Optum Health Education™

Mitigation of Acute Risk of Suicidal Acts

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Outline

- The standard of care in working with suicidal patients
- Suicide risk assessment (SRA) and Suicide risk formulation (SRF)
- SRF has no positive predictive value
- What you have been taught is mostly wrong
- The Stress-Diathesis Model: Differentiating chronic from acute risk
- Indicia for acute risk of suicidal action: The what
- Contributory stressors: The most likely when
- Treatment planning and interventions to mitigate acute risk
- Documentation: The key to staying out of court

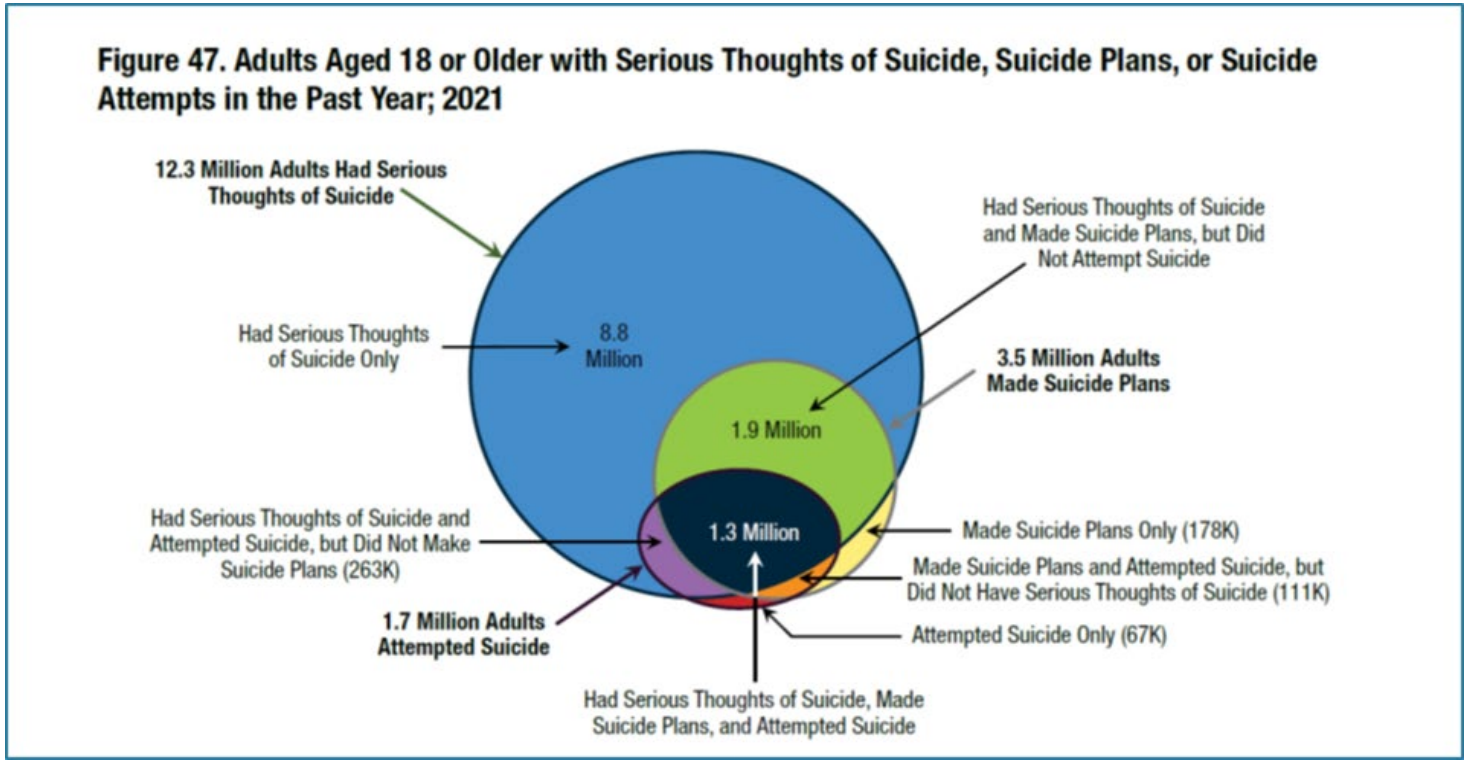
Disclosures

I have a consulting agreement to advise Modern Health

If you attended my October, 2022 *AbleTo* presentation and remember anything from that, you will note some redundancy; but redundancy is good…redundancy is good.

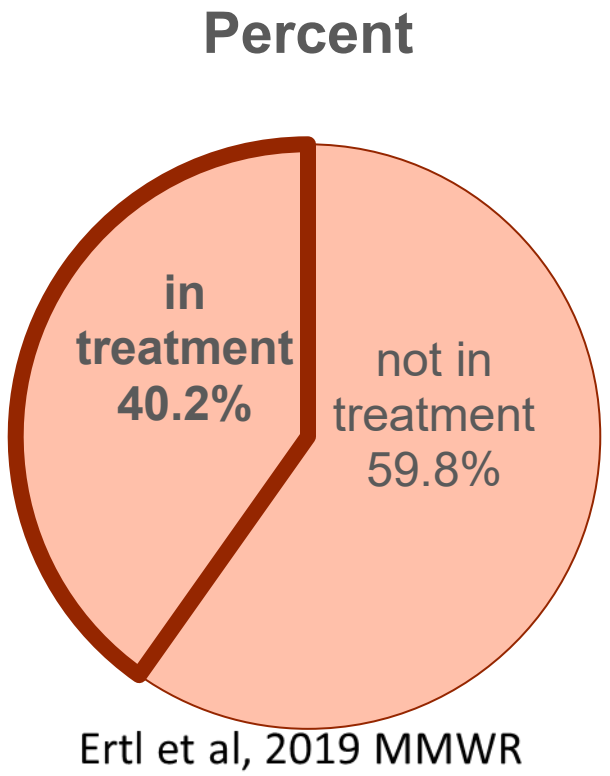
S_____ Happens!

Substance Abuse and Mental Health Services Administration. (2021).



In 2021, the N of deaths by suicide in the U.S. = 48,183 (CDC)

US HealthCare Providers Have Opportunities to Prevent Suicide: At time of Death by Suicide – Percent FEMALES in Treatment



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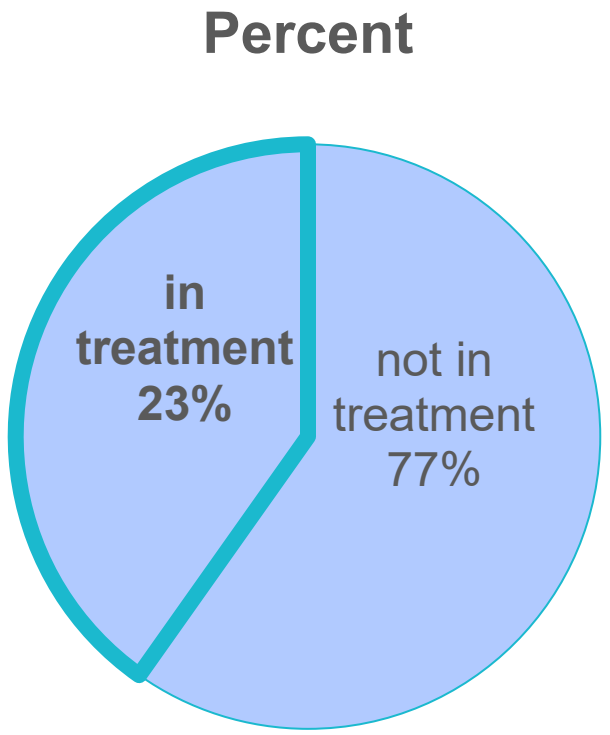


Ertl et al, 2019 MMWR

Understanding the standard of care in working with suicidal patients

- Once a therapist-patient relationship exists, the therapist has a duty to care.
- Clinicians have a duty to possess a reasonable specialized knowledge and reasonable skills.
- Clinicians have a responsibility/duty to protect the patient from violent acts against the self, i.e. **to act to prevent** suicide.
- Ethical standards require COMPETENCY

Standard of Care

- Legal concept
  - The standard of care is the benchmark that determines whether professional obligations to patients have been met. Failure to meet the standard of care is negligence, which can carry significant consequences for clinicians.
  - Defined as that level of care, skill and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by ***reasonably prudent*** similar health care providers."

Defined by:

Statutes, regulations, and court opinions

Policies and guidelines from professional organizations, such as from the APA or AACAP

Journal/research articles, e.g. re evidence-based practices

Accreditation standards

Facility policies and procedures

- ***Opined by experts***

What is expected of the ***reasonable and prudent*** clinician

Reasonable and Prudent Practitioner Behaviors

- Reasonably formulate a diagnosis based on presenting symptoms
- Systematically assess and formulate **acute risk** of suicidal behavior
  - Functionally analyze motive and intent to suicide
- Formulate treatment plan to treat diagnosis and reduce assessed **acute risk**
  - Monitor, Observe, Decrease Isolation, Protect vs. Self; Be available and accessible; Follow P&Ps; Medicate, if indicated
- Reliably implement treatment plan
- Decrease **acute risk**, Increase protections, decrease chronic risk
  - Use evidence-based interventions and best practices
- Evaluate progress and revise/modify and/or refer, as needed
- Recognize need for continuity of care

Differentiating a suicide risk assessment from a suicide risk formulation

Can You Identify the Following?

- 1 1/2 pounds ground beef
- 1 egg
- 1 onion, chopped
- 1 cup milk
- 1 cup dried bread crumbs
- salt and pepper to taste
- 2 tablespoons brown sugar
- 2 tablespoons prepared mustard
- 1/3 cup ketchup

Think Again…

What distinguishes this list of ingredients from the final preparation they comprise?

Recipe: A set of instructions re using the list of ingredients to arrive at a final preparation

- Preheat oven to 350 degrees F (175 degrees C).
- In a large bowl, combine the beef, egg, onion, milk and bread OR cracker crumbs. Season with salt and pepper to taste and place in a lightly greased 5x9 inch loaf pan, or form into a loaf and place in a lightly greased 9x13 inch baking dish.
- In a separate small bowl, combine the brown sugar, mustard and ketchup. Mix well and pour over the meatloaf.
- Bake at 350 degrees F (175 degrees C) for 1 hour.

SRA & SRF

Suicide Risk Assessment

Relies on **data gathering** of risk factors, protective factors, warning signs, triggers, motivations, intent, etc. that informs a…

Suicide Risk Formulation

A **judgment** of level of risk that determines triage, disposition, treatment and safety planning, management, etc.

Levels of Risk, for example:

Imminent
High
Moderate
Low
None

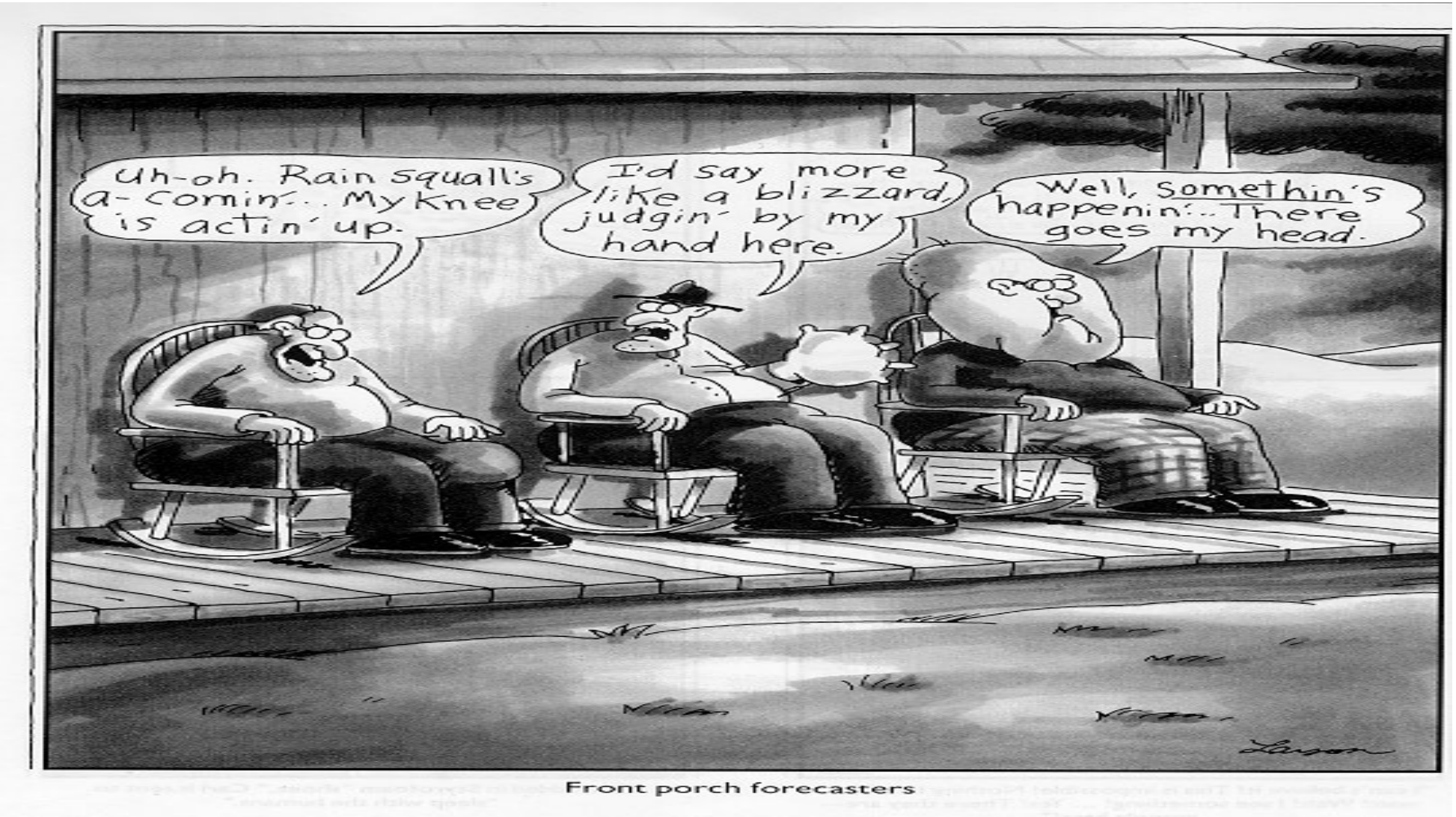
Skill Set

Formulating a Judgment of Level of Risk

Make a clinical judgment of the likelihood that a patient will attempt suicide in the short-term (**acute risk**) and long-term (chronic risk)

- Apply understandings of risk based on research
- Integrate and prioritize information
- Engage in critical thinking
    - Assess patient's motivation to minimize risk
    - Assess patient's motivation to exaggerate risk

There is simply no agreed-upon risk formulation strategy (“recipe”)



Front porch forecasters

Why does a suicide risk formulation have no positive predictive value?

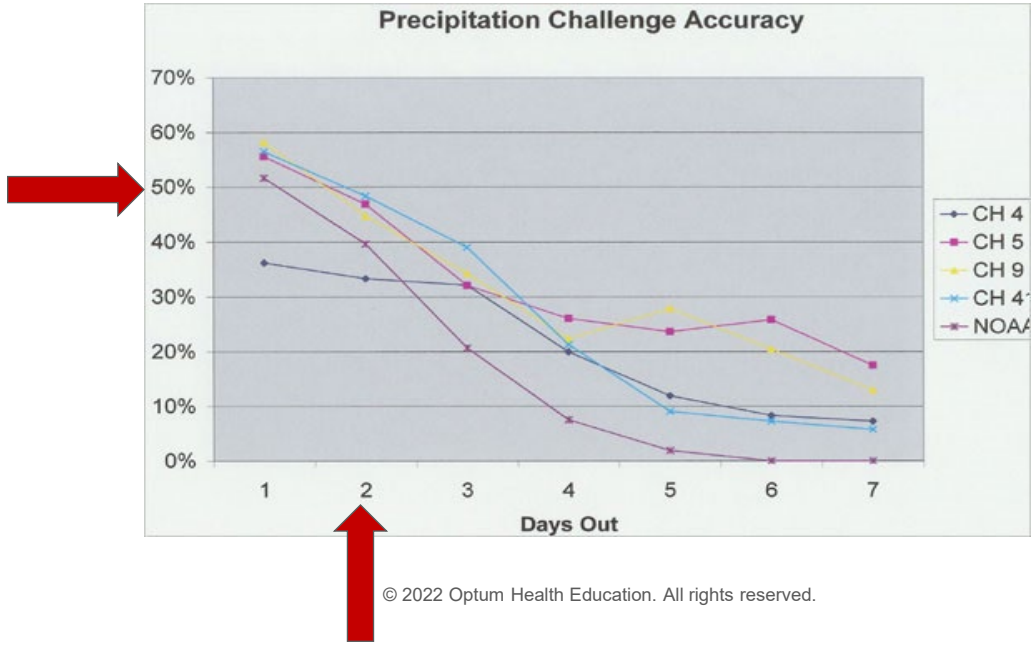
"Prediction is hard, especially when you're talking about the future."

(*Yogi Berra, undated*)

Foreseeability v. Prediction

Excluding those days where there is 0% chance of any rain, meteorologist's predictions of rain in the next 48 hours are wrong more than ½ the time! (Eggleston, 2008)

- At 2 days - all were wrong more than ½ the time
- At 3 days - correct forecasts averaged about 30%
- At 7 days - correct forecasts averaged about 10%



Are clinicians capable of formulating/foreseeing imminent risk of Suicide Risk?

Research has consistently shown that clinicians are not very accurate in making risk formulations

(Erdman et al, 2013; Gustafson et al, 1977,1981; Nock et al, 2010)

…at last contact, the clinician assessed no suicide risk in 30% and low risk in 54% of patients who then died by suicide.

(Appleby et al., 2012; Appleby, Shaw, & Amos, 1999)

…at last contact, suicide risk was estimated to be high in only 2% of 10,000 cases of people who died by suicide who had contact with mental health services in the 12 months before death.

(Appleby et al.,1999)

The positive predictive value of risk categorization among six cohort studies was 0.43%

(Large M, Myles N, Myles H, Corderoy A, Weiser M, Davidson M, Ryan CJ. (2018)

About 60% of patients who die by suicide (within a year) are likely to be categorized as low risk.

(Large et al., 2011)

While risk assessments do generate some information about future suicide, suicide risk categorization results in an unacceptably high false positive rate, misses many fatalities, and therefore, is unable to usefully guide prevention strategies. *The assessment of suicidal patients should focus on contemporaneous factors and the needs of the patient*, rather than probabilistic notions of suicide risk.

Large MM. The role of prediction in suicide prevention. Dialogues Clin Neurosci. 2018 Sep;20(3):197-205.

What you have been taught is mostly wrong:

Several Facts that Inform Acute (Near-term) Risk

The normative approach to assessing acute suicide risk is to ask about the presence of SI

- **This is all well and good.**
- **If SI is present, clinicians should "*peel the onion*" and further inquire about:**

  - Frequency (how often?)
  - Type: Active versus Passive (Use patient's own words)
  - Intensity/Severity (how strong is the urge to act?)
  - History (have you had similar thoughts in the past?)
    - If so, when, what was going on, what happened,…?)
  - Duration (how long?)
  - Planning (specificity of)
  - Method, and its Accessibility
  - Preparations and/or Rehearsal
  - Intent (aim, purpose, goal…)
  - Controllability ("Resist-ability"?) vs. Impulsivity
  - Reasons/Motivations for (driver[s]?)
  - Variability (Waxing/Waning)

A Typical Strategy: The C-SSRS

Minimum of 2 Questions Maximum of 6 Questions

COLUMBIA-SUICIDE SEVERITY RATING SCALE
Screen Version - Recent

SUICIDE IDEATION DEFINITIONS AND PROMPTS	Past month	
Ask questions that are bolded and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) Wish to be Dead: ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) Suicidal Thoughts: ***Have you actually had any thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): E.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it.*" ***Have you been thinking about how you might do this?***		
4) Suicidal Intent (without Specific Plan): As opposed to "*I have the thoughts but I definitely will not do anything about them.*" ***Have you had these thoughts and had some intention of acting on them?***		
5) Suicide Intent with Specific Plan: ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***		

6) Suicide Behavior Question: ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?***	**YES**	**NO**
Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask: *Was this within the past three months?***		

If 2 is Yes, ask 3-6

If 2 is No, go to 6

Fact 1 about Suicide Ideation (SI)

The presence of current or recent SI is a better predictor of future risk (in the longer term) of suicide than a predictor of near-term risk of suicide

a. The report of current or recent SI is highly correlated with the occurrence of future SI

SI has been shown to be "episodic, with quick onset and short duration."

(Kleiman & Nock, 2019),

b. Suicidal thinking changes rapidly. Elevated states of SI last an average of 1-3 hours

(Coopersmith et al., under review)

c. The report of current or recent SI has very little correlation with the progression to suicide attempts or to death by suicide ***in the near-term***

(Fawcett et al., 1990; Kessler, Borges & Walters, 1999, Isometsa et al., 1995; Borges et al, 2006, 2008; Berman, 2018)

d. Meta-analysis of 81 studies:1.4% of psychiatric patients who had expressed SI died by suicide ***in the first year of follow-up***

(Hubers et al., 2018)

"

Fact 2 about Suicide Ideation (SI)

Planning is no more predictive of behavior than is impulsivity

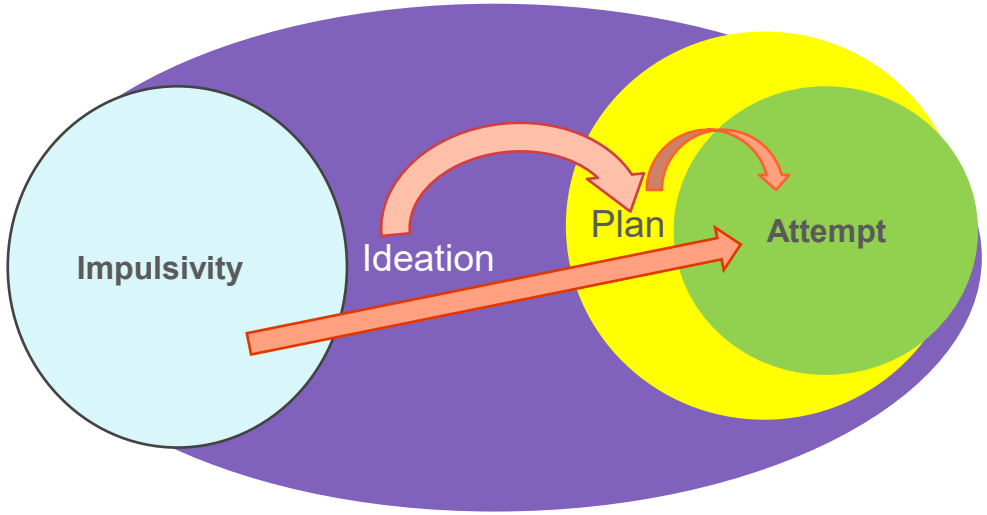
About 1/3rd of ideators transition to a plan

- Between 2/3rds and 3/4ths of those who plan make an attempt.

Hence about 1/4th (24.5%) of ideators make a planned attempt.

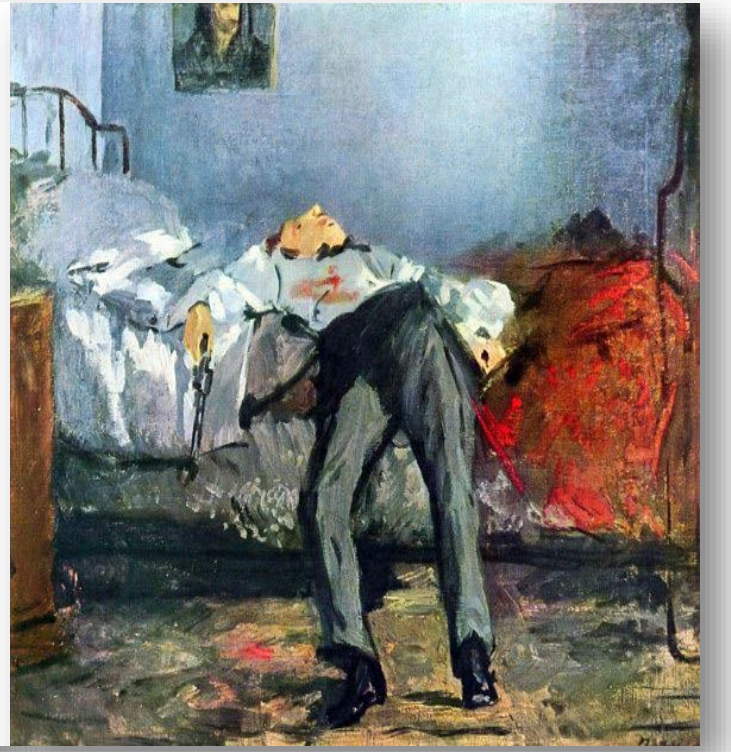
Yet, about 1/4th (26%) of ideators make an unplanned attempt

Ergo, the proportion of patients who act on suicidal thoughts with plans equals that of patients who make an unplanned attempt. (Kessler et al., 1999)



Suicide Is A Powerful, But Brief Impulse

Simon (2001) interviewed 153 young high lethality suicide attempters and found that fully 87Simon (2001) interviewed 153 young high lethality suicide attempters and found that fully 87% of them had only decided to make the attempt within 24 hours of the attempt; and most had decided within the hour



Fact 3 about Suicide Ideation (SI)

COLUMBIA-SUICIDE SEVERITY RATING SCALE
Screen Version - Recent

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Ask questions that are bolded and underlined.		
Ask Questions 1 and 2		
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6) Suicide Behavior Question:	YES	NO
Have you ever done anything, started to do anything, or prepared to do anything to end your life? Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. If YES, ask: ***Was this within the past three months?***		

A patient expressing active suicide ideation is not necessarily at greater risk of future suicide than one expressing passive SI.

The scaling of active SI as more predictive of suicide risk than passive SI is questioned by the current data in that **nearly equal proportions of active versus passive SI were expressed by decedents who admitted to SI when last asked before they took their lives**

(Berman, 2018; Baca-Garcia et al., 2011) .

Active SI appears to be no more associated with death by suicide than is passive SI

(Simon, 2008; Silverman & Berman, 2014; Szanto et al., 1996).

Fact 4 about Suicide Ideation (SI)

T***he severity of past SI at the worst point in a patient's life*** as a better predictor of later death by suicide (Beck et al, 1999).

In a study of 157 patients who died by suicide while in -- or recently in -- clinical care, prior SI was charted more frequently (71%) than current SI when assessed immediately prior to death by suicide (27%) (Berman, 2018).

Fact 5 about Suicide Ideation (SI)

If SI is denied, clinician's typically chart "No SI" and assume "No SI" = No Suicide Risk

Yet, ***at least 15 studies*** have confirmed that:

The majority of patients who die by suicide actually *deny* having suicidal thoughts when last asked prior to their death

- Appleby et al., 1999
- Berman, 2018
- Barraclough et al., 1974
- Busch et al., 2003
- Chavan et al., 2008
- DeLong & Robins, 1961
- Denneson et al, 2010
- Hall et al., 1999
- Hjemeland, 1996
- Isometsä et al., 1995
- Louzon et al., 2016
- McKelvey et al., 1998
- Simon et al, 2013; 2016
- Smith et al, 2013

Clearly, the absence of SI is not synonymous with the absence of near-term risk

Fact 6 about Suicide Ideation (SI)

Whether or not a patient will respond to your inquiry about SI depends greatly on how you ask the question.

- 191 bipolar patients were asked whether they had ever seriously considered suicide during their current bipolar episode and further evaluated SI via the Scale for Suicide Ideation (SSI), the Beck Depression Inventory (BDI, Item 9) and the Hamilton Depression Scale (HAM-D, Item 3).
  - In all, *74% of patients were suicide ideators as measured by at least one of the three measures; but **only 29%** of patients met the criteria for having SI on all measures*. (Valtonen et al., 2009).

- 153 patients diagnosed with MDD were asked about the presence of SI via six different scales.

  Only 8% tested positive for SI across all measures. (Vourilehto et al., 2014)

What are you asking?

In the past (1) _____ have you had (2) ____ thoughts about (3) _____?

(1) Several days; 2 weeks; 1 month; 12 months; 2 years

(2) Any; Serious; Frequent; Uncontrollable

(3) Being better off dead; going to sleep and not wanting to wake up in the morning; not wanting to live; dying; just giving up; life not being worth living; killing yourself; harming yourself; hurting yourself; dying by suicide

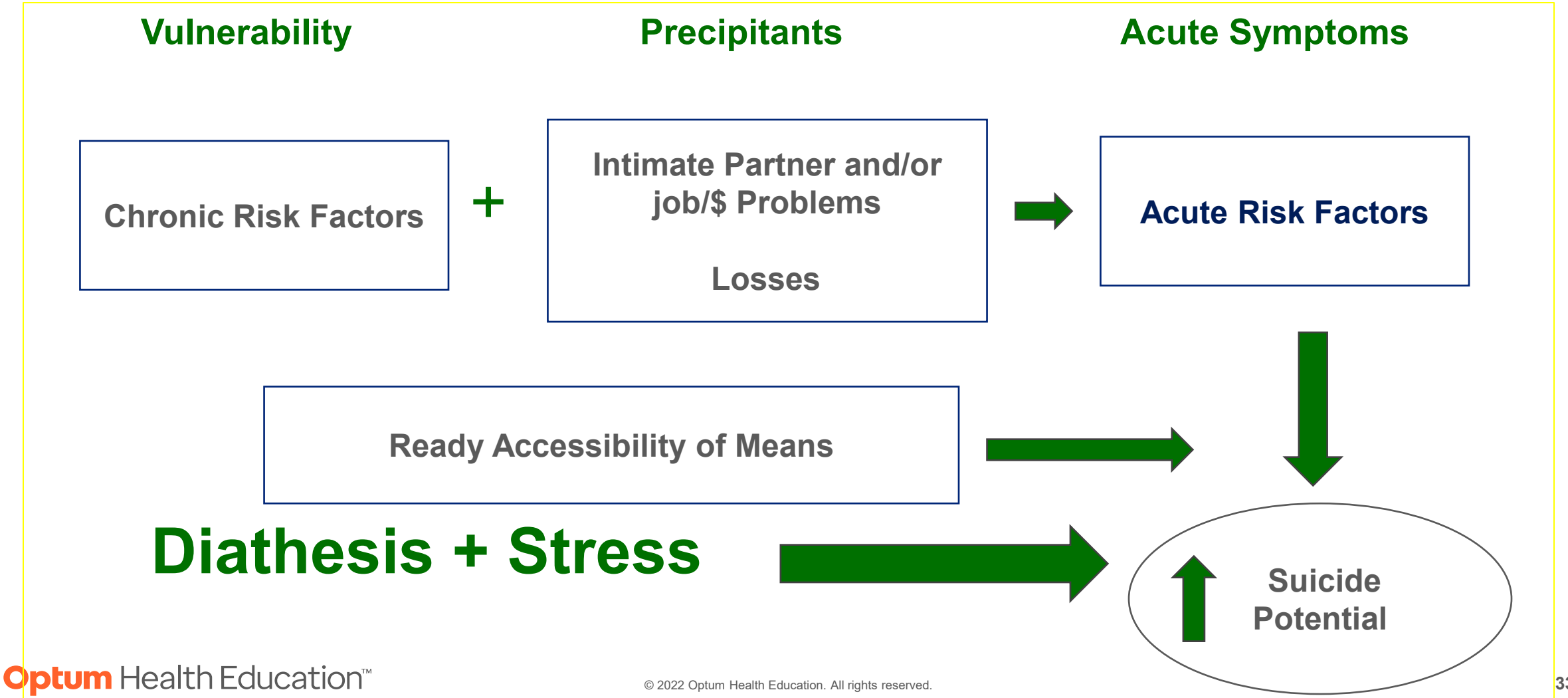
Fact 7 about Protective Factors

Protective Factors Do Not, (note to self, repeat this), ***DO NOT*** Protect *if there is Acute Risk*.

- Married folks kill themselves

  Married folks with children kill themselves
- Priests, ministers, and rabbis kill themselves
- Parents looking forward to their daughter's wedding kill themselves
- Psychiatrists, psychologists, social workers, etc. kill themselves…
- People with easy access to clinical care kill themselves; patients take their lives

The Stress-Diathesis Model:
A Model for Understanding the Pathway to Suicidal Behavior



Differentiating chronic from acute risk

Chronic vs. Acute Risk Factors

Examples:

Chronic (Elevated Lifetime) Risk	Acute (Elevated Near-term/Next 30 days) Risk:
A history of psychiatric hospitalization	Recent discharge from inpatient psychiatric hospitalization.
Hx of major psychiatric d/o	Feelings of entrapment
Exposure to another's suicide	Current NSSI
Adverse childhood experiences (ACE)	Insomnia
Axis II and/or Axis III d/o	Agitation

Acute Risk Factors

Demographics: Recently Divorced or Separated with Feelings of Victimization or Rage
Excessive or Increased Use of Substances (alcohol or drugs)
Psychological Pain (acute distress in response to loss, defeat, rejection, etc.)
Recent Discharge from psychiatric hospitalization
Withdrawal from Usual Activities, Supports, Interests, School or Work; Isolation (e.g. lives alone)
Intense affect states (e.g. desperation, intolerable aloneness, self-hate…)
Suspiciousness, Paranoia (ideas of persecution or reference)
Sense of Purposelessness or Loss of Meaning; No Reasons for living
Negative or mixed attitude toward help-receiving

Feeling Trapped, Like There is No Way Out (other than death); Poor Problem-Solving
Negative or mixed attitude by potential caregiver to individual
Recklessness or excessive risk-taking behavior, especially if out of character or seemingly without thinking of consequences; Tendency toward Impulsivity
Poor therapeutic alliance in context of acute risk
Severe feelings of confusion or disorganization
Hopelessness, Poor Problem-solving, Cognitive Constriction (thinking in black and white terms, not able to see gray areas, alternatives…), Rumination, Few Reasons for Living, Inability to Imagine Possibly Positive Future Events

Current NSSI
Recent Suicide Attempt
Anger, Rage, Seeking Revenge
Aggressive Behavior [Bullying]
Anhedonia
Agitation
Insomnia
Anxiety, Panic
Persistent Nightmares

Command Hallucinations Urging Suicide
Dramatic Mood Changes
Perceived Burdensomeness

Recent diagnosis of terminal condition

Suicide Crisis Syndrome (see Igor Galynker et al)

A. Frantic Hopelessness/Entrapment:

- A persistent or recurring overwhelming feeling of urgency to escape or avoid an unbearable life situation that is perceived to be impossible to escape, avoid, or endure

B. Associated Disturbances:

B1. Affective Disturbance: Manifested by at least one of the following:

- Emotional pain
- Rapid spikes of negative emotions or extreme mood swings
- Extreme anxiety that may be accompanied by dissociation or sensory disturbances
- Acute anhedonia (i.e., a new or increased inability to experience or anticipate interest or pleasure)

B2. Loss of Cognitive Control: Manifested by at least one of the following:

- Ruminations – an intense or persistent rumination about one's own distress and the life events that brought on distress
- Cognitive rigidity – an inability to deviate from a repetitive negative pattern of thought
- Ruminative flooding – an experience of an overwhelming profusion of negative thoughts, accompanied by head pressure or pain and impairing the ability to process information or make a decision
- Failed thought suppression – repeated unsuccessful attempts to suppress negative or disturbing thoughts

B3. Hyperarousal: Manifested by at least one of the following:

- Agitation
- Hypervigilance
- Irritability
- Insomnia

B4. Acute Social Withdrawal: Manifested by at least one of the following:

- Reduction in frequency and scope of social activity
- Evasive communication with close others

Last 30 Days' Study of Patients in Clinical Care

89/157 patients ***DENIED SI***, when last asked (49% within 2 days):

	(N: 89)
• **Anxiety/Agitated**	75%
• **Sleep Problems**	76%
• **Comorbid Dxs**	79%
• Hx **Prior** SI or SA	84%
• **Current IPP or Job/Financial Strain**	73%

Three of these five signs are acute risk factors
One of these five signs is a contributory risk factor
One of these five signs is a unmodifiable chronic risk factor
70% of these patients had 4 or more of these 5 signs

(Berman, 2018)

Contributory stressors: The most likely when

Relationship strain
Financial strain/job strain
Social rejection/bullying
Intolerable aloneness
Overwhelming burdensomeness
Unbearable, unremitting pain
Shame, Guilt, Despair, Humiliation,
Transitions:

- Changes in meds
- July in inpatient settings
- Therapist vacations

Real or anticipated loss of:

- function
- role
- significant attachment…

Mitigation of Acute Risk

Purpose of an SRF is to ascertain targets for treatment/intervention,

i.e. clinical care planning and implementation

(Pisani et al., 2016. Reformulating Suicide Risk Formulation: From Prediction to Prevention)

Triage and treatment decisions follow a careful assessment and formulation of level of risk.

- Closeness of observation/monitoring
- Decision to hospitalize
- Need for means restriction
- Targeted risk-factors to decrease
- Targeted protective factors to strengthen

Mitigation of Acute Risk:
Good Practice based on evidence-based treatments and best practices

Focus on:

- Efforts at reducing **ACUTE RFs**
- Restricting access to lethal means – **lethal means counseling**
- 24/7 access to caregiver or surrogate caregiver/**support** system
- Suicide-related coping skills/**Safety planning**
- Awareness of periods of/contexts for heightened risk, e.g., transition-based anxiety; changes in medications
- Consultations with colleagues/input from collaterals

Mitigation of Acute Risk: Evidence-based Treatments

Focus on:

- The importance of a good therapeutic alliance
- Evidence that treatment is working; lacking that, evidence of modification or referral
- Consent to treat; consent to consult with collaterals
- Treatment based on SRA/SRF
- Collaborative safety planning, continuously addressed/rehearsed
- Means restriction counseling
- Split treatment consultations/documented
- Attention to continuity of care

Mitigation of Acute Risk: High Quality Safety Plans

Step	Boilerplate (low quality)	Some evidence of personalization (moderate quality)	Strong evidence of personalization (high quality)
1. Warning signs (list three items)	Sad	Feel sad, cry	Feeling like I can't stop crying or can't stop being sad; Feeling trapped or hopeless
2. Internal coping strategies (list three items)	Read	Read a book	Read The Great Gatsby
3. People and places that provide distraction (list two people and two places)	a. People: friend b. Places: public place	a. Bob b. Mall	a. Bob (555)555-5555 b. Northwest Mall
4. People I can ask for help (list three people)	Friend	Bob	Bob (555)555-5555 5
Professionals and agencies (list two providers, one urgent care service, one Suicide Prevention Coordinator, VA Suicide Prevention Hotline)	VA Suicide Prevention Hotline	Dr. Paul Town Hospital VA Suicide Prevention Hotline	Dr. Paul (555)555-5555 Dr. Mary (333)333-3333 Town Hospital, 100 Hospital Way; VA Suicide Prevention Hotline
6. Making my environment safe (list two items)	Alcohol	No alcohol in house Remove firearm	Throw out alcohol from liquor cabinets, garage Give handgun to cousin Phil until crisis has passed

Mitigation of Acute Risk
Treatment Planning: Medication Adherence

71% of 370 patients who presented to the hospital were suboptimal in their medication adherence presented a significantly higher depression severity, more psychiatric hospitalizations, suicidal ideation, physical pain, negative medication side effects, and antecedents of emotional maltreatment. (Baeza-Velasco et al., 2019).

Studies conducted in primary care as well as in psychiatric settings show that more than half of patients suffering from major depressive disorder (MDD) have poor adherence to antidepressants. (Dell'Osso et al., 2020)

Very few youth who died by suicide were found to have been positive for *prescribed* antidepressants. (Dudley et al., 2010)

Mitigation of Acute Risk
Addressing Non-Adherence

Make a focus of treatment

Functionally analyze to recognize factors leading to noncompliance

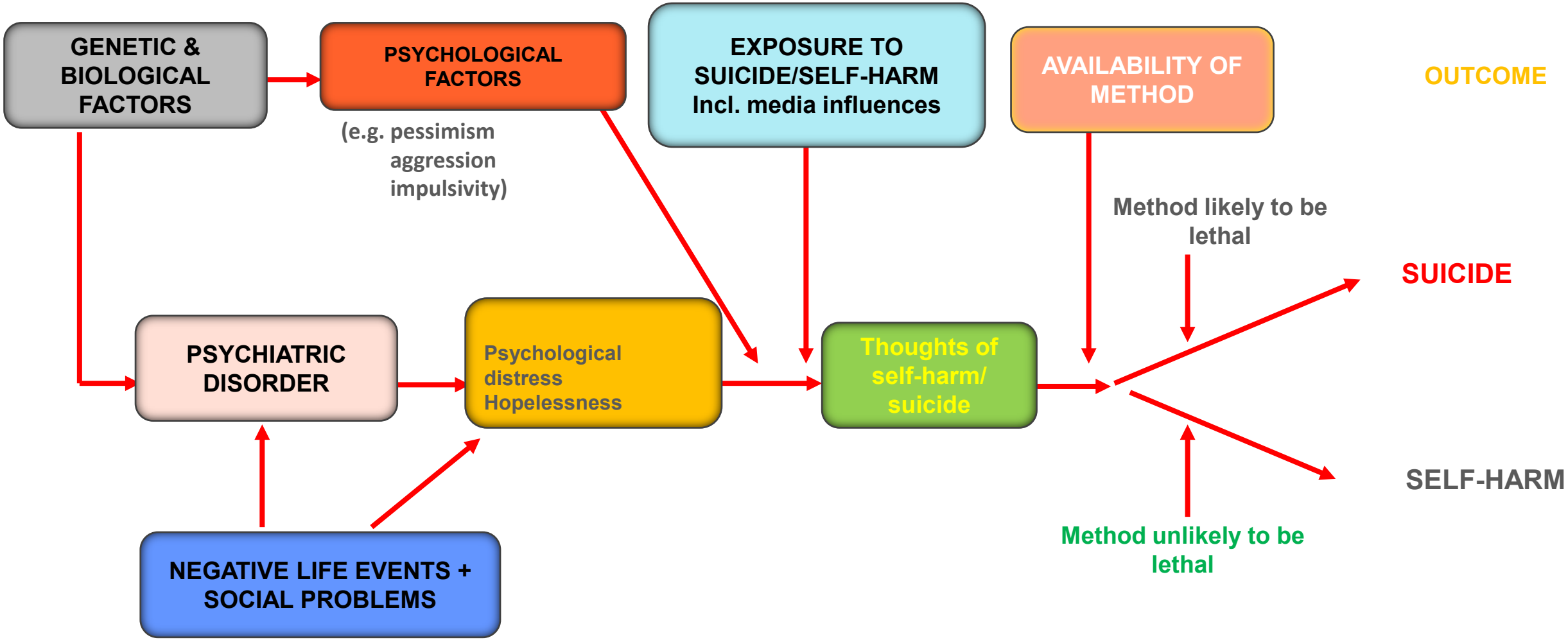
Establish a strong alliance with the patient and significant others - Build collaborative alliance with family

Use CBT approaches/Motivational Interviewing

Educate about the illness and the importance of maintenance treatment, adherence, and/or communication if barriers

Educate about medication, drug interactions, pharmacokinetics and side effects; and monitor

Simplistic model of some causes of fatal and non-fatal suicidal behaviour



Mitigation of Acute Risk: Why Means Restriction?

Not all people who die by self-harm are determined to die (i.e. are without ambivalence).

Some are acting impulsively during a short-term crisis period.

- 25% of 153 survivors of near lethal suicide attempts acted within 5 minutes of the impulse to do so; 71% acted within one hour (Swahn et al. 2001).

Availability and **Accessibility** are the two most common reasons for choice of method in suicides

If a method of suicide is made less lethal, or if a highly lethal method is made less available and an attempter substitutes a less lethal method, the odds are increased that an attempt will be nonfatal.

90% or more of those making nonfatal attempts will not go on to die by suicide (Owens, 2002)

Mitigation of Acute Risk:
Lethal Means Counseling

Aim: To reduce the likelihood of suicide by making less accessible highly lethal methods of suicide

Among ED patients with SI/SA and having at least one firearm at home, only ½ had a documented assessment of lethal means access (Betz et al., 2016)

A free, online version of Counseling on Access to Lethal Means (CALM) offered by the Suicide Prevention Resource Center aims to equip mental health providers and other professionals working with this at-risk population with the tools to address the issue of lethal means restriction (https://zerosuicidetraining.edc.org/)

Mitigation of Acute Risk:
Targeted Evidence-based Treatments of Acute Risk Factors

Acute RF	Targeted Treatments
Insomnia	Riemann et al.(2017). European guideline for the diagnosis and treatment of insomnia. *Journal of sleep research*, *26*(6), 675–700.
Agitation	Verbal de-escalation; atypical antipsychotics; knowing what elements in the environment can trigger agitation and adjusting/managing those appropriately
Anxiety	CBT, Relaxation, Exercise, Anxiolytics, Self-regulation
Social isolation/withdrawal	Zagic et al., D., (2022). Interventions to improve social connections: a systematic review and meta-analysis. *Social psychiatry and psychiatric epidemiology*, *57*(5), 885–906.

Mitigation of Acute Suicide Risk
Evidence-based Psychosocial Interventions

CBT – repeat self-harm (6, 12 months), SI, Hopelessness

- Key elements: crisis response plan, emotion regulation skills (e.g., meditation, mindfulness), modifying maladaptive beliefs/assumptions, suicide-specific relapse prevention skills)

DBT – SI and repeat self-harm

ASSXIP (Attempted Suicide Short Intervention Program (Gysin-Maillart et al, 2018) - SI and repeat self-harm

DBT-A – limited evidence

CAMS - SI

Documentation: The key to staying out of court (if and when S___ happens)

The single most important factor that *plaintiff's* attorneys consider in deciding to litigate -- or not -- is documentation in the patient's chart.

A Jury's Mindset

"*If it wasn't documented, it wasn't done*"

A failure to adequately and contemporaneously document clinical observations, judgments, and rationales for or against treatment choices/interventions exponentially puts you at risk.

A Plaintiff Attorney's Mindset

When a lawyer initially reviews a potential case, all he or she typically has are the medical records. Accordingly, nothing will stop a malpractice lawyer dead in his or her tracks quicker than a well-documented chart reflecting careful and thoughtful suicide assessments. A well-documented case reflecting good care means a plaintiff's lawyer is likely to lose the case. Losing a malpractice case means the lawyer will lose hundreds, possibly thousands of hours of attorney time preparing the case (for no fee), along with approximately $40,000-$100,000 in expenses the lawyer has advanced for the cost of the lawsuit. Lawyers expect no sympathy from physicians, but like other people investing their own money, we want good investments, not chancy ones.

Simpson & Michael (2004, p. 185)

DOCUMENT Good Treatment Actions

- Observations of observable conduct/symptoms/complaints
- Mental Status Evaluation, each session
- Presence/Absence of Current/Recent SI
  - If SI, ***use patient's own words*** (don't paraphrase) and explicate frequency, duration, intensity, controllability, etc.
- Hx of prior suicide attempt(s) and contexts (motivators, precipitants, outcomes…)
- Risk Formulation: Listing chronic v acute v contributory v precipitants that provide your rationale; listing what makes risk wax and wane
- Observed pertinent negatives
- Disposition decisions and their rationale
- Interventions and discharge instructions
- Contacts with/learnings from collaterals and consultants
- Attempts to get and consideration of prior records, if accessible
- Safety Planning
- Means Restriction Counseling

Documentation No-Nos

- Stating that the patient contracted for safety
- Using pejorative language/Blaming the patient
- If patient is not compliant/adherent, this is **your** problem to be addressed/solved
  Therapists are more manipulative than are patients, and we are OK with that
- Expressions of your powerlessness/helplessness
- Abandoning vs effecting a referral
- Assuming that an inebriated patient who expressed SI while drunk, is now not suicidal because they now deny SI when sobered up
- Re: Medications
  - Prescribing new meds without F2F evaluation
  - Prescribing excessive refills
  - Failing to account for known hx substance abuse
  - Failing to inquire about/follow-up complaints of side effects/worsening symptoms
  - Failing to closely monitor response to changes in medication
- Not documenting communications/not communicating with co-caregivers providing split treatment

DOCUMENTATION

- Bad documentation:
  - "No SI/HI"
- Reasonably good summary documentation:
  - This 19 y.o. college sophomore is experiencing his first episode of major depressive disorder. He denies current SI. Nevertheless, he is at moderate to high risk for suicide because of his depression, his continued anxiety and feelings of hopelessness. He has no hx of prior suicidal behavior and denies ever seriously considering suicide. He does not want to be, nor needs to be, hospitalized at this time. Safety plan collaboratively created (see notes) and reviewed with him. He does not have access to a firearm. He has accepted an outpatient referral to see Dr. _____ for CBT and Rx; and has an appointment scheduled tomorrow afternoon. Lives with roommates, one of whom accompanied him to ER and states will not leave him alone between now and tomorrow's appointment. We have scheduled a follow-up telephone check-in with him tonight and have consulted with his parents.
    - The risk level;
    - The rationale for the risk level
    - The treatment plan for reducing the risk

Stop Worrying: Start Focusing

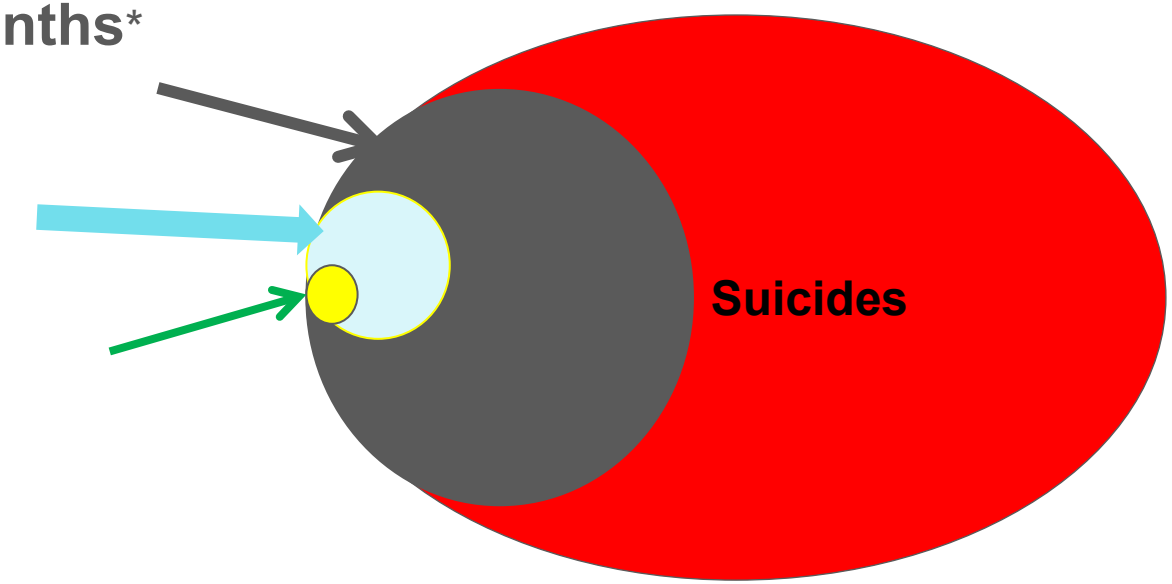
Defensive practice is not helpful practice: Think Venn:

Suicide is rare (US, 2021: N = 48,183)

About 1/3rd contacted a MH provider in the prior 12 months*

Litigation after a suicide is rarer.

A finding of malpractice is rarer still.



Patients want their clinician to be empathic re their pain and to provide best care

***(Luoma, Martin, & Pearson, 2002)**

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