Assessing, Managing, and Documenting Suicide and Violence Risk

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The Steps

1. Assess the level of risk.
   a. Gather information
   b. Estimate the level of risk.
2. Act based on risk-assessment.
3. Document carefully.

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When to Assess Danger Risk

- Client has been brought in for emergency evaluation.
- Any change in observation status or treatment setting
- Any abrupt change in clinical presentation
- Lack of improvement or gradual worsening
- Any significant stressor.

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What Information Do You Need?

Demographics
Recent Events
Past Mental Health History
Medical History
Social History
Mental Status Examination
Possible Diagnoses
Receptiveness to Treatment

Where to Gather Information:

1. Client
2. People familiar with the client.
3. Written documents.

Gathering Information…

- Demographics:
  - **Sex:** Men 9x more prone to violence and 4x more prone to suicide.
  - **Age:** Violence decreases with age (much lower after 40). Suicide risk is greater after middle age.
  - **Poverty:** Correlated with violence.

Gathering Information…

Demographics:

–**Race:** Nonwhites are more prone to violence (?socioeconomic interplay). Whites are more prone to suicide.

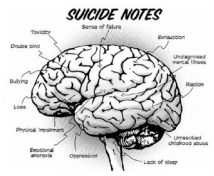
–**Sexual Preference:** Gays and lesbians more prone to suicide.

–**Education:** Correlated with lower violence risk.

–**Marital status:** being unmarried correlates with suicide, especially in men.

Gathering Information…

- Recent / Current Social Circumstances:
  - **Correlating with violence:**
    - Unemployment, gang membership
    - Possession of or access to a weapon.
  - **Correlating with suicide**:
    - recent loss
    - recent increase in isolation
      - move, immigration, death, job change
    - serious medical illness
    - unemployment
    - recent financial loss
    - poor family relationship
    - Possession of the means to commit suicide.
    - [children in home is protective against suicide]



Gathering Information…

- Recent Symptoms and Behaviors:

  - **Correlating with violence:**
    - recent violence
    - recent acquisition of a weapon
    - recent increase in paranoia, suspicion of others
    - recent ideas, plans, intent, or attempts to harm others.
  - **Correlating with suicide**:
    - recent suicidal ideas, intent, plan, or attempts
    - recent symptoms of a depressive episode, mixed episode, anxiety, panic, borderline behavior
    - suicide rehearsals or preparations for death
    - suicide notes
    - any kind of poor impulse control.

Gathering Information…

- Recent Substance Abuse:
  - **Correlating with violence and suicide:**
    - Any substances that increase aggression or paranoia or that lower impulse control.
    - Alcohol, PCP, cocaine, amphetamines, other stimulants.

Gathering Information…

- Past Symptoms, Behaviors, Diagnoses:
  - **Correlating with Suicide:**
    - *History of suicide attempts*
    - History of psychopathy, suicide, mood disorders, panic disorder, schizophrenia, low IQ.
    - History of impulsivity
    - History of hospitalizations
    - History of substances that increase impulsivity or aggression
  - **Correlating with Violence:**
    - *History of being violent*
    - History of psychopathy
    - History of impulsivity
    - History of using substances that increase impulsivity or aggression
    - Childhood hyperactivity or serious inattention.

Gathering Information…

- Medical Problems:
  - **Correlating with Suicide:**
    - Any medications which decrease impulse control.
    - Medications or illnesses that increase depression or anxiety.
  - **Correlating with Violence:**
    - Medications or illness which decrease impulse control or increase paranoia or agitation.

Gathering Information…

- Family History:
  - **Correlating with Suicide:**
    - Family history of suicide
    - Family history of mental illness

Gathering Information…

- Social History:
  - **Correlating with Violence:**
    - Unstable work history
    - History of physical or sexual abuse
    - History of being violent
    - Brutal parent
    - Delinquent as adolescent
  - **Correlating with Suicide:**
    - History of sexual or physical abuse

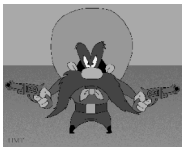
Gathering Information…

- Appearance and Behavior

  - **Correlating with Violence:**
    - Pacing, threatening or menacing
  - **Correlating with Suicide:**
    - Consistent with depression, anxiety

Gathering Information…

- Mood and Affect



  - **Correlating with Violence:**
    - Anger, agitated, distrustful, menacing.
  - **Correlating with Suicide:**
    - Sadness
    - "too tired to go on"
    - Calm or happy having decided to die
    - Severe anxiety
    - Shame or humiliation
    - Psychological turmoil

- Perceptions
  - Voices may command violence or suicide

Gathering Information…

- Thought Content
  - **Correlating with Violence:**
    - thoughts of assault, control and revenge
    - view of others as malevolent, dangerous, or the cause of one's problems
      - due to psychosis, e.g. delusions of persecution or external control
      - due to externalizing personality
    - plan
    - intent
    - specific target

Gathering Information…

- Thought Content
  - **Correlating with Suicide:**
    - suicidal ideas
    - suicidal plan for how to die
    - suicidal intent / decision to die
    - sense of hopelessness
    - identification with someone who has committed suicide
    - ideas about joining dead loved ones.
    - psychotic ideas about dying
    - polarized thinking

Gathering Information…

- Diagnoses
  - **Correlating with Suicide:**
    - current depression
    - panic or anxiety
    - schizophrenia
    - anorexia
    - substance use disorder
    - physical illness
    - Cluster B personality disorders
    - Psychopathy

Gathering Information…

- Diagnoses
  - **Correlating with Violence:**
    - substance use disorder
    - Cluster B personality disorders
    - Psychopathy

Gathering Information…

- Factors affecting disposition
  - How well does this person follow up?
  - Is there a treatment alliance?
  - Does this person adhere to treatment.
  - Can he / she contract for safety?
  - Is there someone trustworthy who can guard his or her safety between appointments?

Outside Informants

- Clients often cannot or will not provide accurate information.
- Suspected risk of violence or suicide constitutes a mental health emergency.
- In an emergency, responsible assessment demands outside information.
- Tell the client: "*I need to speak to someone to find out how you've been. It should be someone who knows you well and who you have seen recently.*."
- If the client doesn't consent, the emergency justifies a break in confidentiality sufficient to assess risk. The goal of protecting the client trumps protecting confidentiality.

Minimizing the Confidentiality Breach with Outside Informants

- e.g. "*Hello ____, this is _____ in the emergency room. Your son is here. It would really help us care for him if you could answer some questions. But to maintain confidentiality, I will reveal as little as possible about what is going on.* "
- *When possible, reassure that nothing horrible has happened: "Don't be alarmed, he is okay."*
- *"I'd be happy to let him know that you want to know what's going on and ask him to call you."*

More on Outside Informants…

- Since the client will often refuse to give you numbers of people to call or deny that there is anyone to call, be sure to get contact information from anyone who has accompanied him or spoken to you about him.
- Informants often provide impressions, not facts, for their own reasons (e.g. being angry at, protective of, afraid of, tired of, or protective of the client).
- Concentrate on facts (e.g., "*When was the last time he had a knife?*") rather than impressions (e.g., "*He's not dangerous at all. He's okay.*")
- Informants may provide deliberately false information for ulterior motives.
- Look for inconsistencies or outside motives in the accounts of informants to try to estimate how reliable they are.

The Steps

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Facts: An unkempt 37 year old man is in your office. He is angry, speaking rapidly, and very disorganized. He has a history of assault, public intoxication, sex offenses, and terrorist threats. He has not been sleeping and is talking rapidly. He has been homeless. He reports being on Geodon and Depakote in the past, but has not taken them in months. He says his diagnosis was bipolar, but that that was wrong. He denies that he has used any substances in five years, but later says he uses very occasionally. Later, he seems to calm some but is still speaking rapidly. He denies suicidal and homicidal ideation. He refuses medication. He denies that he has any friends or relatives.

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Risk Factors	Protective Factors

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Risk Factors	Protective Factors
• history of violence • relatively young man of poor socioeconomic status • angry • symptoms suggest mania v. intoxication • past & possibly current substance abuse • poor insight into need for medication • nobody to speak with.	• not currently endorsing violent ideations

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RISK LEVEL: Moderate to High

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Law: When in doubt, acquit.

Psychiatry: When in doubt, admit.

Managing the Client with a Recent Suicide Attempt

- Usually 5150 if the client…
  - is psychotic
  - has made a violent, near lethal, or premeditated attempt
  - still has a plan or intent
  - is a man over 45 and has a new mental illness or suicidal thinking
  - has limited support
  - has poor judgment due to impulsivity or agitation
  - has a change in mental status that might be biological in nature
- Often 5150 even if the client doesn't have any of the above.

•Possible release with follow-up if the client…

–attempted suicide in reaction to an event and now is thinking differently about it

–has a plan / method / intent with low lethality

–has a stable and supportive living situation

–can cooperate with outpatient treatment

• Outpatient treatment may be more beneficial than hospitalization if

•patient is chronically suicidal without a history of medically serious attempts, has a safe and supportive living situation, and is in ongoing outpatient mental health care.

Managing the Client with Suicidal Ideation, but No Recent Attempt

- USUALLY 5150 if the client…
  - a specific plan with high lethality
  - a high suicidal intent
- OFTEN 5150 if the client:
  - is psychotic
  - has a major psychiatric disorder
  - has made attempts, especially if serious
  - may have suicidal ideas because of a medical condition
  - has limited support or an unstable living environment
  - cannot get timely outpatient follow-up or is unlikely to cooperate with outpatient treatment

•Possibly release with follow-up if the client…

–has a plan / method / intent with low lethality

–has a stable and supportive living situation

–can cooperate with outpatient treatment

• Outpatient treatment may be more beneficial than admission if

- patient is chronically suicidal without a history of medically serious attempts, has a safe and supportive living situation, and is in ongoing outpatient mental health care.

DUTY TO PROTECT THIRD PARTIES

Managing the Client Who You Assess to be a Violence Risk

• If violence risk is due to mental illness and the client is in custody, don't release the client until treated, regardless of whether danger is imminent. (Hospitalize if needed.)

• If violence risk is imminent, but not the result of mental illness (e.g., gang member swearing vengeance).

-double and triple check your mental health assessment.

-when in doubt, admit

- If there is a violence risk and for some reason the client must be released, you must take steps to protect any reasonably identifiable victims.

-call the police.

-warn potential individual victims.

-call others who could reasonably act to prevent tragedy.

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3. Document your work.

Why Document Carefully?

- If you gather facts diligently and thoroughly, consider them carefully, and act responsibly and act reasonably based on them, you won't make negligent decisions.
- However, your client may end up being violent or committing suicide, even if your decision was not negligent.
- When such tragedies occur, there must be real-time written proof that you were diligent, thorough, and responsible-- i.e.,your documentation.
- If there is no proof that you acted correctly, lawyers and juries may assume that the tragedy is due to your negligent behavior.
- Thus the dictum: "If you didn't write it, it didn't happen."

What to Document

- Be explicit about the decision you are facing
  - 5150 or not
  - release from the hospital, or not
  - duty to protect, or not

Show that you have gathered facts diligently
- Note when you attempted to contact informants but they were unavailable
- Note the reliability of your informants and of the client

Document your risk assessment
- Note what facts raise the risk
- Note what facts lower the risk
- Note your decision and the reasoning behind it.
- The less conservative your decision, the more you need to document it.

Quality Control

- Ask yourself: What ambiguity or misperception may arise when this note is read, in the future, by a stranger motivated to demonstrate my negligence?
- Never be derogatory, judgmental, value-laden, abusive, sarcastic, mocking, ridiculing, facetious, or witty.
  - i.e., do not make your note the expression of your negative countertransference to the client.
  - e.g., words like "uncooperative" and "manipulative" have no place in written documentation.
  - Judges and juries may not be able to appreciate how infuriating the client was and may instead simply see you as unsympathetic and callous.

Defense Attorney Dream Note

The client is currently at acute risk for being violent on the basis of mental illness. He has a history of being arrested for assaults, sex offenses, and making threats. He currently has symptoms of rapid speech and sleeplessness consistent with Bipolar Disorder or Substance Abuse. He denies current substance abuse, but is vague about the history of his use and has a history of public intoxication. This may indicate that he is minimizing his substance use. Although he presents in an organized fashion, he earlier was disorganized and angry. Although he denies current homicidal ideation, based on his past dangerous behavior and on the fact that his current behavioral dyscontrol suggests an exacerbation of mental illness, he is not safe for community follow-up. A 5150 hold for further evaluation and treatment is thus indicated.