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Coping with Clinical Challenges of Risk Assessment: Towards a New Comprehensive Instrument

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COPING WITH CLINICAL CHALLENGES OF RISK ASSESSMENT: TOWARDS A NEW COMPREHENSIVE INSTRUMENT

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COPING WITH CLINICAL CHALLENGES OF RISK ASSESSMENT: TWOWARDS A NEW COMPREHENSIVE INSTRUMENT

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How was the need for this workshop, course or symposium determined?

There is significant gap between the expectation and the outcome in assessment of suicidality in clinical practice. Nothing surprises us more than failure of risk assessment. It is a potential area for contemporary legality and complains in the mental health profession. Evolving science and practice guidelines demand a very high quality Risk assessment

How will the participants receive feedback about their learning?

The workshop is based on model of interactive leaning. Participants will be actively involved in hands-on training using case vintage. This will provide dual evaluation i.e., participants will have ratings of their learning and they will be evaluating the course as well using semi-structured proforma.

Learning Objectives at the end of the session the participants should be able to:

1. Recognize complexity and significance of a reliable risk assessment

2. Understand merits and limitations of available measurement tools & need for New Measurement.

3. Develop skills of assessment on proposed Scale fro assessment of suicidal ideation fro measurement, administration and planning. (SIS-MAP)
Introduction: Risk assessment is an important area of clinical work. All of us are constantly engaged in improving it and bridging the gaps between assessment and outcome. Suicidal ideation is common in about 4% in general population and about 20% in Psychiatric population. Suicide attempt and suicidal threats are together seen in about 60-70% in acute psychiatric wards as well as in crisis services. There are tools available for Risk assessment of such patients however almost always this is done based upon personal clinical judgment of the clinicians. The science of suicidology is constantly evolving with changing socio-cultural perspectives. Literature suggests three main domains for origin of suicidal ideas i.e. Biological domain, Psychological domain and Social-Environmental domain. The suicidal ideas have constant interplay with risk factors present in the individual who gives rise to suicidal thoughts. The cognitive set changes and cognitive control is lost which then leads to an ‘attempt’. An adequate risk assessment is one, which incorporates all the three domains of risks in the background of suicide protectors. A new comprehensive scale “Scale for assessment of suicidal ideation for management, administration and planning of care (SIS-MAP) may enhance the quality and reliability of assessment.

The educational sessions is expected to enhance their competency in recognizing and dealing with issues of clinical challenges,

Abstract Presenter 1

Amresh Srivastava

Title: The Challenges and gaps in current Risk assessment & Conceptual framework of New Measurement.

Learning Objective

1. Understand limitations and complexity of risk assessment

2. Understand measures to improvise the clinical risk assessment

3. Recognize the concept of new ways of comprehensive risk assessment

The presentation shall focus to sensitize of areas of existing gaps and limitations in available risk assessments and shall deal with limitations of some contemporary assessment tools.
The main issue involved in the gaps between expectations and outcome is the quality of risk assessment. It is now understood that Risk assessment is multidimensional as well as cross sectional i.e. it has ‘trait Risk’ and ‘state risk’. Biological, Psychological, Social, and Environmental arms need to be assessed for arranging at a comprehensive assessment. It is further hypothesized that a net sum of risk shall be the quantum of risk factors in relation to risk protectors in a given individual at a given situation. Based upon these understanding a new scale has been developed named SIS-MAP.

Abstract Presenter 2

Charles Nelson

Title: Understanding the Risk assessment using SIS MAP (Scale for Suicidal ideation for management, administration and planning of care)

Learning objectives
1. Understand concept of SIS-MAP Development
2. Understand administration and scoring of new scale,
3. Recognize merits, limitations of SIS-MAP.

Abstract

The presentation shall highlight on concept of comprehensive risk assessment and discuss in details the present format of SIS-MAP.

The process of administration and scoring shall be discussed. Hands on training will be provided by using case vintage to allow participants to learn the process of assessment and test/retest their ability to classify management and service planning based upon the results of assessment.
Summary:

The present study examined the utilization of a new structured clinical interview called the Scale for Impact of Suicidality Management, Assessment and Planning of Care (SIS-MAP). SIS-MAP ratings were evaluated against a group of incoming psychiatric patients over a 6-month period. Participants consist of adult male and female patients at Canada between February and August 2008. Preliminary analysis supported that the SIS-MAP is a valid and reliable tool to determine the level of psychiatric care needed for adults with suicidal ideation. Clinical cut-off scores were established from the observed mean differences in the patients’ total scores and level of care needed. A canonical discriminant function analysis was conducted in order to evaluate whether SIS-MAP total scores were predictive of admission. The analysis resulted in a total 74.0% of original grouped cases were correctly classified (Wilks Lambda = .749, p<0.001). The specificity of the scale (correctly identifying individuals who did not require admission) was 78.1% while the sensitivity of the scale (correctly identifying individuals who required admission) was 66.7%. The false positive rate was 33.3% while 21.9% of cases resulted in a false negative. The measure also demonstrated moderate-high inter-rater reliability (between 0.70 and 0.81 (X=.76), N=20, p<.001).
Review of Literature

List of Risk factors in suicide: as per Pub med,

Personal and psychological

1. Previous attempt
2. Impulsivity
3. Interpersonal discord
4. Unhealthy relationship
5. Emotional distress
6. Sex abuse
7. Childhood sex abuse
8. Poor quality of life
9. Depressive symptoms
10. Persistent suicidal thought
11. Exposure to single parenthood in childhood
12. Impulsive aggression
13. Self-reported depression
14. Parental disharmony
15. Prior suicide attempt
16. Emotional abuse and exploitation
17. Sexual abuse
18. Victim of violence
19. Repeated suicide
20. Recent romantic break up,
21. Hopelessness
22. Negative life events
23. Recipient of social benefits
24. Antidepressant drugs
25. Loss of child’s custody
26. Interpersonal grief
Social and Environmental

27. Homeless
28. Aboriginal status
29. Disaster
30. Socio-economic differences
31. Social disparities
32. Political unsteady situation
33. War and regional conflicts
34. Stress
35. Unemployment
36. Stressful –after discharge home conditions
37. Living alone

38. Traditional role of male gender
39. Pesticide
40. Persistent unemployment

Biological, familial,
Psychiatric & Medical

41. Tobacco
42. Alcohol Acute and chronic illness-
43. Physical dating violence
44. Domestic violence
45. Violence
46. Drug involvement Access to pesticides
47. Anxiety disorders
48. Eating disorders
49. Cognitive deficit-mental distress
50. Pituitary tumor
51. Obesity, dyslipidemia, hypertension, diabetes, and cigarette smoking
   schizophrenic individuals
52. Family history of suicide
53. Mental illness
54. Physical illness
55. I Adjustment disorders
56. IV Drug users
57. Personality disorder
Suicide ideation and attempts pose significant risk for self-harm, and pose unique and challenging treatment management considerations. Suicidal ideation is common in about 4% in general population and about 20% of the psychiatric population. Suicide attempts and gestures represent as much as 60-70% of referrals to acute care psychiatry. There have been many clinical rating scales and questionnaires developed to argument risk assessment. However, the management and planning for treatment interventions are almost exclusively based upon clinical judgment.

The science of suicidology is constantly evolving with changing socio-cultural perspectives. Much more research is required in formulating objective decisions for the management of acutely distressed individuals, those with moderate risk of self-harm and those with suicidal ideation secondary to major psychopathology and/or personality disorders. Suicidal ideation is rarely a static phenomenon. Specifically, thoughts of suicide have constant interplay with other biopsychosocial risk factors, which interface with and mediate morbid cognitions.

The cognitive set changes and cognitive control is lost which can gives rise to an attempt. For an adequate risk assessment one needs to take into consideration all domains and known risk factors against the background of suicide protective factors.
There is a need for more research in developing tools that can assess with some certainty the impact of ideations and/or attempts, guide the disposition and management of the perhaps.

This could directly benefit efforts by the client/family, referring sources, and the treatment team in developing consistent models of care that extends policy to the management, assessment and treatment of suicidal individual.

Professional guidelines that inform the responsible clinician of empirically supported best practices could protect the consumer and the hospital. Hospital accreditation standards highly recommend that policy standard be developed to protect patient safety. In particular section 7.0,8.0,10.0,15.0, and 16.0 speak to the importance of policy development for at-risk patients.

Efforts by Residential Assessment Inventory to codify admissibility criteria for at-risk patients has been encouraging. Unfortunately, the interRAI EMERGENCY SCREENER FOR PSYCHIATRY is only utilized once the patient has entered hospital care.

Suicide behavior is an area of clinical research and practices which in constantly evolving. While judgments are made based on clinical experience in assessment of risk, it is necessary that decisions be based on evidence in modern times. There are several scales and inventories available for prediction of suicidality however there is none to measure its impact help clinician’s decide of course of management for a particular client while working in E-R or assessment units or acute psychiatry. Suicide is a bio-behavioral symptom having three main domains from where the risk arises and becomes uncontrollable. These are biological domains, psychological domains and social-Environmental domain. Rating of case vintage and exercise in inter-rater reliability will be discussed along with merits and shortcomings of the new measurement tool. Suicide behavior is central to emergency psychiatry. The new scale might be add-on information along with the existing ones with the objective of help in management and planning. There is also scope for development for administrative clinical excellence in guiding principle for policy and programs.

Risk assessment for suicidality is the top most clinical priority.
2. **Theoretical construct**

Since quite some time a trend has been seen in the literature that suicidal ideation and attempt has been quantified to predict possibility however the success of these attempts in real life situations is questionable. Statistical measures do show that power of predictability of a given scale is grate but the experience tells different story. Number of patients losses their lives after attending an assessment in a hospital or a clinic. In fact number of suicide is high in recently discharged patients and patients who have recently communicated. The question arises that is it an area we just cannot nip in bud or there are barriers. If there are barriers to accurate assessments? Why do we accept that it happens and that's the way it is. It's a challenge to science of modernity that some one’s committed suicide surprises us and the lives lost. The trend does not stop it extends, in older people in young children. The causes are many folds. More we explore more we get bewildered. The numbers are rising day by day and we have to watch helplessly. Young children as young as four years and older as old as eighties are committing suicide and there are no pointers, no predictors, which prove correct in measures to saves them. What can be of more significant in evolved civilization? More evolved societies get into more problems. It’s so diverse in different cultures that it becomes difficult to find common denominators. Still, in spite of differences there are commonalities, which can possibly help us, curb what best needs to be curbed. Suicide prevention is life prevention and perhaps the most important public health issue asking for new initiatives in research and practice. The first step in any given society will be to develop a belief that it’s possible. The second would be to explore contemporary pattern, and the facts that perpetuate; the next would be to develop best clinical practices for the cause. Prevention is a concerted work to be done by multidisciplinary team and networking the agencies which come in contact of suicide.

3. **Justification for new scale**

There are three different types of scales and inventories available in field of suicide research and practice.

1. For measurement of suicide intent
2. For assessment of suicide potential and prediction of possible attempt
3. For assessment of suicide potential in certain disorders like personality disorder and substance abuse.
Besides these there are basic screening tools available, which provide very basic information for possible psychiatric diagnosis and possibility of risk.

There are no scale or measurement tools, which can reasonably assess:

1. The global impact of an attempt on an individual
2. Can guide for management and disposition by accurately measuring the risk e.g. to hospitalize, not to hospitalize, kind of management to be given in community, use mental health act or not to use.
3. Can assess risk and vulnerability in both, suicidal ideators and suicide attempters.
4. Can work as a guiding instrument for developing policy and planning measures to be applied across institutions.
5. Can help in planning prevention work based upon multidisciplinary concepts.

There is also no instrument available which has been designed based upon current understanding of genesis of suicide ideation and behavior. E.g.

1. Which takes into account all possible factors in to account: the biological, the psychological, the social and the environmental
2. Which takes into account the known risk factors
3. Which fives factor analysis to guide the management based upon ‘fixed risks’ or permanent risks like personality and diseases.

Thus it is felt that a new instrument to measure suicidality keeping the above mentioned aspect would be helpful in individual clinical practice and also in policy planning for disposition of attempters in emergency and assessment units.
## Domains

1. **Demographic**
2. **Psychological**
   1. Ideation;
   2. Management of ideation;
   3. Assessment of current state
   4. Planning for subsequent attempt
3. **Comorbidities**
4. **Family history**
5. **Biological Domain**
6. **Protective factors**
7. **Clinical rating observations**
8. **Psychosocial/Environmental domains**

### SIS-MAP Clinical Profile:

<table>
<thead>
<tr>
<th>I-MAP subscales</th>
<th>Demographics:</th>
<th>Psychological Domain:</th>
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</thead>
<tbody>
<tr>
<td>2I- Ideation</td>
<td></td>
<td>Comorbidities:</td>
</tr>
<tr>
<td>2M- Management</td>
<td></td>
<td>Family History:</td>
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<tr>
<td>2A- Assessment</td>
<td></td>
<td>Biological Domain:</td>
</tr>
<tr>
<td>2P- Planning</td>
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<td>Protective Factors:</td>
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<td></td>
<td>Clinical ratings/observations:</td>
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<td></td>
<td></td>
<td>Psychosocial/Environmental:</td>
</tr>
</tbody>
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**Total of all above sections:**
One million People commit suicide every year

More than any war or Disaster

making it one of the world's leading causes of death. There are an estimated 10 to 20 million attempted suicides every year.