Risk Assessment of Patients with Suicidal and Homicidal Ideations

Dear UBH Provider,

UBH is committed to working with our providers in a collaborative manner to ensure high quality clinical care for our members. A key factor in providing quality care to members is to keep in mind that suicidal urges are the most frequently encountered mental health emergencies. It is imperative that members receive a thorough assessment including an evaluation of the potential for suicide. Once a member is determined to be at risk, appropriate interventions are needed to ensure the member's safety.

We recognize that it is difficult to predict who will act upon suicidal thoughts and that there is no clear consensus among authorities in determining which risk factors are most important to identify. However, we do know that substance abusers are at higher risk to act upon suicidal thoughts and require careful screening. Additionally, substance abusers with comorbid mental health diagnoses are at an even greater risk for suicide.

Some of the other factors that have been identified include:

- One or more previous suicide attempts
- A history of aggressiveness and/or impulsivity
- Depression, especially hopelessness
- History of/or evidence of bipolar disorder
- Suicide attempt or completed suicide of a friend or peer or family member
- Previous suicide attempt using a method other than ingestion
- Any drug or alcohol abuse greater than three times per week or intoxication
- Multiple consequences due to substance abuse
- Males are at greater risk for completed suicide and risk increases with age
- Females are 5 times more likely to attempt suicide

Ideally, the risk assessment should involve both the patient and significant others. This is especially true if the patient appears to be an unreliable informant, a minor child living at home, a history of substance abuse or have a past history of attempted suicide.

A good risk assessment should be direct in asking if there have been thoughts of hurting them self or someone else, if there is a plan, the lethality of the plan, and means to carry out the plan. It should also include a history of people in their life who may have attempted or completed suicide, if the patient lives alone and if there is a support system for the patient. There should also be an assessment as to the level of major life stressors (i.e. divorce, loss of job, bankruptcy, legal problems, death of a loved one).

The care management staff is available to our providers at 800-711-6089 to assist in providing appropriate referrals for any member who has been found to be at risk for harming them self or someone else. The UBH Best Practice Guidelines are available to our providers at http://www.ubhonline.com/. Please let us know if we can be of any assistance to you or your facility in determining resources for our members.

THE ASSESSMENT OF RISK TO SELF AND OTHERS

Suicidal and/or homicidal urges are of significant a variety of DSM-IV disorders in all age groups. The primary clinical focus of suicide prevention is the effective treatment of the underlying depressive or other mental disorder. Homicidal urges are not as clearly related to specific psychiatric conditions. As is suicide, when homicidal urges can be related to a specific mental disorder, the primary clinical focus of prevention is the effective treatment of the underlying disorder. Containment is a secure psychiatric setting is necessary whenever suicidal or homicidal risk is imminent and otherwise uncontrollable. Further, in many instances, it is also necessary to warn potential victims and/or legal authorities of the homicidal urges of a patient.

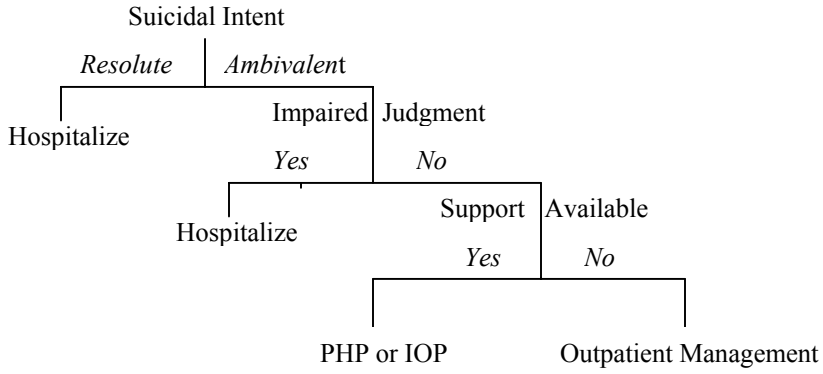
Suicidal Risk

Most experts note that suicide is almost impossible to predict. There is no test both sensitive enough to identify most people who will go on to kill themselves and so accurate that it will not falsely predict suicide for many others. The difficulty predicting death from suicide is due in large part to the relatively low incidence of completed suicide in the general population, combined with the unacceptability of false negative predictions. Fortunately, approximately 80% of suicidal individuals appear to give some indication of their intention, and thus present opportunities for intervention, assessment, and treatment. Crisis intervention is essential in the prevention of both potentially fatal and non-life-threatening suicide attempts (also referred to as parasuicidal behavior). In large part this is due to the fact that the suicidal urges are frequently acute in duration, ranging from minutes to days. The assessment of acute suicide risk is a subjective clinical judgment based on a review of the known risk factors (both aggravating and mitigating), current intent and planning, prior history of suicidal thought/behavior, and current emotional state. Most individuals will reveal suicidal thoughts/urges in response to direct questions. In fact, there is some evidence that suicidal patients often hope to be asked about their suicidal intentions. There is no evidence that, when asked in a progressive, professional, and sensitive manner, asking direct questions about suicidal ideation implants thoughts of suicide in otherwise non-suicidal individuals. Although most suicidal individuals are depressed, most depressed individuals are not suicidal. For this

reason, depression alone is a poor predictor of suicide risk. A sense of hopelessness, loss of control, and anger are some other important clinical predictors of risk and should be assessed with direct questions. In particular, the degree of hopelessness should be assessed. Effective questions may include "Have you had thoughts of hurting or killing yourself?" or "Are you having thoughts of hurting yourself now?" If suicide ideation is present, the existence of a specific plan should be assessed. The more specific and detailed the plan, the greater the danger. Effective questions may include "What have you thought of doing?" or "Have you tried to hurt or kill yourself in the past? When? How?" The clinician should never agree to keep suicidal threats or plans confidential. Rather, they should take whatever steps are necessary to prevent the individual from self-harm. High-risk individuals should never be left unsupervised for any period of time and should be monitored constantly.

The decision tree described below is adapted from Oxely and Van Meter. It is meant as a general guideline, as each case must be assessed individually. Suicidal patients can be managed in various levels of care, including outpatient, inpatient, and partial hospitalization settings. The decision regarding level of care is based on an ongoing assessment of risk. This involves determining the patient's current level of ambivalence regarding suicide. Impaired judgment is another factor and can result from depressive, psychotic, or substance abuse related conditions. The availability and degree of psychosocial support is a further consideration.

GUIDELINES FOR TREATMENT SETTING



Due to the significant risk of claims against the professionals following a completed suicide, sound record keeping is essential, particularly in regard to treatment rationale and the assessment and management of risk. All contacts with the patient (e.g., phone calls, correspondence, etc) must be included. The response to any non-compliance (e.g., failed appointments, refusal to take medications as prescribed, refusal to accept treatment recommendations, etc.) must also be documented fully. Documentation of collaboration with others is an essential element of both effective treatment and risk management. Finally, the record should include evidence that the risks associated with suicidal urges, the underlying psychiatric disorders, and treatment interventions have been adequately explained to the patient.

Homicidal Risk

In 1983, the American Psychiatric Association (APA) indicated, "psychiatrists have no special knowledge or ability with which to predict dangerous behavior." More recently, as a result of a growing body of research, certain acute symptom clusters, rather than diagnoses, are emerging as having at least some short-term predictive power. These symptoms can include active psychotic symptoms, manic symptoms, comorbid substance abuse and treatment non-compliance. The victims of violence by psychiatric patients are most often family members, or others in a care-taking role for the patient. Other factors to consider include demographic factors (such as older age, male sex, lower socioeconomic status, and a cultural tradition of masculine defensiveness); direct violent threats toward identifiable others (particularly if the patient has a plan and access to lethal weapons); a past history of threats or acts of violence; active or past history of substance abuse (current intoxication substantially increasing the risk of violence); a history of serious head injury,

epilepsy, or neurological impairment; psychological factors, including externalizing or projecting anxiety or hostility (particularly if expressed in an impulsive, explosive, suspicious, or persecutory manner); the patient's family or caretaker's willingness and ability to control the patient's behavior; and the patient's ability to participate in and maintain a therapeutic alliance. Finally, it is important to note that violence per se does not indicate the presence or absence of psychiatric illness. Violence can, and does, take place in the context of criminal activity and often requires the intervention of the appropriate legal authorities.

COMMUNITY SUPPORT RESOURCES

Friends for Survival, Inc.

Support for relatives, friends, and associates of suicidal deaths

1-800-646-7322

REFERENCES

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Washington, D.C., 1995.

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- American Academy of Child and Adolescent Psychiatry. *Practice Parameters for the Psychiatric Assessment of Children and Adolescents;* J. American Academy of Child and Adolescent Psychiatry, 34: 1386-1401, 1995.
- The Harvard Mental Health Letter; *Suicide (Part 1 & 11*), The Harvard Mental Health Letter, 13 (5&6): 1-5, 1996.
- Task Force on the Psychiatric Aspects of Violence, American Psychiatric Association, Washington, D.C., 1999.