Suicide Prevention:  
A Few Examples of Assessing Risk...

EVALUATION OF SUICIDE RISK AMONG ADOLESCENTS

This is an evaluation form for one-on-one assessment of suicide risk for adolescents. Included are sections on current suicidal ideation and behavior, personal and family history of suicidal behavior, precipitating events, and warning signs. Suicide risk scoring instructions are provided. “Imminent Danger Assessment” and “Plan of Action” forms are included as follow-up materials.

Source: Mary Jane Rotheram-Borus & Jon Bradley  
Columbia University, Division of Child Psychiatry  
Research Foundation for Mental Hygiene  
722 West 168th Street  
New York, NY 10032  
(212) 960-2548

A MEASURE OF ADOLESCENT POTENTIAL FOR SUICIDE (MAPS)

This journal article describes an assessment instrument designed to address suicide potential of youth ages 14-18, who are at risk for suicidal behaviors. Qualities of the scale are evaluated.

SUICIDAL ASSESSMENT -- CHECKLIST*

Student's Name: _____________________  Date: _________  Interviewer: ____________

(Suggested points to cover with student/parent)

(1) PAST ATTEMPTS, CURRENT PLANS, AND VIEW OF DEATH

Does the individual have frequent suicidal thoughts? Y  N

Have there been suicide attempts by the student or significant others in his or her life? Y  N

Does the student have a detailed, feasible plan? Y  N

Has s/he made special arrangements as giving away prized possessions? Y  N

Does the student fantasize about suicide as a way to make others feel guilty or as a way to get to a happier afterlife? Y  N

(2) REACTIONS TO PRECIPITATING EVENTS

Is the student experiencing severe psychological distress? Y  N

Have there been major changes in recent behavior along with negative feelings and thoughts? Y  N

(Such changes often are related to recent loss or threat of loss of significant others or of positive status and opportunity. They also may stem from sexual, physical, or substance abuse. Negative feelings and thoughts often are expressions of a sense of extreme loss, abandonment, failure, sadness, hopelessness, guilt, and sometimes inwardly directed anger.)

(3) PSYCHOSOCIAL SUPPORT

Is there a lack of a significant other to help the student survive? Y  N

Does the student feel alienated? Y  N

(4) HISTORY OF RISK-TAKING BEHAVIOR

Does the student take life-threatening risks or display poor impulse control? Y  N

*Use this checklist as an exploratory guide with students about whom you are concerned. Each yes raises the level of risk, but there is no single score indicating high risk. A history of suicide attempts, of course, is a sufficient reason for action. High risk also is associated with very detailed plans (when, where, how) that specify a lethal and readily available method, a specific time, and a location where it is unlikely the act would be disrupted. Further high risk indicators include the student having made final arrangements and information about a critical, recent loss. Because of the informal nature of this type assessment, it should not be filed as part of a student's regular school records.
FOLLOW-THROUGH STEPS AFTER ASSESSING SUICIDAL RISK -- CHECKLIST

___(1) As part of the process of assessment, efforts will have been made to discuss the problem openly and nonjudgmentally with the student. (Keep in mind how seriously devalued a suicidal student feels. Thus, avoid saying anything demeaning or devaluing, while conveying empathy, warmth, and respect.) If the student has resisted talking about the matter, it is worth a further effort because the more the student shares, the better off one is in trying to engage the student in problem solving.

___(2) Explain to the student the importance of and your responsibility for breaking confidentiality in the case of suicidal risk. Explore whether the student would prefer taking the lead or at least be present during the process of informing parents and other concerned parties.

___(3) If not, be certain the student is in a supportive and understanding environment (not left alone/isolated) while you set about informing others and arranging for help.

___(4) Try to contact parents by phone to
   a) inform about concern
   b) gather additional information to assess risk
   c) provide information about problem and available resources
   d) offer help in connecting with appropriate resources

   Note: if parents are uncooperative, it may be necessary to report child endangerment after taking the following steps.

___(5) If a student is considered to be in danger, only release her/him to the parent or someone who is equipped to provide help. In high risk cases, if parents are unavailable (or uncooperative) and no one else is available to help, it becomes necessary to contact local public agencies (e.g., children's services, services for emergency hospitalization, local law enforcement). Agencies will want the following information:
   * student's name/address/birthdate/social security number
   * data indicating student is a danger to self (see Suicide Assessment -- Checklist)
   * stage of parent notification
   * language spoken by parent/student
   * health coverage plan if there is one
   * where student is to be found

___(6) Follow-up with student and parents to determine what steps have been taken to minimize risk.

___(7) Document all steps taken and outcomes. Plan for aftermath intervention and support.

___(8) Report child endangerment if necessary.
Suicidal ideation can be a symptom of depression. At the same time, other symptoms of depression can serve as warning signs for suicidal ideation...

**DSM-IV CRITERIA FOR DIAGNOSIS OF MAJOR DEPRESSIVE EPISODE**
(Diagnostic and Statistical Manual of Mental Disorders (DSM-IV),
American Psychiatric Association, 1994)

Five or more of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

(1) depressed mood most of the day, nearly every day, as indicated by either subjected report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). **Note: In children and adolescents, can be irritable mood.**

(2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)

(3) significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. **Note: In children, consider failure to make expected weight gains.**

(4) insomnia or hypersomnia nearly every day

(5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restless or being slowed down)

(6) fatigue or loss of energy nearly every day

(7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)

(8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)

(9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

**Culture and age considerations:** In some cultures, depression may be expressed through somatic symptoms. In addition, somatic complaints, irritability, and social withdrawal tend to be especially common in children, whereas psychomotor retardation, hypersomnia, and delusions are less common in children than adolescents.