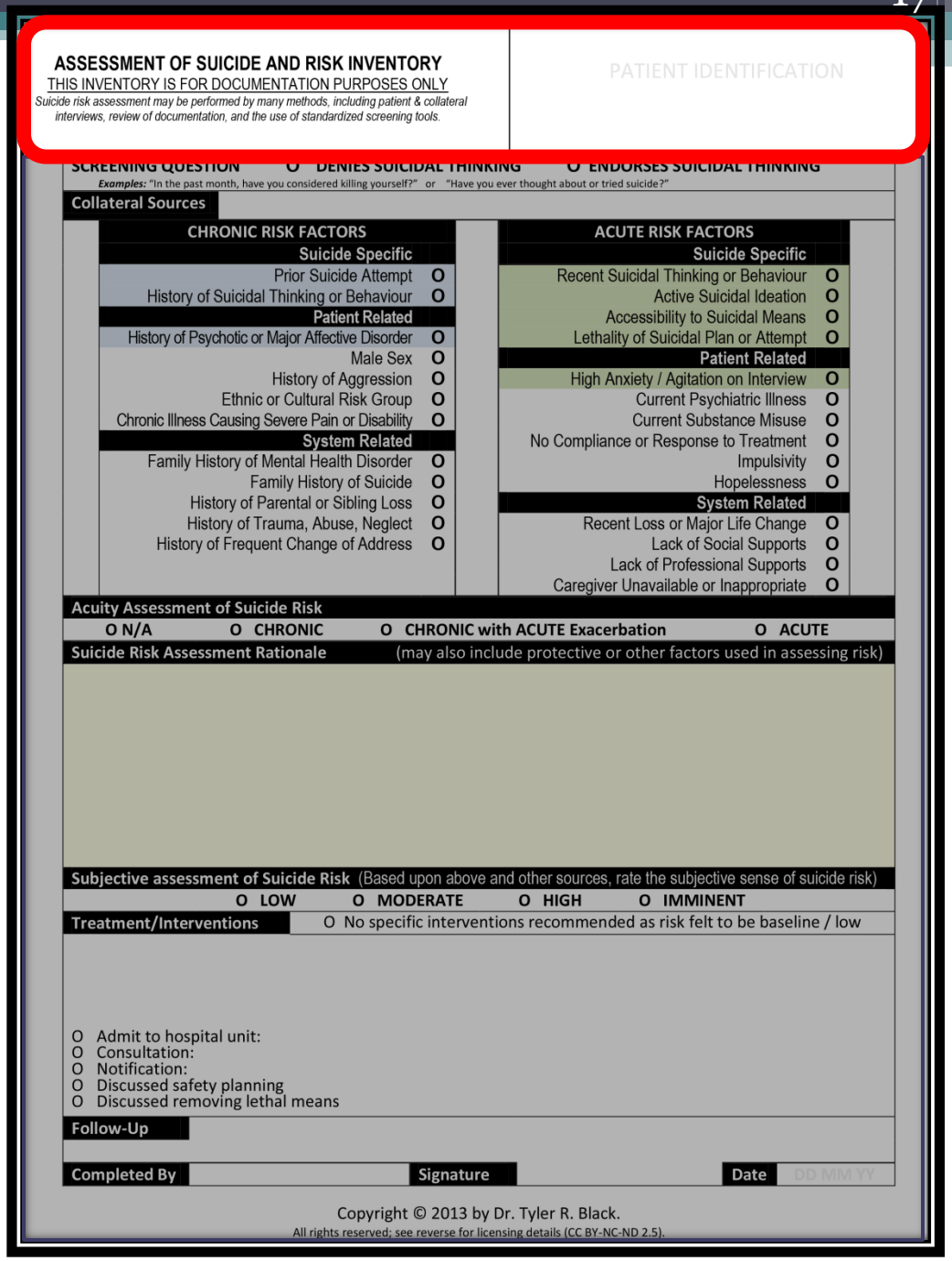
ASARI General Tips

- There is an ASARI Follow-Up Form
  - Use when scheduled follow-up (routine) occurs, or points of transition occur where there is no significant change to risk.

- If risk changes significantly, it is recommended to complete a new ASARI.

Using the ASARI

Patient Information



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Examples: "In the past month, have you considered killing yourself?" or "Have you ever thought about or tried suicide?"

Collateral Sources

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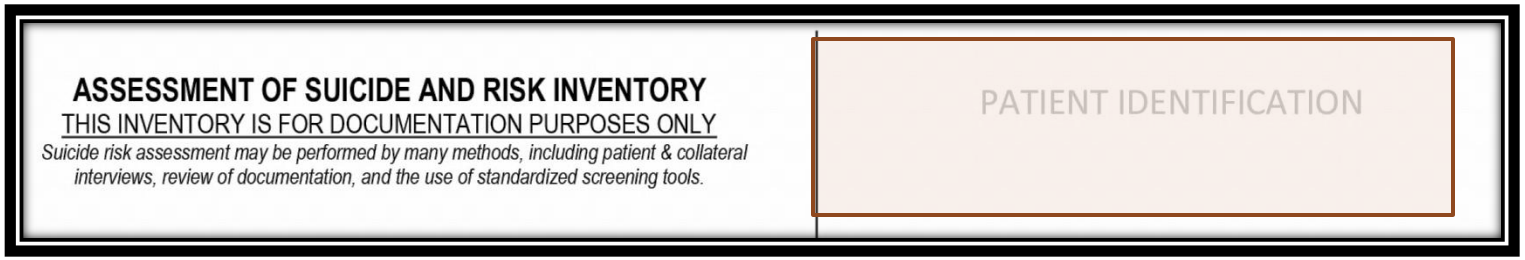
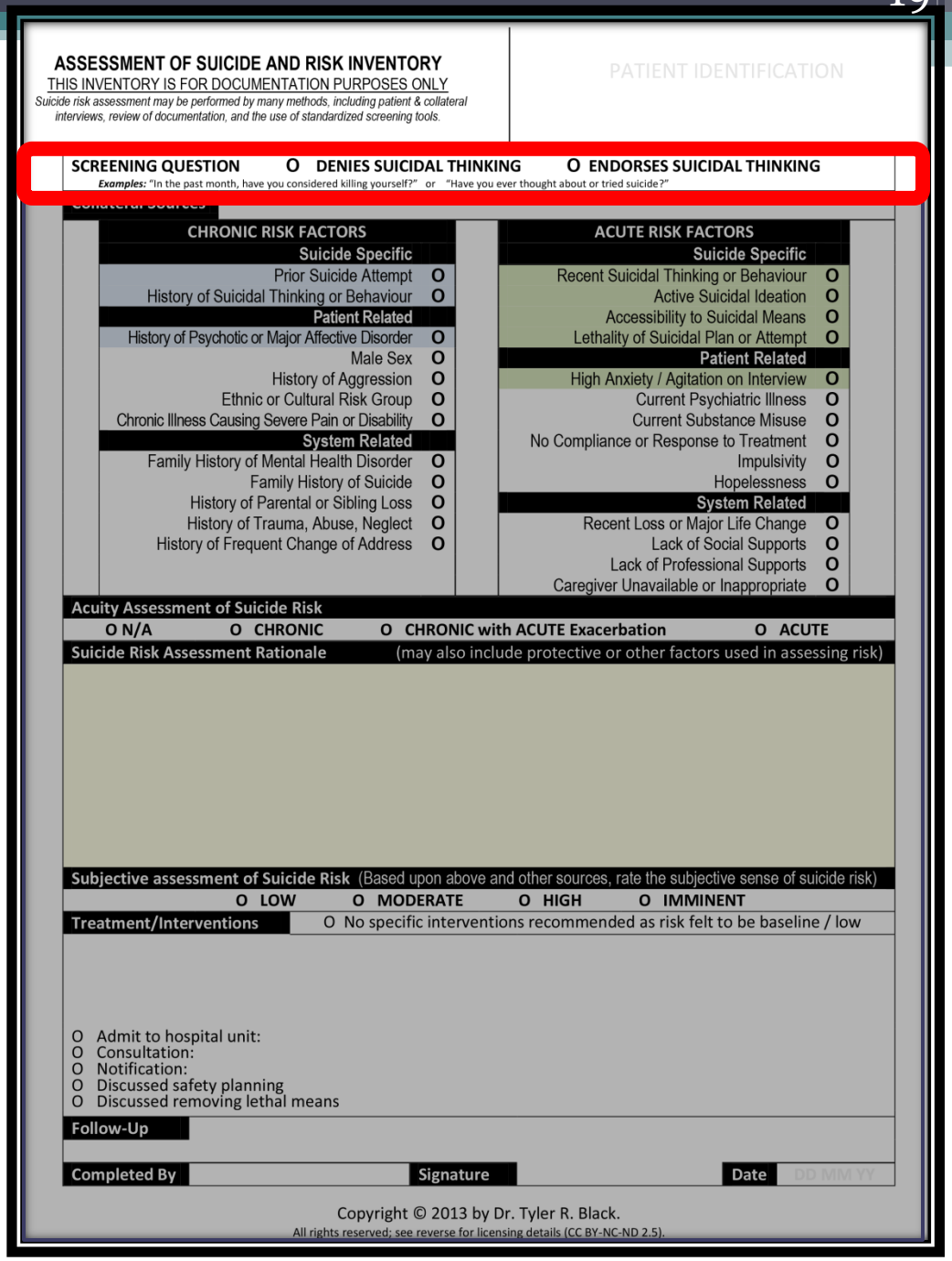


Here, you can write in the patient's name and identifiers, apply a sticker or stamp.

EXAMPLES:

Screening Question



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Screening Question

- This section is intended to document the response given when the person was asked a question screening for suicidal thought.
- Simply check the box that accurately represents this response:

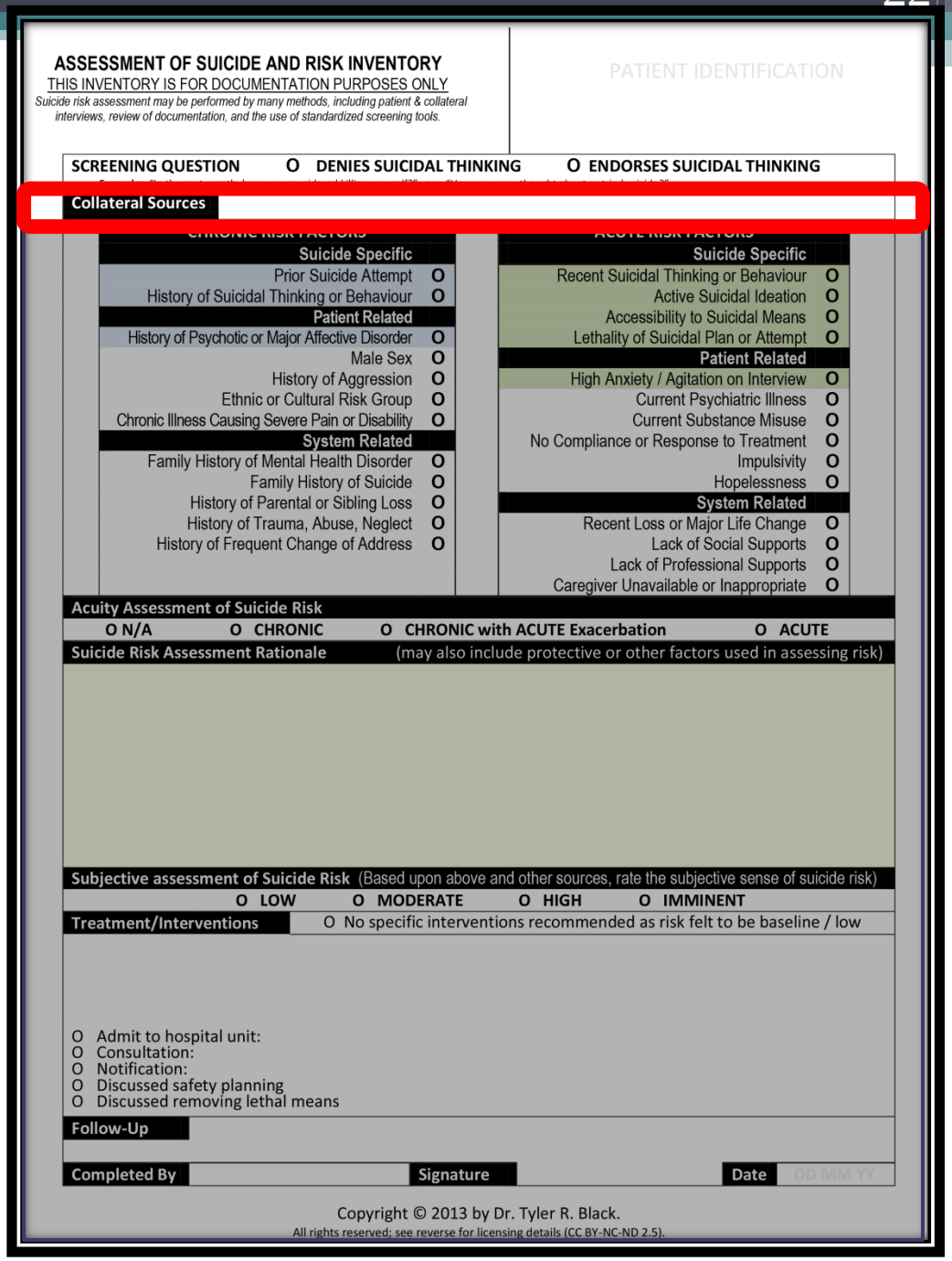
- There are many ways to ask this question. Generally, suicide-specific screens follow meet the following criteria:
  1. A Question about stress or distress (helpful information!)
  2. A Question about hopelessness (helpful information!)
  3. **A Question about suicidal behaviour (← the screening question)**

Example Screening Script

"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 considered harming or killing yourself?"**

Collateral Sources



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Collateral Sources

- This section is intended to reflect the variety of sources used to gather the information for suicide risk assessment.

Collateral Sources	

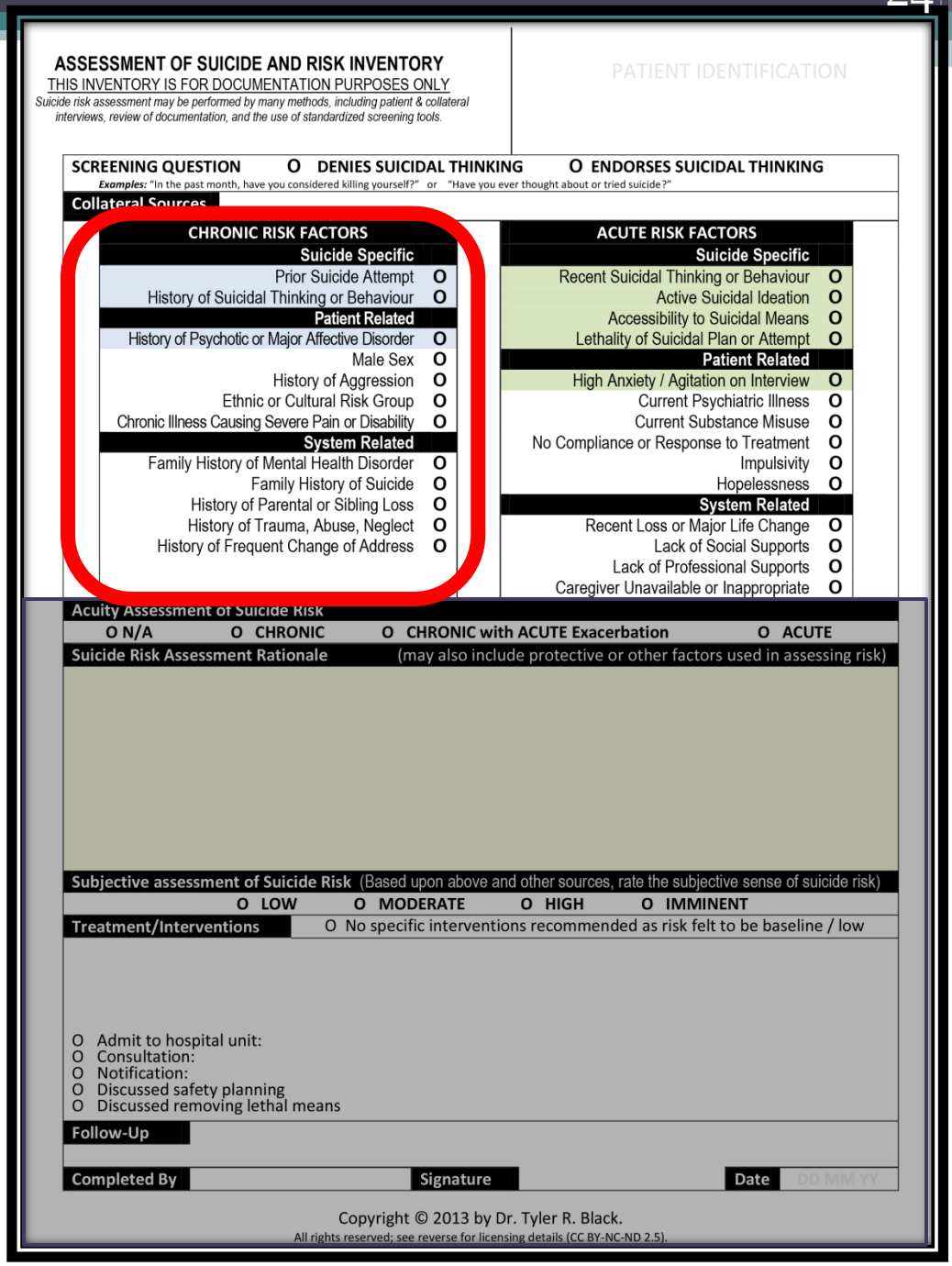
- Possible collateral sources include: ***family members, teachers, coworkers, friends, previous reports, clinical charts, colleagues, other physicians, etc.***

- Examples:

Collateral Sources	No collateral information available.

Collateral Sources	Father (Joseph), medical chart, Dr. John Jones (GP)

Chronic Risk Factors



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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	
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Lack of Social Supports	O
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Caregiver Unavailable or Inappropriate	O

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Chronic Risk Factors

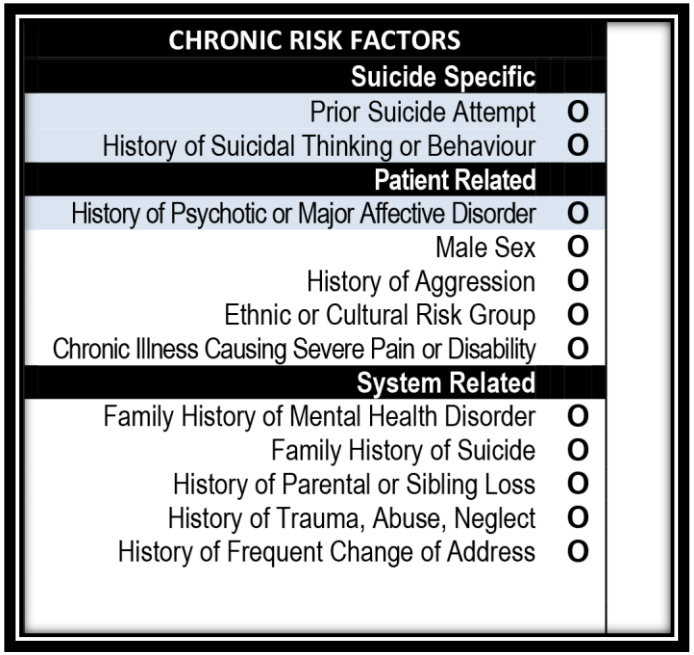
- Definitions for these risk factors are on the reverse side of the ASARI

- Chronic Risk Factors are risk factors that are **ongoing**, likely **longstanding**, and **generally can not change.**

- Chronic Risk Factors are generally **not** targets for intervention.

- Selecting an option is the equivalent of writing a sentence **about that risk factor**. Eg. "Jane has identified herself as being lesbian, which is associated with a higher risk of suicide."

- NOT selecting an option is NOT THE SAME as negating that option, it simply means you did not want to write that sentence. Some clinicians have negated the option by writing NEG or a (-) symbol in the margin beside the risk factor.



CHRONIC RISK FACTORS	
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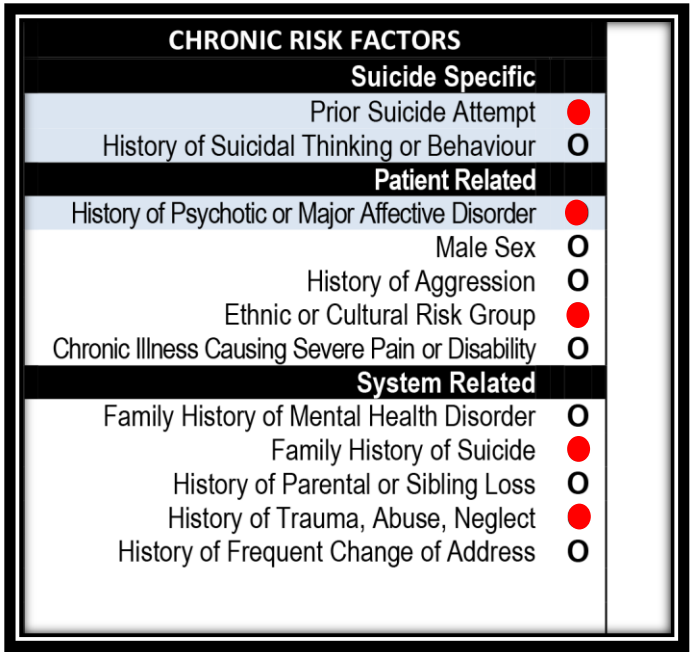
Chronic Risk Factors Example

The example Chronic Risk Factors below:

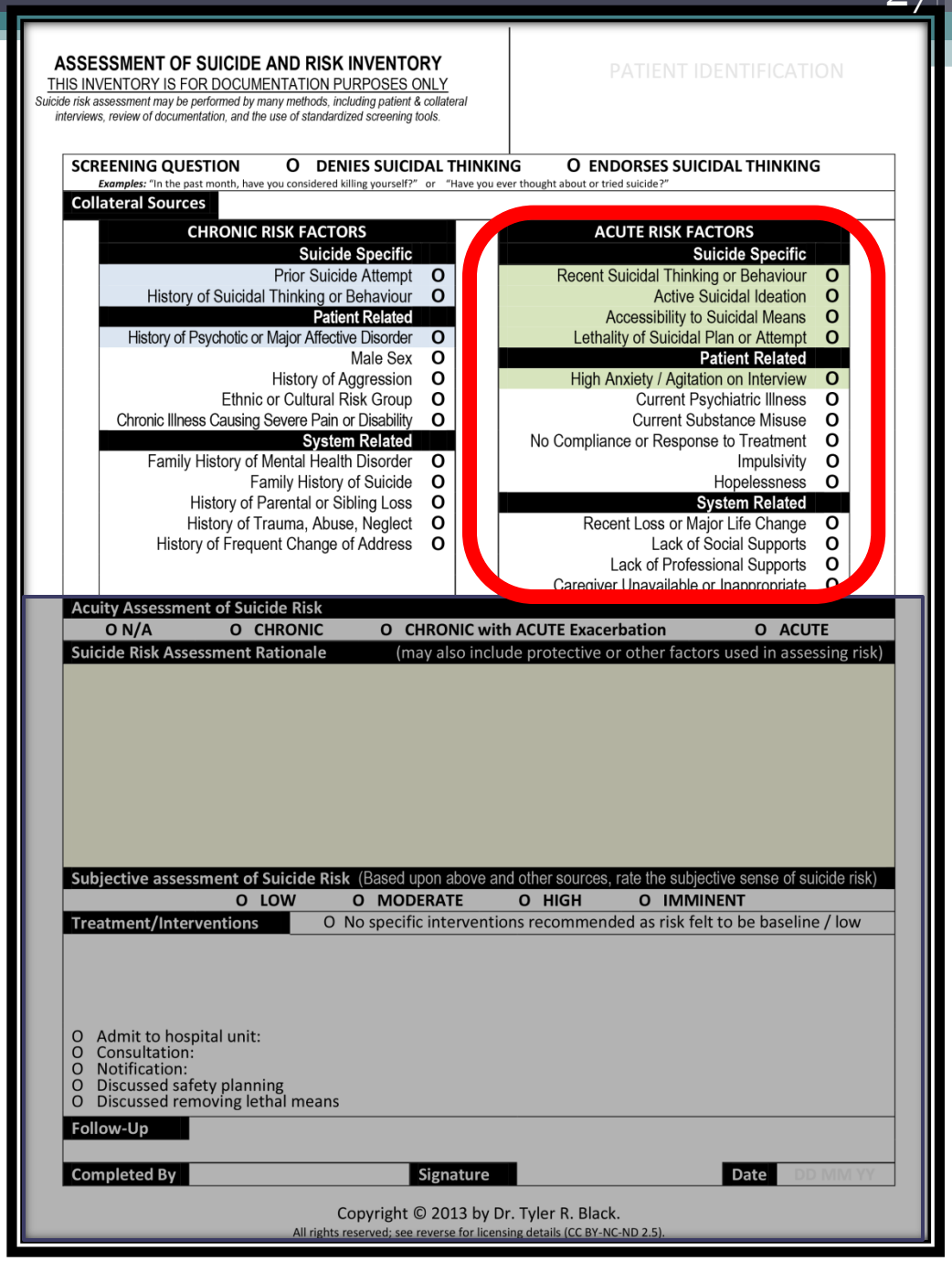


CHRONIC RISK FACTORS	
Suicide Specific	
Prior Suicide Attempt	●
History of Suicidal Thinking or Behaviour	O
Patient Related	
History of Psychotic or Major Affective Disorder	●
Male Sex	O
History of Aggression	O
Ethnic or Cultural Risk Group	●
Chronic Illness Causing Severe Pain or Disability	O
System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

Replaces the paragraph on identified risk:

In terms of chronic risk factors, I note that Jane has a history of a prior suicide attempt, a major depressive disorder, and a family history of suicide attempts. She identifies as lesbian. She has a history of being exposed to abuse. These factors increase her baseline, chronic risk of suicide, and are unlikely to change across her lifespan.

Acute Risk Factors



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Examples: "In the past month, have you considered killing yourself?" or "Have you ever thought about or tried suicide?"

Collateral Sources

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ACUTE RISK FACTORS	
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Accessibility to Suicidal Means	O
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Patient Related	
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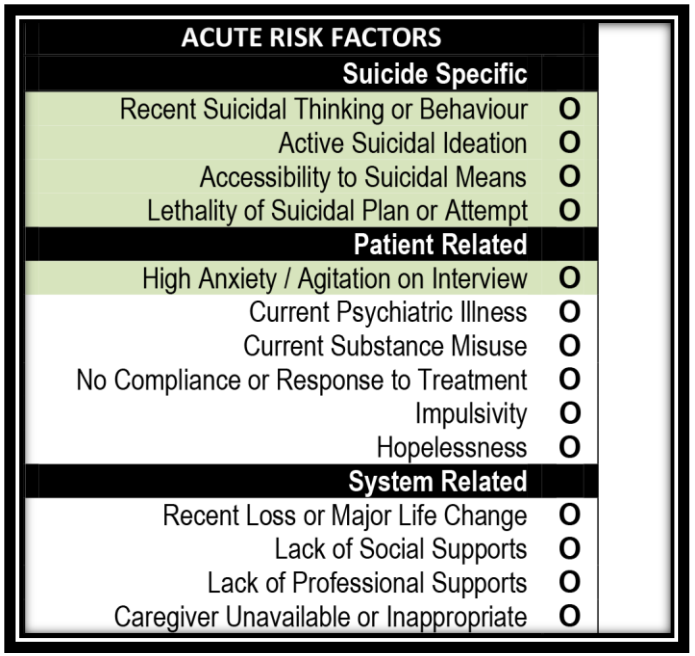
Completed By **Signature** **Date** DD MM YY

Acute Risk Factors

- Definitions for these risk factors are on the reverse side of the ASARI
- Acute Risk Factors are **recent**, often **transient**, and are often **modifiable**.
- Acute Risk Factors are generally **targets for intervention.**
- Selecting an option is the equivalent of writing a sentence **about that risk factor**. Eg. "Jane has recently had active suicidal ideation."



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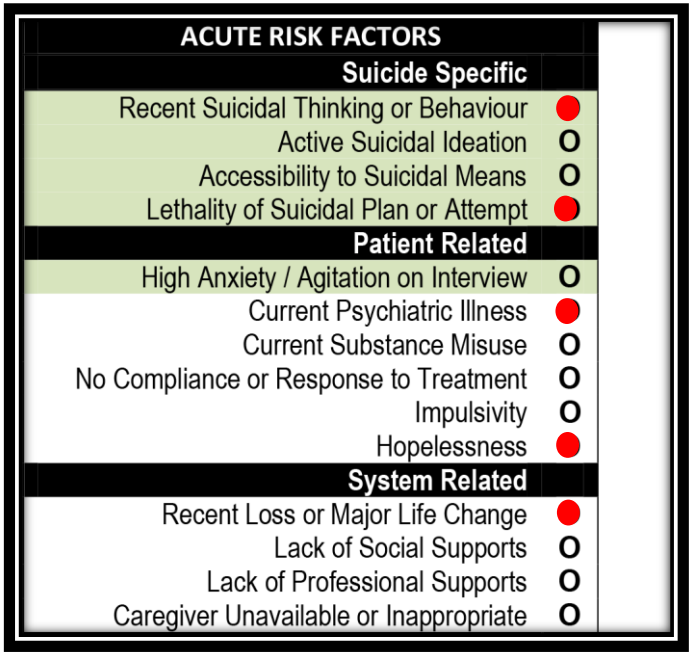

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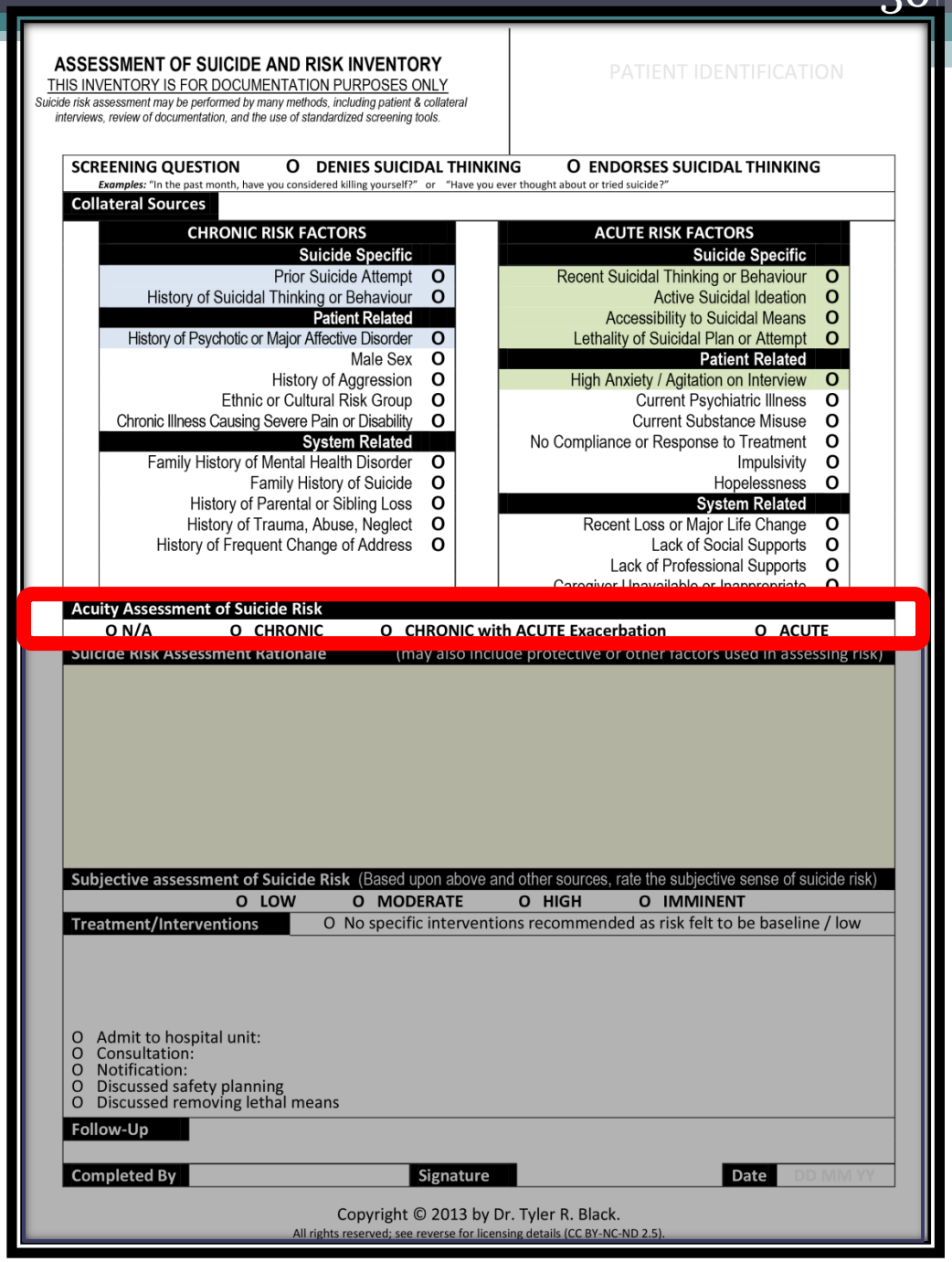
Replaces the paragraph on identified risk:

In terms of acute risk factors, I note that Jane has recently endorsed thinking about suicide, and has considered jumping off of a bridge or hanging herself. She is currently depressed, and reports that she finds no hope in the future. She recently has been through a significant crisis. These risk factors increase her acute risk of suicide and should be targets for intervention.

Acuity Assessment of Suicide Risk



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Collateral Sources

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Suicide Specific		**Suicide Specific**	
Prior Suicide Attempt	O	Recent Suicidal Thinking or Behaviour	O
History of Suicidal Thinking or Behaviour	O	Active Suicidal Ideation	O
		Accessibility to Suicidal Means	O
		Lethality of Suicidal Plan or Attempt	O
Patient Related		**Patient Related**	
History of Psychotic or Major Affective Disorder	O	High Anxiety / Agitation on Interview	O
Male Sex	O	Current Psychiatric Illness	O
History of Aggression	O	Current Substance Misuse	O
Ethnic or Cultural Risk Group	O	No Compliance or Response to Treatment	O
Chronic Illness Causing Severe Pain or Disability	O	Impulsivity	O
		Hopelessness	O
System Related		**System Related**	
Family History of Mental Health Disorder	O	Recent Loss or Major Life Change	O
Family History of Suicide	O	Lack of Social Supports	O
History of Parental or Sibling Loss	O	Lack of Professional Supports	O
History of Trauma, Abuse, Neglect	O	Caregiver Unavailable or Inappropriate	O
History of Frequent Change of Address	O		

Acuity Assessment of Suicide Risk

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

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

Acuity Assessment of Suicide Risk

Acuity Assessment of Suicide Risk			
O N/A	O CHRONIC	O CHRONIC with ACUTE Exacerbation	O ACUTE

- Considering the **acute** and **chronic** risk factors, this section is intended to document your assessment of the acuity of risk:

Acuity Assessment of Suicide Risk

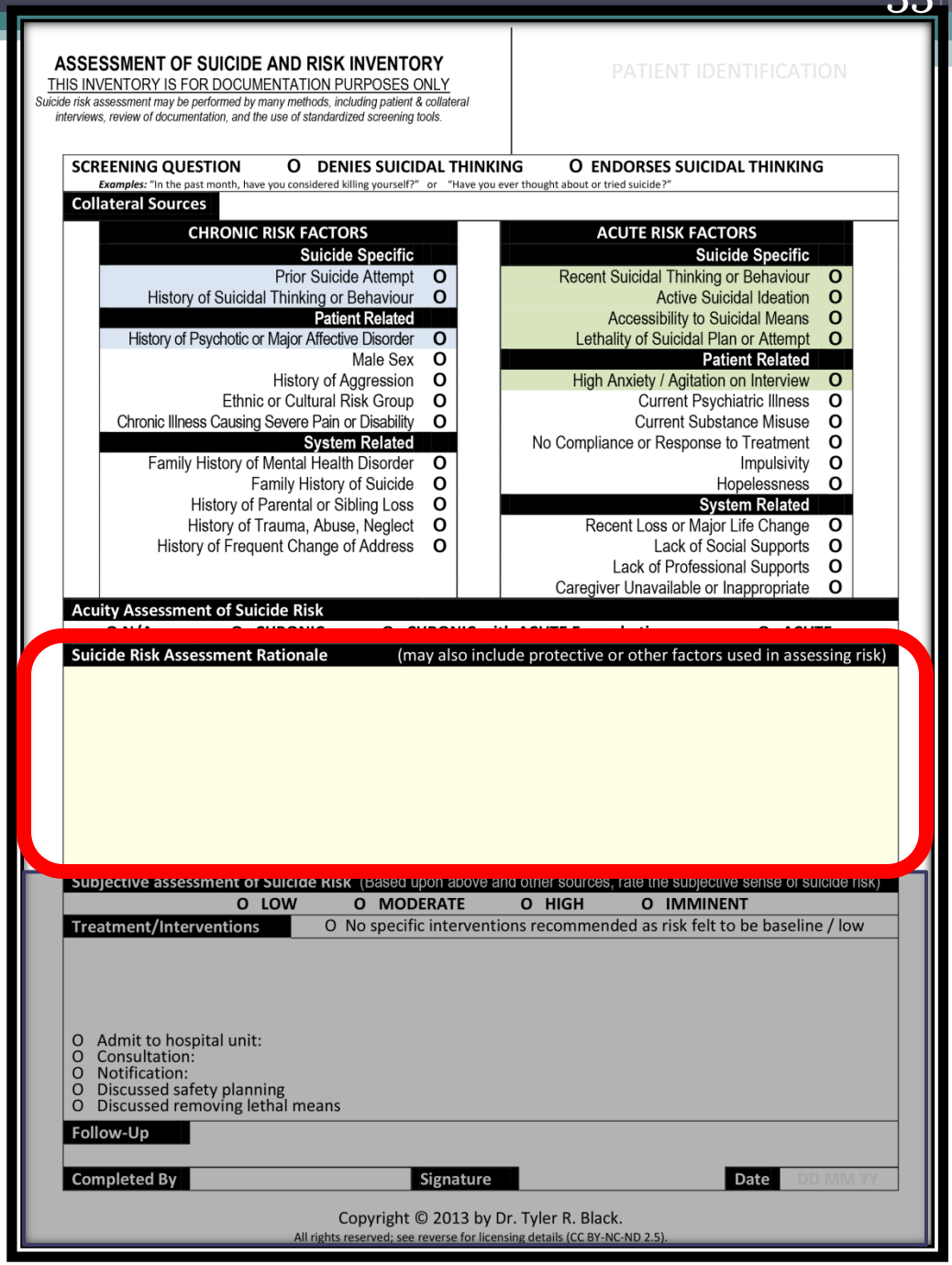
EXAMPLES

- No significant risk factors, does not apply.

- Mostly chronic risk factors; generally goals in intervention involve improving **coping**, **detection**, **access to help**, and **safety planning**.

- Mostly acute risk factors; generally goals in intervention involve **modifying the acute factors** to return the person to their baseline risk level.

Suicide Risk Assessment Rationale



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**

Examples: "In the past month, have you considered killing yourself?" or "Have you ever thought about or tried suicide?"

Collateral Sources

CHRONIC RISK FACTORS		ACUTE RISK FACTORS	
Suicide Specific		**Suicide Specific**	
Prior Suicide Attempt	O	Recent Suicidal Thinking or Behaviour	O
History of Suicidal Thinking or Behaviour	O	Active Suicidal Ideation	O
Patient Related		Accessibility to Suicidal Means	O
History of Psychotic or Major Affective Disorder	O	Lethality of Suicidal Plan or Attempt	O
Male Sex	O	**Patient Related**	
History of Aggression	O	High Anxiety / Agitation on Interview	O
Ethnic or Cultural Risk Group	O	Current Psychiatric Illness	O
Chronic Illness Causing Severe Pain or Disability	O	Current Substance Misuse	O
System Related		No Compliance or Response to Treatment	O
Family History of Mental Health Disorder	O	Impulsivity	O
Family History of Suicide	O	Hopelessness	O
History of Parental or Sibling Loss	O	**System Related**	
History of Trauma, Abuse, Neglect	O	Recent Loss or Major Life Change	O
History of Frequent Change of Address	O	Lack of Social Supports	O
		Lack of Professional Supports	O
		Caregiver Unavailable or Inappropriate	O

Acuity Assessment of Suicide 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

Suicide Risk Assessment Rationale

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

- This is the **heart** of suicide risk assessment. If there are other identified risk factors, **including protective factors**, they can be added here.
- This **compulsory requirement of suicide risk assessment** is where the known risk and protective factors are **synthesized** with the clinical and historical knowledge of the person.
- Next you will be assigning a risk level. This box should explain *why* you selected that level.

Suicide Risk Assessment Rationale

EXAMPLE

Suicide Risk Assessment Rationale (may also include protective or other factors used in assessing risk)
In reviewing Jane's risk profile, I have no significant concerns of elevated risk of suicide.

This simple sentence indicates that you considered the risks above, and feel that there is no need for further suicide intervention. This sentence is also many times more useful than "denies suicidality."

Suicide Risk Assessment Rationale

EXAMPLE

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

Jane participated fully in the interview, providing clear and seemingly genuine answers to the questions asked. She presented her concerns to me appropriately, and is clearly asking for help. We discussed the interventions below, and seemed engaged and willing to try. Despite her acute risk factors, the treatment strategy adequately addresses her risk profile.

I was able to review the treatment plan with Jane's sister, Jill, who agreed to help Jane attend her next session.

This clearly optimistic report provides the clinical context, or reasoning, as to why the plan was developed in the fashion it did. It is clear from this rationale that the writer feels that interventions are likely to be tried and could be successful.

Suicide Risk Assessment Rationale

EXAMPLE

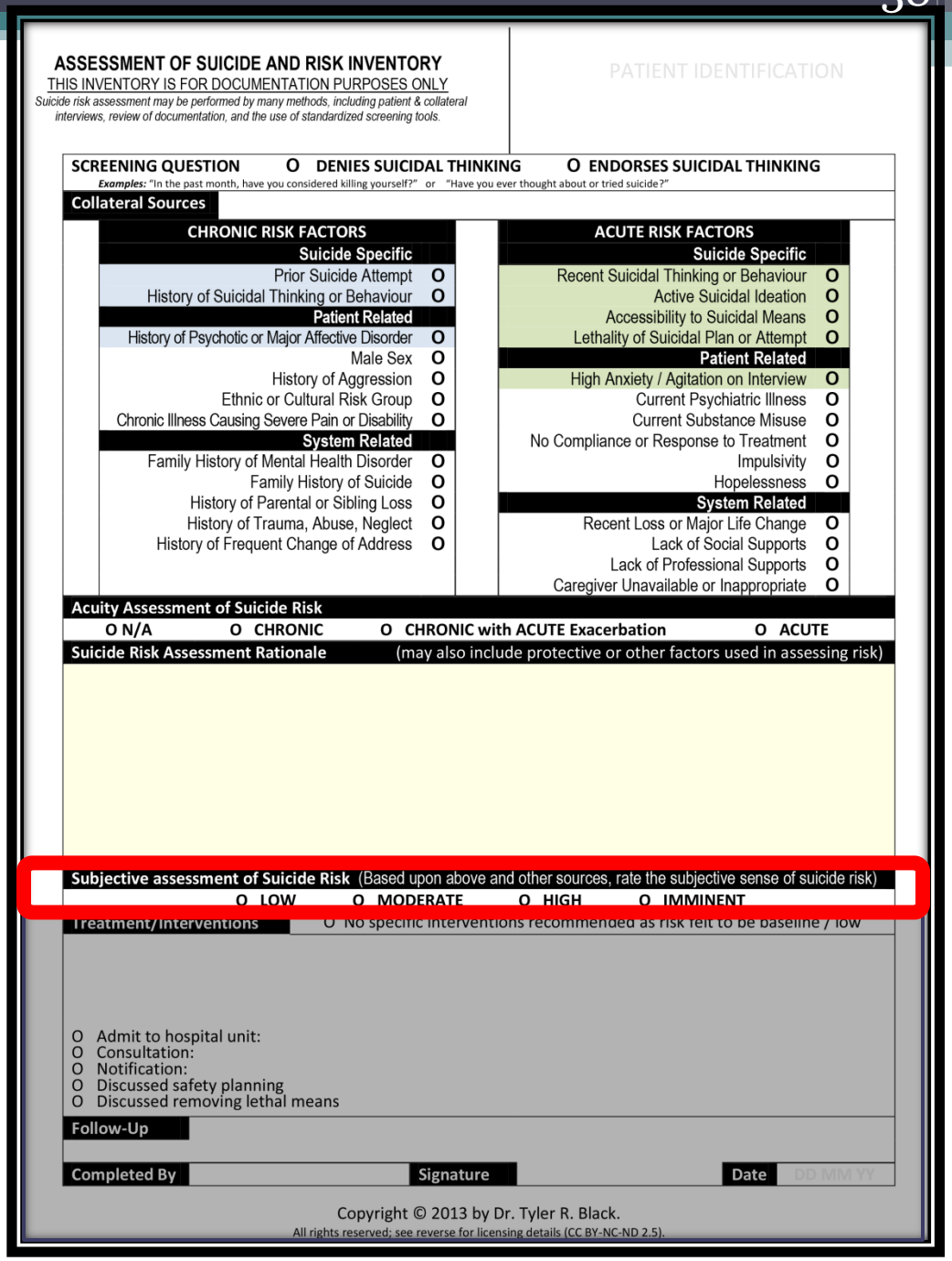
Suicide Risk Assessment Rationale (may also include protective or other factors used in assessing risk)

Jane provided almost no answers willingly and responded to only the most superficial of questions. Her sister did most of the talking, and Jane would not even acknowledge her. She appeared sullen and distressed during the interview, and when suicide plans were asked about, she smiled but did not respond. She did endorse suicidal thinking.

Jane's sister does not feel that she can adequately ensure Jane's safety, and knows that as soon as Jane leaves, she will not be able to find her.

Even if the risk factors are the same as in the previous example, it is obvious that this interview did not go as well, and undermined the confidence in the treatment plan.

Subjective Assessment of Suicide Risk



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**

Examples: "In the past month, have you considered killing yourself?" or "Have you ever thought about or tried suicide?"

Collateral Sources

CHRONIC RISK FACTORS		ACUTE RISK FACTORS	
Suicide Specific		**Suicide Specific**	
Prior Suicide Attempt	O	Recent Suicidal Thinking or Behaviour	O
History of Suicidal Thinking or Behaviour	O	Active Suicidal Ideation	O
Patient Related		Accessibility to Suicidal Means	O
History of Psychotic or Major Affective Disorder	O	Lethality of Suicidal Plan or Attempt	O
Male Sex	O	**Patient Related**	
History of Aggression	O	High Anxiety / Agitation on Interview	O
Ethnic or Cultural Risk Group	O	Current Psychiatric Illness	O
Chronic Illness Causing Severe Pain or Disability	O	Current Substance Misuse	O
System Related		No Compliance or Response to Treatment	O
Family History of Mental Health Disorder	O	Impulsivity	O
Family History of Suicide	O	Hopelessness	O
History of Parental or Sibling Loss	O	**System Related**	
History of Trauma, Abuse, Neglect	O	Recent Loss or Major Life Change	O
History of Frequent Change of Address	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 (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

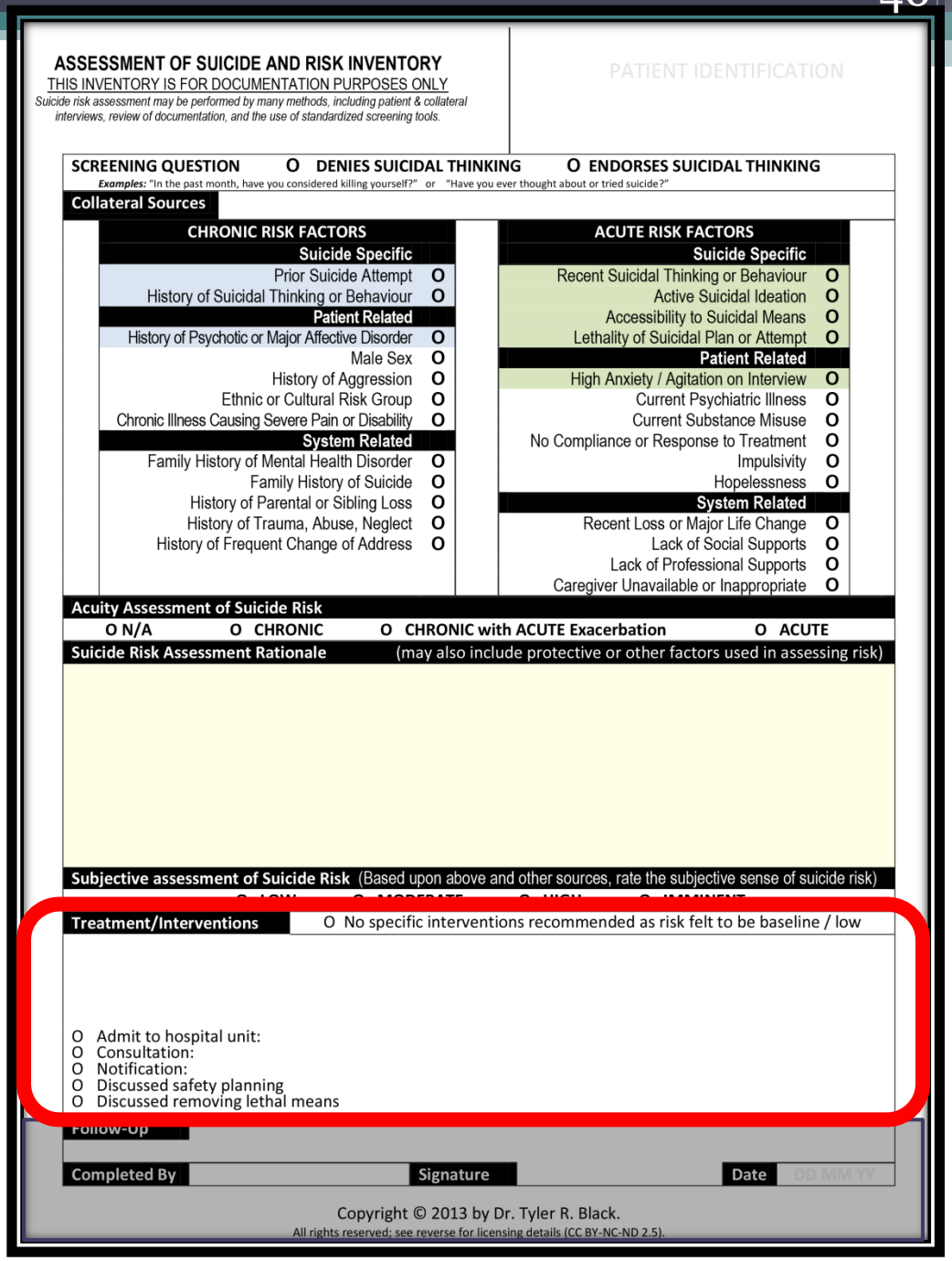
Follow-Up

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

Subjective Assessment of Suicide Risk

- This section intends to document your *subjective sense* of suicide risk. There is no valid way to predict suicide, but a thorough and complete risk assessment informs this subjective sense.
- **Low risk** generally implies that there are no specific risk factors to be intervened upon, and there are few active concerns about suicide.
- **Moderate risk** generally implies that there are some identified risk factors that may impact risk, and there is a need for care and caution regarding suicide.
- **High risk** generally implies that there are multiple risk factors that convey a strong degree of risk, and that a high level of intervention or monitoring is required.
- **"Imminent" is a medicolegally and unreliable term, and has thus been removed from current versions of the ASARI.**

Treatment and Interventions



ASSESSMENT OF SUICIDE AND RISK INVENTORY

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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**

Examples: "In the past month, have you considered killing yourself?" or "Have you ever thought about or tried suicide?"

Collateral Sources

CHRONIC RISK FACTORS		ACUTE RISK FACTORS	
Suicide Specific		**Suicide Specific**	
Prior Suicide Attempt	O	Recent Suicidal Thinking or Behaviour	O
History of Suicidal Thinking or Behaviour	O	Active Suicidal Ideation	O
Patient Related		Accessibility to Suicidal Means	O
History of Psychotic or Major Affective Disorder	O	Lethality of Suicidal Plan or Attempt	O
Male Sex	O	**Patient Related**	
History of Aggression	O	High Anxiety / Agitation on Interview	O
Ethnic or Cultural Risk Group	O	Current Psychiatric Illness	O
Chronic Illness Causing Severe Pain or Disability	O	Current Substance Misuse	O
System Related		No Compliance or Response to Treatment	O
Family History of Mental Health Disorder	O	Impulsivity	O
Family History of Suicide	O	Hopelessness	O
History of Parental or Sibling Loss	O	**System Related**	
History of Trauma, Abuse, Neglect	O	Recent Loss or Major Life Change	O
History of Frequent Change of Address	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 (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)

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

Treatment and Interventions

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	

- This section outlines the ***suicide specific*** treatments and interventions that will be undertaken to address the identified risk factors or to reduce risk overall.
- There is a checkbox at the top for a common statement that no interventions are needed.
- Common interventions are made as options below, and can optionally be used to save time. It is recommended to add writing after these options to add specificity.

Treatment and Interventions

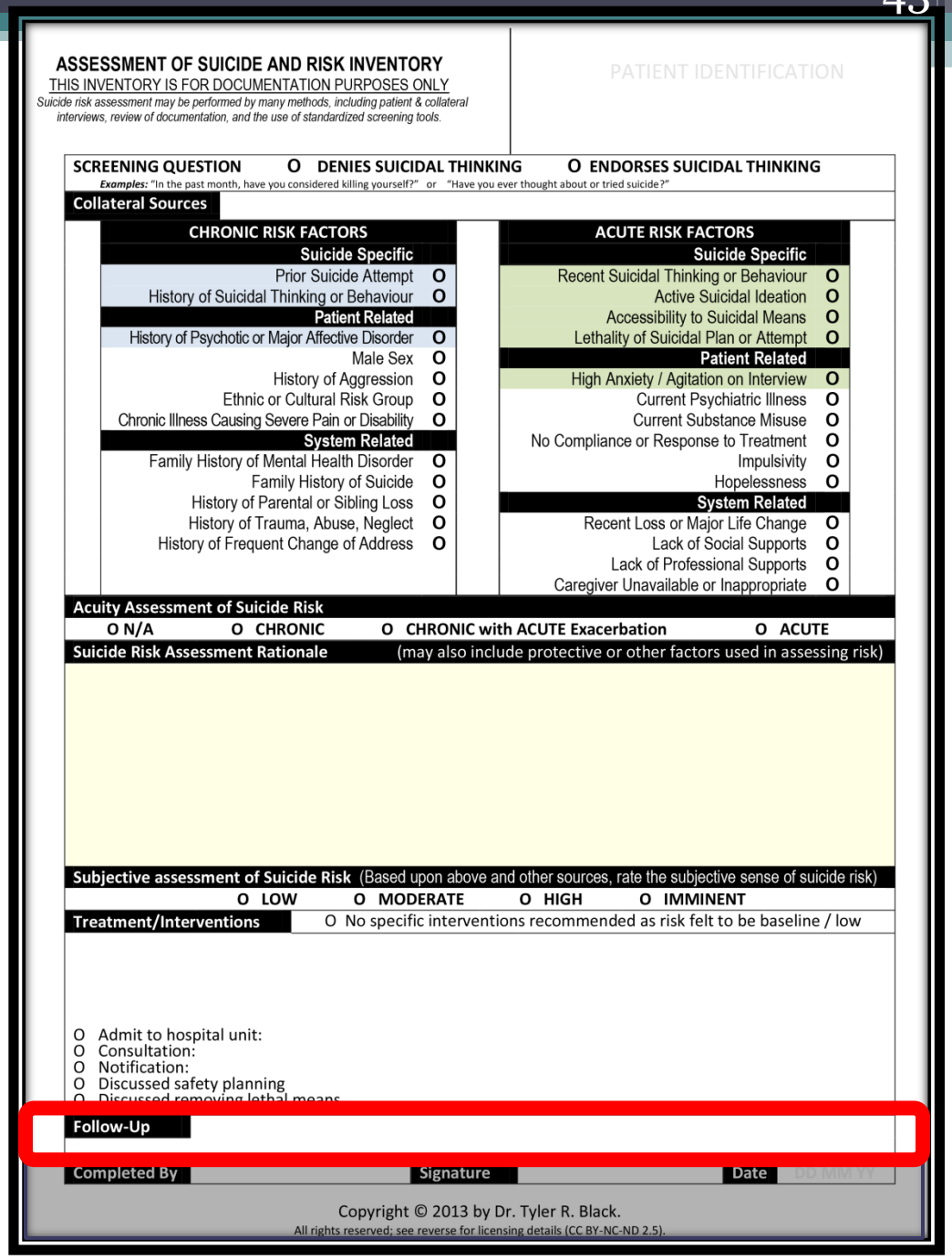
Treatment/Interventions	O No specific interventions recommended as risk felt to be baseline / low

Treatment of identified depression; regular and rapid follow-up; safety numbers discussed; information on emergency services provided.

O Admit to hospital unit:
O Consultation:
O Notification:
O Discussed safety planning
● Discussed removing lethal means Partner will secure medication in lockbox

- Hint: Identified Acute Risk Factors are often excellent targets for treatment to reduce risk, and are generally, by their nature, modifiable.
  - EG: "Accessibility to lethal means" → "discussed or ensured removal of lethal means"
  - EG: "Current psychiatric illness" → "organizing treatment for depression"
  - EG: "Lack of professional supports" → "connect to victims support group"

Follow-Up



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Examples: "In the past month, have you considered killing yourself?" or "Have you ever thought about or tried 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

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

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O Discussed safety planning
O Discussed removing lethal means

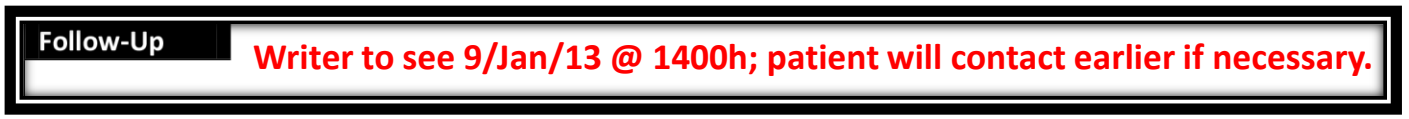
Follow-Up

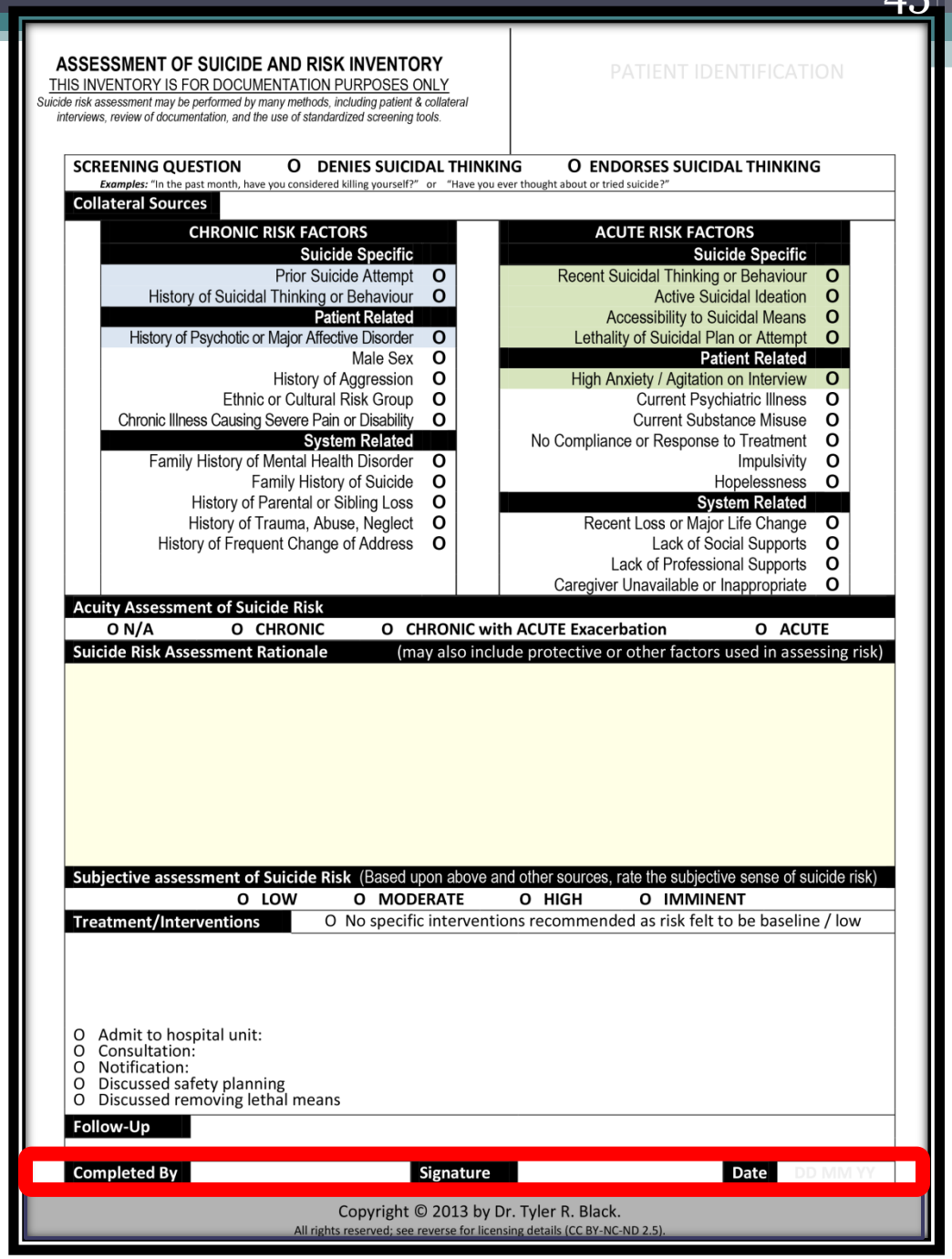
Completed By **Signature** **Date** DD MM YY

Follow-Up

- Ensuring follow-up is a *crucial aspect* of proper suicide risk care. This section documents the next person who will follow up to:
  - Ensure treatments and interventions have occurred as planned
  - Monitor for change in risk profile
  - Identify who will make sure that follow-up occurs.

- Follow-up should be *as specific as possible*. See examples below.





ASSESSMENT OF SUICIDE AND RISK INVENTORY

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Examples: "In the past month, have you considered killing yourself?" or "Have you ever thought about or tried suicide?"

Collateral Sources

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Suicide Specific	
Prior Suicide Attempt	O
History of Suicidal Thinking or Behaviour	O
Patient Related	
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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 (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:
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O Notification:
O Discussed safety planning
O Discussed removing lethal means

Follow-Up

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

Signature Line

Signature Line

- Hopefully self-evident
- Remember, your name should be printed clearly and your standard signature should be used.
- The date should be of the **time of assessment**; obviously good recordkeeping would dictate that the assessment and documentation occur on the same date.

Frequently Asked Questions

I normally just write "denies suicidality." Isn't that sufficient?

- Absolutely not.
  - 78% of inpatient suicide completers reported no suicidality prior to their successful attempt.
  - Consider this:
    - If someone TRULY wanted to die by suicide, what would they tell an **assessor / helper** of suicide risk?

- Confirming or denying suicidal thinking **is NOT** a predictor of future suicide.

Journal of Clinical Psychiatry, 2003:64(1)

I'm worried that if I document "low risk," I could be held responsible if the person dies by suicide. Shouldn't I avoid this?

- There is *no* legal or medical expectations for any professional to **predict** suicide.
- You **will** be held to the standard of assessing suicide risk to the best of your ability, and constructing a plan for that person that addresses the identified risk.
- This is why the complete ASARI is more helpful, as it indicates a thoughtful, complex process.

This is too much – I've already written a lot of the ASARI's info in the persons History of Presenting Illness. Isn't that sufficient?

No. Because of its singular importance,

- the collection of identified risks,
- the synthesis of those risks with the clinical interview, AND
- the clinical decision-making process,

should be located in a separate, easy-to-access section of an assessment. It is not acceptable to simply document risk factors in the history section.

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.

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

I have no suicide concerns about my client. How can I document this efficiently?

The following sections should be completed:

- **Screening Question**: negative
- **Collateral Sources**: (whichever)
- **Risk factors**: (whichever)
- **Acuity**: N/A
- **Rationale**: In reviewing _____'s risk profile, I have no significant concerns of elevated risk of suicide.
- **Subjective Assessment:** Low
- **Treatment:** ( ) No specific…
- **Follow-Up:** (whichever)
- **Signature Line**

This can be completed in <1 minute.

Can't there be a selection box for the rationale section, so I can more quickly document if I have no concern?

- Sorry, no. The ASARI has been developed to be as quick as possible, but the rationale needs to demonstrate that you have adequately considered the risk.
- Find a phrase that makes you feel comfortable and use it, but you will find that you are generally writing different things for each person.
- *That's a good thing*.

What screening tools, assessment tools, or inventories are available?

- Columbia-Suicide Severity Rating Scale (C-SSRS)
  - Available at http://www.cssrs.columbia.edu/
- Scale for Suicidal Ideation (SSI)
  - Commercially available
- Beck Scale for Suicide Ideation (BSI)
  - Commercially available
- Suicide Behaviour Questionnaire – Revised (SBQ-R)
  - Available at http://www.integration.samhsa.gov/images/res/SBQ.pdf

Remember…

… Suicide risk assessment is one of the most **important functions** of a mental health assessment; it should be treated as such in your documentation!

Thank you

- Acknowledgements

  - Dr. Robert I. Simon
  - Pamela Joshi, MSc

  - Colleagues and friends at BC Children's Hospital, BC Mental Health and Addictions Services, Vancouver Coastal Health