Beyond “Denies SI/HI:” Conducting and Utilizing Risk Assessments to Improve Patient Care

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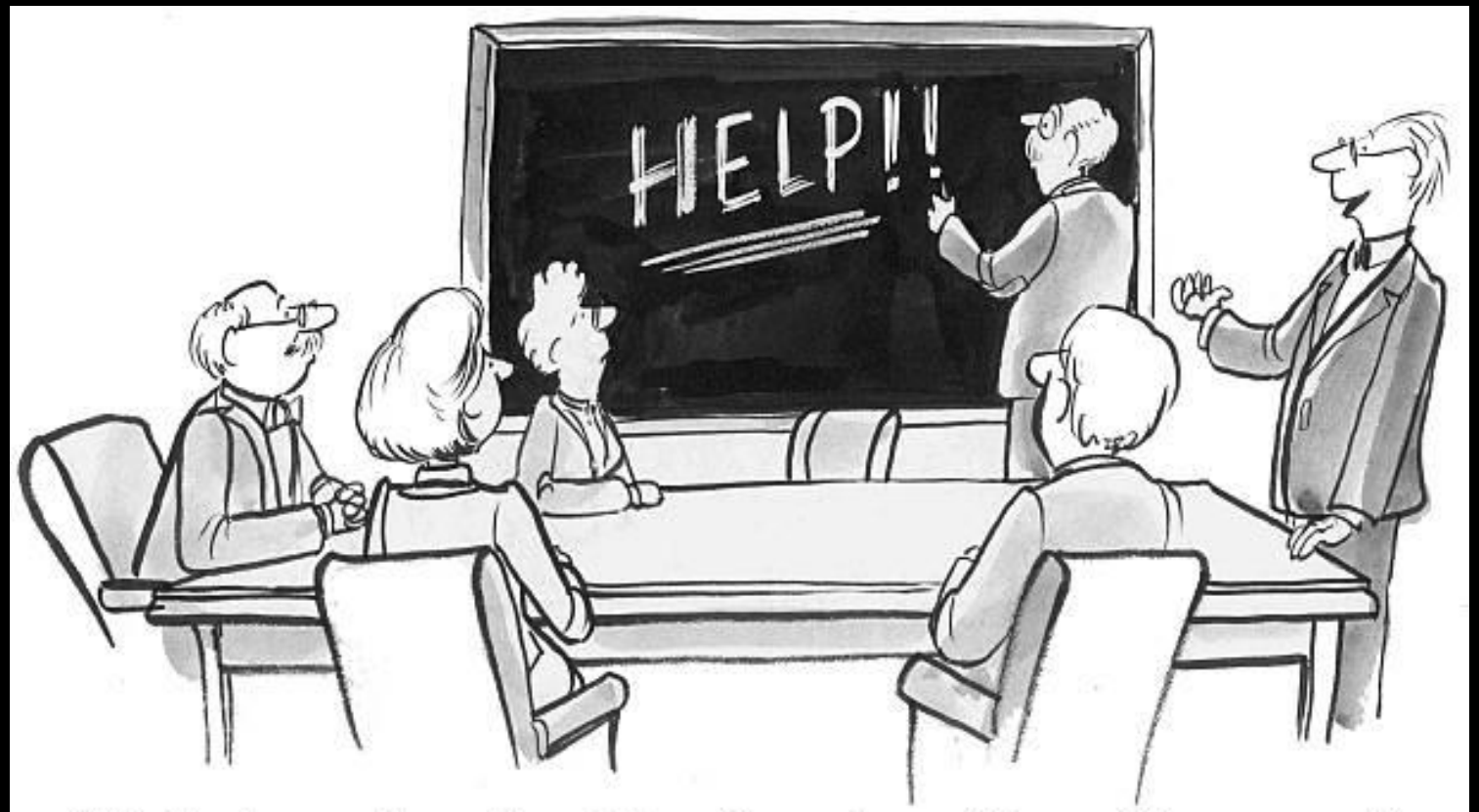


"We like to greet our Regulatory Compliance hires with one word."

Objectives

- Describe the CMS/Joint Commission requirements that went into effect July 2019
- Explain the relationship/overlap between risk factors for suicide and violence
- Explain why we do risk assessments when we cannot predict suicide or violence very well
- Identify risk factors in specific diagnostic groups
- Discuss the concept of therapeutic risk management

Joint Commission and CMS Requirements

- Screen all patients for SI using a validated risk assessment tool
- Suicide risk assessment, using an evidence- based process, for all who screen positive (may use one tool/process to screen and assess risk)
- Document level of risk and plan to mitigate risk
- Follow up care and counseling (period post discharge is high risk)

https://www.jointcommission.org/-/media/tjc/documents/standards/r3-reports/r3_18_suicide_prevention_hap_bhc_cah_11_4_19_final1.pdf

Assessing for Risk of Suicide and Violence: Why Both Together?

- The risk factors overlap a lot
- Two dreaded outcomes, both for the patient and those around them
- Potential causes of action

But, we are not very good at prediction, so why do we have to assess risk??

- Prediction is not the point.
- Mitigation and improving outcomes is the point – we do this work to improve our patients' quality of life.
- If those are not good enough reasons, there are medicolegal and reimbursement requirements.

“Therapeutic Risk Management”

- Coined by Robert Simon MD and Daniel Shuman JD in 2009
- Urges clinicians to “achieve optimal alignment between clinical competence and an understanding of legal concerns applicable to psychiatric practice.”
- Mitigate the patient’s risk of an adverse outcome, and you’ll manage liability along the way

Simon, Robert I., and Daniel W. Shuman. "Therapeutic risk management of clinical-legal dilemmas: should it be a core competency?." Journal of the American Academy of Psychiatry and the Law (2009).

Types of Risk Factors/Considerations

Modifiable/Dynamic

Non-modifiable/static

General; across diagnoses

Conditional-specific to a particular patient

Risk factors specific to diagnostic categories

General Risk Factors: Modifiable/Dynamic

- Substance/etOH use
- Access to Firearms
- Insomnia
- Treatment non-adherence
- Homeless/unstable housing
- Active psychotic sx (especially + sx)
- Mood sx (mania, depression)
- Impulsivity
- Panic/anxiety
- SI/HI (current or recent)

Fazel, S., Smith, E. N., Chang, Z., & Geddes, J. R. (2018). Risk factors for interpersonal violence: an umbrella review of meta-analyses. The British Journal of Psychiatry, 213(4), 609-614.

Turecki, G., Brent, D. A., Gunnell, D., O'Connor, R. C., Oquendo, M. A., Pirkis, J., & Stanley, B. H. (2019). Suicide and suicide risk. Nature reviews Disease primers, 5(1), 74.

General Risk Factors: Non-modifiable/static

- Recent loss (death, divorce)
- Traumatic past/exposure to violence
- History of suicide attempts
- Family history of suicide
- Legal issues (esp recent or impending incarceration)
- Gender/age (male, old or young)
- Maladaptive personality traits/personality disorder
- TBI
- Chronic Psychiatric Illness, chronic debilitating medical illness/pain

More recent work in suicide risk assessment

Metanalysis of psychological autopsy results of suicide victims

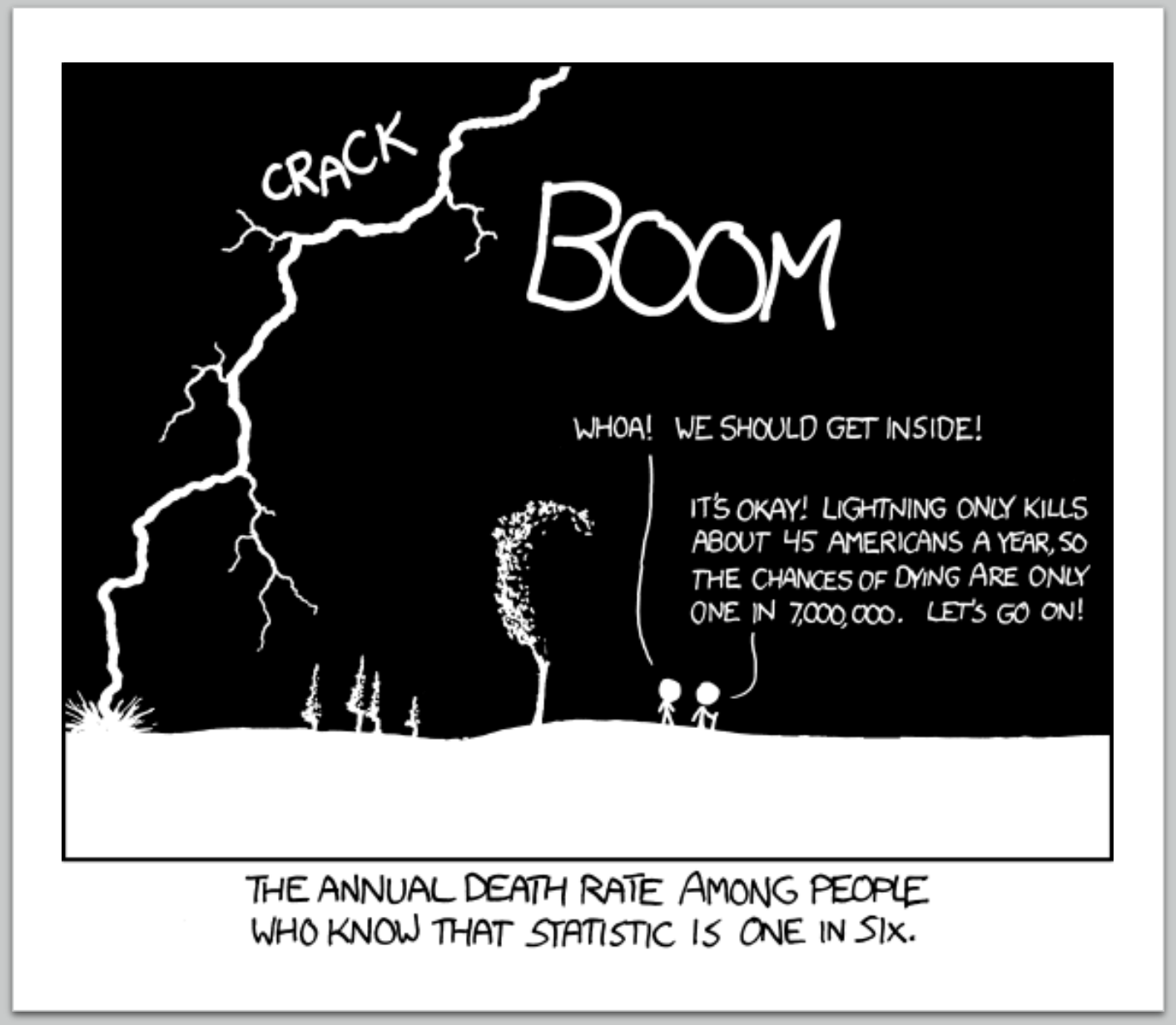
Divided potential risk factors into 3 domains: Sociodemographic, Clinical, and Adverse Life Events

The strongest effect sizes (increased odds ratio) were in the clinical domain, and included being diagnosed with any mental disorder, prior suicide attempt, and history of self-injury. This does NOT mean that other risk factors were not significant; there were several others that increased the odds ratios in other domains

Favril, L., Yu, R., Uyar, A., Sharpe, M., & Fazel, S. (2022). Risk factors for suicide in adults: systematic review and meta-analysis of psychological autopsy studies. *Evidence Based Mental Health*, *25*(4).

Conditional Risk

- Look for patterns or predictable triggers
- Ex: Patient has had three suicide attempts by OD in the past, each time a girlfriend had just broken up with him.
- his fiancé is considering calling it off.
- If she breaks up with him, and he relapses on etOH, and we cannot mitigate his access to medications, his risk will increase.



Risk Factors: Bipolar D/o

- Rapid cycling
- Mixed state
- Younger age of onset
- Also look at the intensity of the mood state

Gonda, X., Pompili, M., Serafini, G., Montebovi, F., Campi, S., Dome, P., ... & Rihmer, Z. (2012). Suicidal behavior in bipolar disorder: epidemiology, characteristics and major risk factors. *Journal of affective disorders*, *143*(1-3), 16-26.

Risk Factors: Bipolar D/o

- 10-15% die by suicide (estimates vary)
- Swedish study showed that in BPAD, suicidality more likely to be lethal and criminality more likely to be violent
- Most suicide and first incidents of violent crimes were within 5 years of initial BPAD dx
- More recent work shows much the same, points out much lower ratio of suicide attempts to suicide, suggests that under 35 or over 75 at higher risk

Webb, R. T., Lichtenstein, P., Larsson, H., Geddes, J. R., & Fazel, S. (2014). Suicide, hospital-presenting suicide attempts, and criminality in bipolar disorder: examination of risk for multiple adverse outcomes. The Journal of clinical psychiatry, 75(8), 20419.
Dome, P., Rihmer, Z., & Gonda, X. (2019). Suicide risk in bipolar disorder: a brief review. Medicina, 55(8), 403.

Risk Factors: Schizophrenia

- Suicide Risk
- -early age of onset
- -severity of illness
- -frequent psychotic episodes and admissions
- -comorbid depressive sx
- -fear of mental disintegration
- -risk is higher in the first couple of years after dx

Popovic, D., Benabarre, A., Crespo, J. M., Goikolea, J. M., González-Pinto, A., Gutiérrez-Rojas, L., ... & Vieta, E. (2014). Risk factors for suicide in schizophrenia: systematic review and clinical recommendations. Acta Psychiatrica Scandinavica, 130(6), 418-426.

Schizophrenia: Risk Factors

- Agitation/restlessness
- Treatment non-adherence
- **Positive** Symptoms (?)
- One literature review (Hor and Taylor, 2010) found that in addition to substance use in general, “alcohol misuse is a key factor”

Volavka, J. (2013). Violence in schizophrenia and bipolar disorder. Psychiatria danubina, 25(1), 0-33
Hor, K., & Taylor, M. (2010). Suicide and schizophrenia: a systematic review of rates and risk factors. Journal of psychopharmacology, 24(4_suppl), 81-90.

More recent work in violence risk assessment in psychosis: A 10-year review/update

- Strongest associations: substance misuse and criminal history -authors were surprised to note lack of clear evidence of association between positive symptoms and violence. . .a 2026 meta-analysis re: early psychosis agreed.
- -2 studies they reviewed showed association with THC use
- -Antipsychotic use decreased risk

- It's generally accepted that we should use an individualized approach

Lagerberg, T., Lambe, S., Paulino, A., Yu, R., & Fazel, S. (2025). Systematic review of risk factors for violence in psychosis: 10-year update. The British Journal ofPsychiatry, 226(2), 100-107.

PTSD Risk Factors

- prominent arousal sx assoc. w/ increased risk
- PTSD and MDD often co-morbid.
- Trauma, esp adverse childhood events (ACES) increase rz of PTSD and MDD, AND independently increase the risk of suicide attempts
- Much of the risk of violence with PTSD attributable to co-occurring substance use

Elbogen, E. B., Johnson, S. C., Wagner, H. R., Sullivan, C., Taft, C. T., & Beckham, J. C. (2014). Violent behaviour and post-traumatic stress disorder in US Iraq and Afghanistan veterans. The British Journal of Psychiatry, 204(5), 368-375.
Perez, N. M., Jennings, W. G., Piquero, A. R., & Baglivio, M. T. (2016). Adverse childhood experiences and suicide attempts: The mediating influence of personality development and problem behaviors. Journal of youth and adolescence, 45, 1527-1545.
Schalinski, I., Teicher, M. H., Nischk, D., Hinderer, E., Müller, O., & Rockstroh, B. (2016). Type and timing of adverse childhood experiences differentially affect severity of PTSD, dissociative and depressive symptoms in adult inpatients. BMC psychiatry, 16(1), 1-15.

More recent work in PTSD and suicide risk:2023 Meta-analysis

- Strong association between PTSD and attempted suicide
- Association with combat veterans

Akbar, R., Arya, V., Conroy, E., Wilcox, H. C., & Page, A. (2023).Posttraumatic stress disorder and risk of suicidal behavior : Asystematic review and meta-analysis. Suicide andLife-Threatening Behavior, 53(1), 163-184.

Protective Factors

- Familial support
- Meaningful Employment (as perceived by patient)
- Educated (double-edged sword)
- Future oriented
- Motivated for treatment/engaged with treatment team
- Attachment or responsibility to children or other family members
- Spiritual belief against suicide or violence
- Insight?? Double-edged sword.

Kleiman, E. M., & Liu, R. T. (2013). Social support as a protective factor in suicide: Findings from two nationally representative samples. Journal of affective disorders, 150(2), 540-545.

Good Questions to Ask: Suicide

- If patient having SI, how far have they gotten? Vague? Plan but no intent? Rehearsal (physical or mental)? Preparation?
- Prior attempts? Circumstances? Medical sequelae?
- Access to means? Firearms, chemicals, etc?
- What keeps them from acting? Were they interrupted? Changed mind?
- Reasons for living?
- Spiritual beliefs?

Modular Assessment of Risk for Imminent Suicide (MARIS)

- Utility of expressed SI for imminent risk assessment overestimated;
- “Integration of data from multiple informants recommended. . . but underutilized”
- 4 modules

1: Abbreviated Suicide Crisis Inventory

2: General Attitude towards and opinion as re: suicidal behavior (Abbreviated Suicide Opinion Questionnaire)

3: Standard Risk Factors

4: Clinician’s Emotional Response to Patient (Therapist Response Questionnaire)

Calati, R., Cohen, L. J., Schuck, A., Levy, D., Bloch-Elkouby, S., Barzilay, S., ... & Galynker, I. (2020). The Modular Assessment of Risk for Imminent Suicide (MARIS): A validation study of a novel tool for suicide risk assessment. Journal of affective disorders, 263, 121-128.

Suicide Crisis Syndrome (SCS): Igor Galynker et al)

- Criterion A: Entrapment

- Criterion B (need one from each dimension, B1-B4)

- Affective dysregulation
- Cognitive dysregulation
- Overarousal
- Social Withdrawal

SCS: Criterion B Exactly As Described by Galynker, et al

- B1: Affective disturbance: emotional pain; depressive turmoil; extreme anxiety with unusual physical symptoms; acute anhedonia
- B2: Cognitive dysregulation (loss of cognitive control): ruminations; cognitive rigidity; failed thought suppression; ruminative flooding with headache/head pressure
- B3: agitation/restlessness; hypervigilance; irritability; insomnia.
- B4: avoidance of social engagements and evasive communication with others.

Galynker, I., Bloch-Elkouby, S., & Cohen, L. J. (2024). Suicide crisis syndrome: a specific diagnosis to aid suicide prevention. *World Psychiatry*, *23*(3), 362.

CASE: Chronological Assessment of Suicide Events

- Shawn Christopher Shea, MD
- 3 components:
  - gather info related to risk & protective factors, and warning signs
  -info related to ideation, plan, behaviors, desires, intent
  -use the data to formulate risk
- Real Suicidal Intent = Stated Intent + Reflected Intent + Withheld Intent

https://www.psychiatrictimes.com/view/suicide-assessment-part-1-uncovering-suicidal-intent-sophisticated-art
(link/citation for next 3 slides)

CASE Cornerstone Interviewing Techniques

- Behavioral Incident: ask fact-finding and sequencing questions
- Gentle Assumption
- Symptom Amplification (quantify behavior)
- Denial of the Specific
- Free two-part article: https://www.psychiatrictimes.com/view/suicide-assessment-part-1-uncovering-suicidal-intent-sophisticated-art

Good questions to ask: Homicide/Violence

- Not just “any thoughts to hurt anyone?”
- If they say “no,” but there are obvious targets, like a soon-to-be ex, boss that they are angry with; co-workers, etc, be specific.
- Past violence? Circumstances? Magnitude?
- Escalating fear? Changes in patterns (started sleeping with a knife, moved gun closer, etc)
- Thought of consequences?
- What has kept them from acting so far?

So, an initial risk assessment might look like . . .

- The patient's presenting risk and protective factors for suicide include the following:

  Modifiable: anxiety/panic; insomnia; suicidal ideation (current or recent); treatment non-adherence; substance use
  Access to Firearms: no

  Non-modifiable: history of aggression/violence; multiple prior suicide attempts; chronic psychiatric illness; trauma; recent loss of significant relationship (break-up with boyfriend)

  Protective: future-oriented; attachment/responsibility to children or other family; prior positive response to treatment; family or other supports

  Risk State: High

As you learn more, update. . .it's a process not an event

"Although patient initially denied self-injurious behavior, she was seen banging her head when upset. Therefore, the modifiable risk factor of self-injurious behavior has been added"

"Collateral contact revealed the non-modifiable risk factor of a family history of suicide."

"The additional protective factor of religious belief that suicide is immoral was identified."

Or, just do an updated risk assessment and date it.

Using the risk assessment to craft a treatment plan:

- Modifiable risk factors are a “to-do” list.
- If you do it right, the risk assessment is a thumbnail sketch of your initial H&P.
- Not everything can be modified right now, or by you. Note limitations in the chart
- Document your efforts and the outcome.

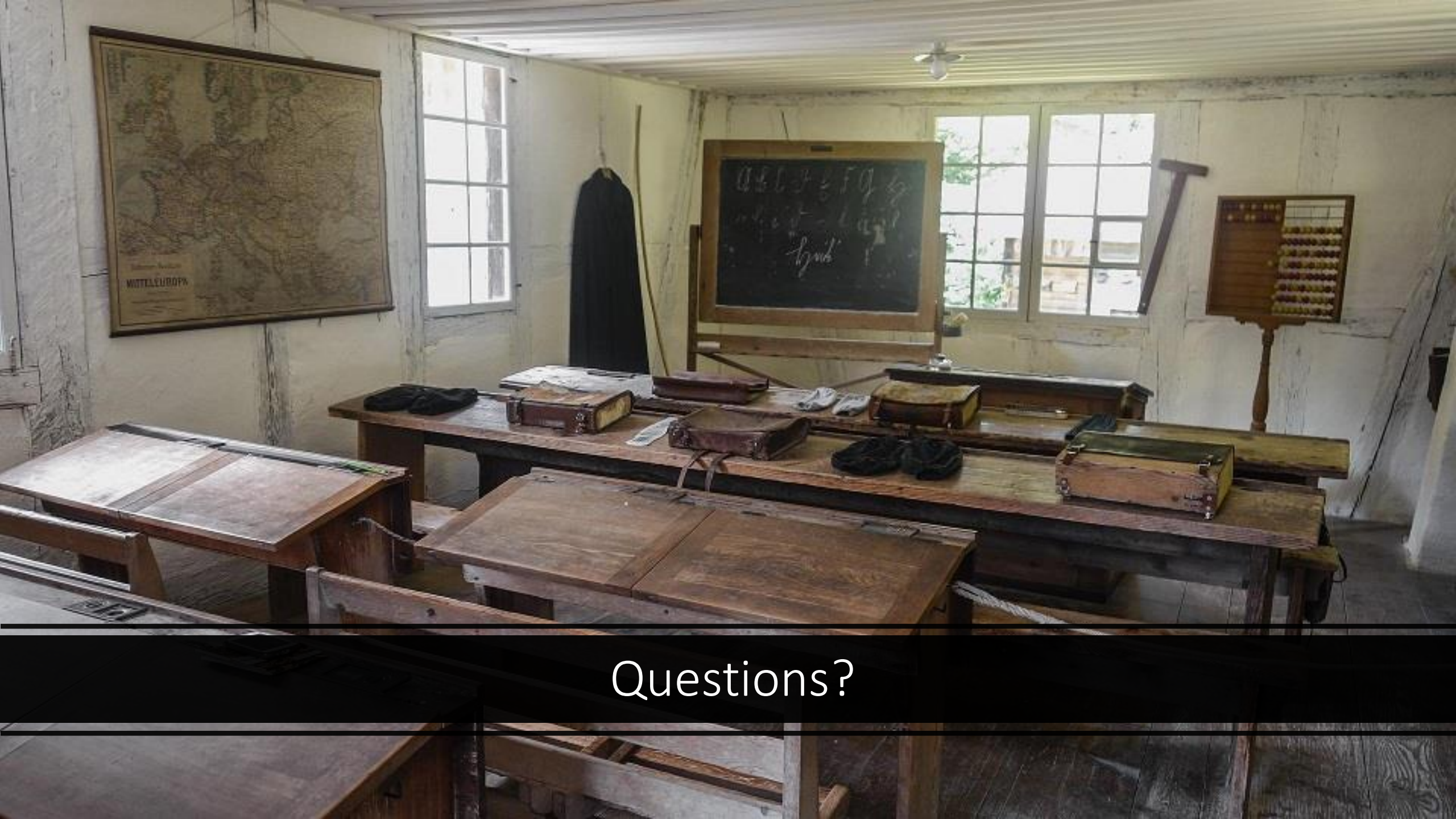
A discharge risk assessment might look like:

- (Include your initial or most updated risk assessment above it)
- During this admission, we were able to take the following steps to mitigate the patient's risk: counseled patient to strictly avoid etOH/substance use; engaged patient's natural supports; mood symptoms responded to medication; long acting injection started/continued to help with treatment adherence; outpatient commitment in place

  If the patient had access to firearms, this was addressed in the following way: not applicable

  Each patient also develops a safety plan with the social worker/treatment team, unless patient declines or is unable to participate.
  In terms of contingency planning, the patient's risk may again increase in the event of: treatment non-adherence; relapse on etOH/substance use; loss of housing
  If the patient or his or her supports detect signs of decompensation, they should: present to the ED; collaborate with outpatient provider (if non-emergent)

  Risk State: moderate; patient is a chronically elevated risk due to nonmodifiable factors. Further risk mitigation will require sustained adherence to outpatient treatment and sobriety.



Questions?

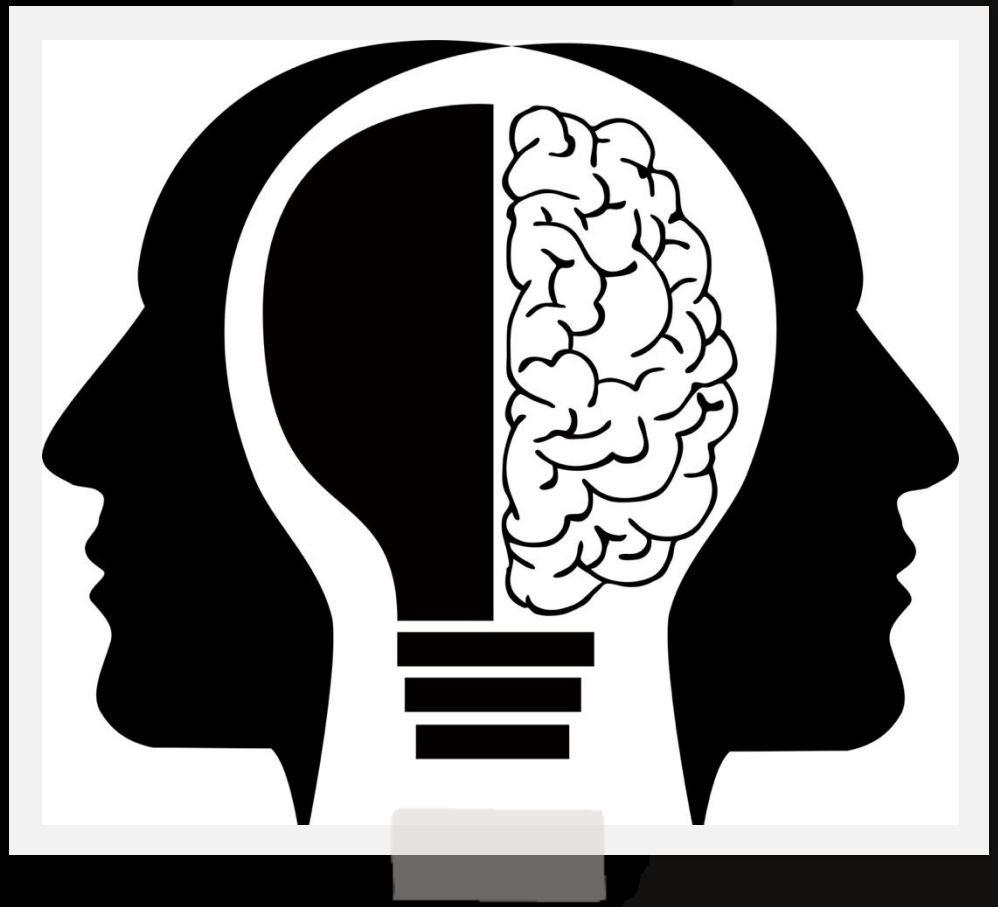
- Bonus Slides if there is time left

What if you get stuck?

Patient still assessed to be at an elevated risk, but you don’t know what else to do?

Second Opinions Can Help:

- offset transference/counter-transference
- Offer a “fresh set of eyes”
- learn from each other
- document commitment to mitigating the patient’s risk



Tips for Documenting Useful Consultation

- Clear consultation question
- Talk before and after seeing the patient
- Realistic recommendations
- Supportive documentation

Managing Malpractice Liability

Manage Liability and Improve Care at the Same Time

Consultation and documentation referred to as “twin pillars” of liability management by Applebaum and Gutheil

“a second opinion exerts a powerful counterforce to the accusation of negligence,” particularly because the standard of care refers to “care that is expected from an ordinary psychiatrist in the same situation”

Gutheil, T. G., & Appelbaum, P. S. (2019). Clinical handbook of psychiatry and the law. Lippincott Williams & Wilkins.

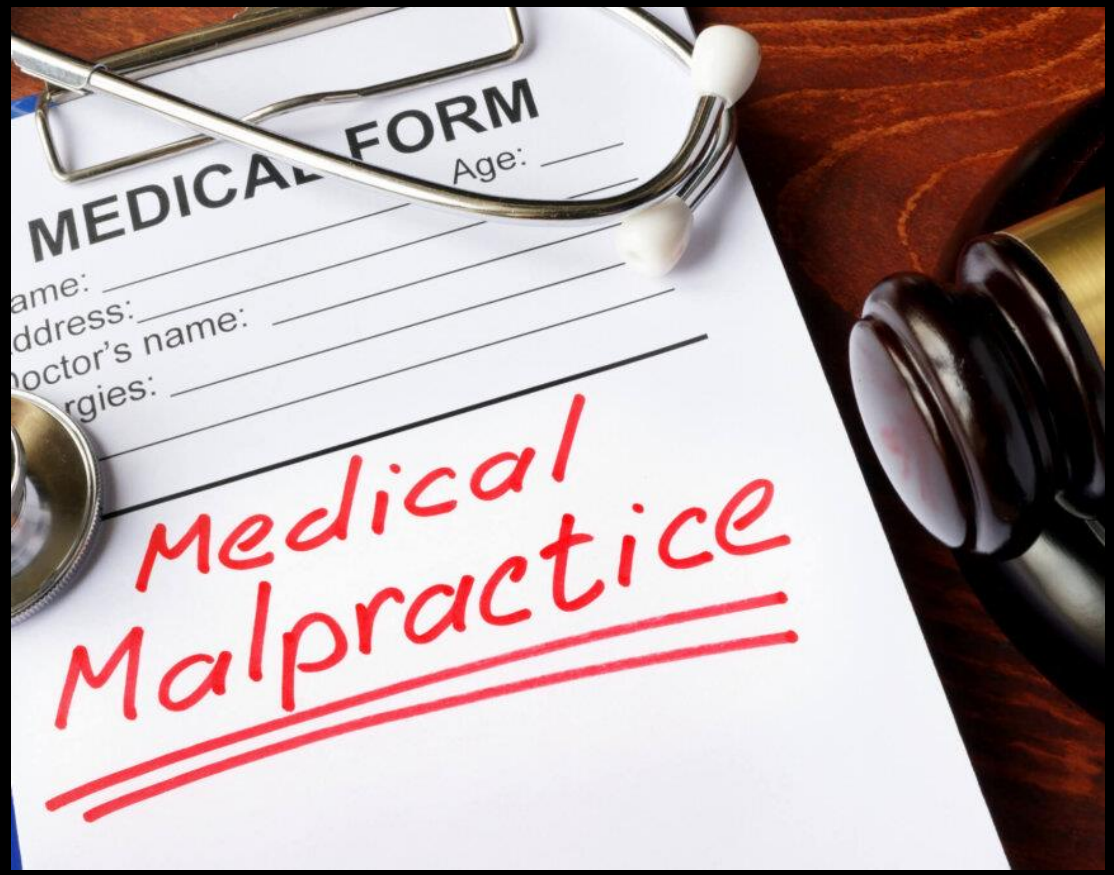
But Does It Really Help?

Canadian study of adjudicated cases

- Second opinion in:

- 43.5% of the cases that were successfully defended

- 14% of the cases decided against the defendant psychiatrist



Mela, M., Luther, G., & Gutheil, T. G. (2016). Forty-five years of civil litigation against Canadian psychiatrists: An empirical pilot study. The Canadian Journal of Psychiatry, 61(2), 112-118.

Documentation

“Never say anything which does not improve on silence.”

-Richard Yates

Documentation Should:

- Be timely
- Clear
- Concise
- Neutral
- Realize that the patient or their family might see it

Purposes of Documentation

- Contemporaneous record
- Remind yourself why you made certain decisions – especially for longitudinal outpatient treatment and lengthy admissions
- Communicate with teammates and with the next person taking care of the patient
- Reimbursement
- Liability management

Documentation Should NOT:

- Reflect your affect
- Be sarcastic
- Be cryptic
- Criticize your team
- Show off your wit or creative writing skills

Take Home Points

We are not in the prediction business; we partner with patients to reduce the risk for THAT PERSON

When in doubt, reach out

“Never say anything which does not improve on silence”

No snark in the chart

No creative writing

Make sure you back up a personality d/o diagnosis

Image Credits

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- slide 32
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