Risk Management with Suicidal Patients

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PROGRAM DESCRIPTION

This workshop describes risk management issues in treating suicidal patients. An emphasis will be placed on therapeutic risk management, using strategies that are consistent with overarching ethical principles, protect the psychotherapeutic relationship, and improve the quality of patient care.

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LEARNING OBJECTIVES

At the end of the workshop, the participants will be able to

1. Identify the essential features of therapeutic risk management and its relationship to overarching ethical principles.
1. Distinguish between false and effective risk management strategies.
2. Describe how to implement therapeutic risk management strategies to help suicidal patients.

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Presenters Objective

Help reinforce the good work you are already doing.

Hopefully, give some ideas or perspectives that will make your work easier or more rewarding.

To learn from you.

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Conflict

The presenter is not declaring any conflict of interest.

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Gratitude Page

The late Patricia M. Bricklin, Joe Cvitkovic, Joe French, Jeff Knauss, John Lemoncelli, Toni Rex, and Dianne Salter.

Ann Marie Frakes, Rachael Baturin, Molly Cowan, Erin Brady, Thomas DeWall, APA Legal and Regulatory Affairs, The Trust, Philadelphia College of Osteopathic Medicine

Vincent Bellwoar, Louis Castonguay, Steve Cohen, Randy Fingerhut. John Gavazzi, Rachel Ginzberg, Michael Gottlieb, Ashley Greenwell, Mitchell Handelsman, Peter Keller, Linda Knauss, Sander Kornblith, Jade Logan, Bruce Mapes, Don McAleer, Jay Mills, Ira Orchin, Eve Orlow, Jeff Pincus, Brett Schur, Max Schmidheiser, Arnold Sheinvold, Jeanne Slattery, Richard Small, Jeff Sternlieb, Alan Tepper, Alan Tjeltveit, Maria Turkson, Leon VandeCreek, Kirby Wycoff, Edward Zuckerman, and many more.

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Commitment to Change

A brief evidence-supported exercise at the end of the program that may help you to benefit more from the program.

(Neimeyer & Taylor, 2019).

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Common Responses of Psychotherapists Working with Suicidal Patients (Fear and Hope)

Fear of a patient's suicide

Fear of being judged by oneself or peers

Fear of legal liability

Also, a deep sense of satisfaction (Conrad et al., 2020)

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Risk Management with Suicidal Patients

Legal risks for inpatient suicides? high

Legal risk for outpatient suicides? low

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Risk Management

Risks occur when patients feel dissatisfied because their psychotherapist has failed to reduce their symptoms of distress.

How do we improve patient outcomes?

How do we respond when patients are not improving or are deteriorating?

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Therapeutic Risk Management

Focus on patient well-being

Enhances the psychotherapy process

Rests on overarching ethical principles (Knapp et al., 2013; Knapp, 2024; Shea, 2003; Simon, 2011; Wortzel et al.,2013),

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Therapeutic Risk Management

Will this intervention promote the patient's well-being? (beneficence)

Will it avoid harm to the patient? (nonmaleficence)

Will it promote patient autonomy? (respect for patient autonomy)?

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False Risk Management Principles

"Any purported risk management principle that tells a psychologist to do something that appears to harm a patient or violates a moral principle needs to be reconsidered"

Knapp et al., 2013, p. 32

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Examples of False Risk Management Principles

1. Using a no-suicide safety contract.

2. Always avoid treating suicidal patients.

3. Use "negative questions."

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Safety Plans and No-Suicide Contracts

Safety Plans	No-Suicide Contracts
Internally Generated	Externally Imposed
Tells Patients How They Cannot Do Reduce Distress	Tells Patients What
Evolving, Changeable Prewritten	Fixed, Static,
Saves Lives	Does NOT save lives

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Refuse to Treat Suicidal Patients?

Many patients with suicidal thoughts deny such thoughts.

Patients may develop suicidal thoughts throughout treatment.

Suicidal thoughts fluctuate a lot.

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Refusal to Treat Suicidal Patients-2

Although a psychotherapist may say, “I don’t treat suicidal patients,” what would be more accurate is that “I do not treat patients who say they are suicidal.”

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Avoid Negatively Worded Questions

Includes a negative in the question, such as “No thoughts of suicide, right?”

McCabe (2017) found that clinicians often used negative questions when asking about suicide, thus conveying the expectation of a negative response and that the clinician did not want to hear the real response.

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Implicit Communications in Negative Questions

Using a negative question can be – often accurately– interpreted by patients as saying,

I don't want to know OR

"If you are having thoughts of suicide, I really do not know how to help you" (Quinnett, 2019, p. 367).

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Standard of Care

What would a prudent professional do under the same or similar circumstances?

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Standards of Care in Suicide Prevention

Based on learned texts

Position papers by respected agencies

Peer-reviewed publications

Commentaries by experts informed by evidence

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Before the Threat Emerges

Are you competent to provide services?

Of course, deliver evidence-supported, collaborative treatments, and monitor patient progress.

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Core Competency Model

e.g. Cramer et al. (2024)

The detailed 250 item self-learning annotated quiz may help you measure your competency and give direction for improvement.

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What Past Workshop Participants Found Helpful

1. Abandon total responsibility for saving the patient's life
2. Narrative assessment
3. Prioritize respect for patient decision-making
4. Use safety plan type interventions
5. Do not overly on levels of risk
6. Ask about suicide-adjacent thoughts.
7. Screening instruments option
8. Ask patients to rate the likelihood of a future suicide attempt.

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1. What Are Realistic Expectations of Yourself?

"We cannot stop people from taking their own lives through coercion, intimidation, or even involuntary hospitalization" (Jobes, 2023, p. 8).

"While we cannot guarantee a nonfatal outcome, we can nevertheless provide *the best possible clinical care* to every patient, including those with suicidal thoughts" (Jobes, 2023, p. 60, italics in original)

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2. Narrative Assessment

Use a narrative assessment-listen to their story and let them tell it at their own pace

Use the assessment to build the therapeutic relationship

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3. Respect of Patient Autonomy in Patient-Centered Care

Listen

Explain (be transparent)

Involve

Ask

Defer

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Principles of Assessment and Intervention

Pillars of the CAMS philosophy:

1. Empathy
2. *Collaboration*– "we cannot make people not take their lives through coercion, intimidation, or inpatient commitment" (Jobes, 2016, p. 5)
3. Honesty

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Example, Informed Consent

Explain process

Emphasize the patient's **involvement** in treatment

Listen and respond to questions and concerns

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4. Address Suicide Risk

Use safety plan-type interventions

Use lethal means counseling

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Promote Patient Autonomy in Safety-Plan-Type Intervention

Listen to their reasons for living and warning signs

Have them chosen distractions or supportive friends.

Ask them how likely they would be to follow the plan.

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5. Do NOT Over-Rely on "Levels of Risk"

Risk fluctuates

Short-term predictions are poor

May lead to confirmation bias

A simple category does not reflect the complexity of the drivers of suicide

Many false negatives and false positives

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6. Suicide Adjacent Thoughts

Perceived burdensomeness– "Do you ever think that others would be better off if you were dead?"

Entrapment: "Do you ever think that life is so unbearable that you cannot stand the pain any longer?"

Passive suicidal ideation: "Do you ever wish that you would just die?"

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Suicide Adjacent Thoughts-2

Predict future attempts just as adequately as direct thoughts of suicide.

They may be precursor thoughts that make suicidal thoughts easier to come.

They may be a more acceptable way to acknowledge their suicidal thoughts without saying so directly.

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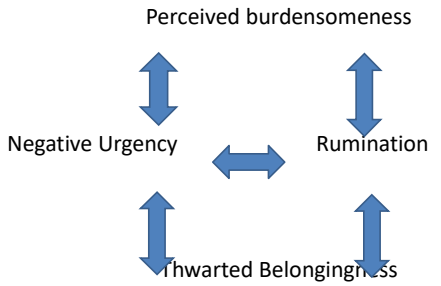
Interaction of Factors- Example



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7. Screening Instruments

No one is noticeably better than others

Columbia Suicide Rating Scale

https://cssrs.columbia.edu/wp-content/uploads/C-SSRS-1-14-09-SinceLastVisit_AU5.1_eng-USori-1.pdf

AsQ

https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials

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8. Importance of Asking Patients

Patients rating of their risk predicted self-harm 2 months later (Peterson et al., 2011, p. 626).

"Youths' expectations of suicidal behavior were independently associated with increased risk of suicide attempts, even after adjusting for key covariates" (Czyz et al., 2016, p. 512).

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After the Threat Emerges

What to do when there is a risk of a treatment failure?

When patients feel dissatisfied with services?

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Quality Enhancing Strategies

As the legal risks, the possibility of treatment failure, or patient complexity increases, the greater the level of attention should be given to quality enhancing strategies.

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Responding to a Threat of Failure:
Risk Management (Quality Enhancement) Strategies

Focus on improving quality

consultation and redundant protections

Empower Patients

Document

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Responding to Non-Improvement

"Adherence to an accurate formulation has been shown to have a positive impact on the process and outcome of a therapy. However, failure to test and reevaluate a formulation across the course of a therapy– in light of a patient's emerging needs and concerns– can result in a failed treatment" (Kealy & Curtis, 2025, p. 150).

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Quality of Service: Consultation

Has a foundation on beneficence and nonmaleficence

Reduces stress and isolation

Increases knowledge, options, and thinking ability

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Benefits of Consultation

Technique-oriented information

Emotional reactions and reduction of any emotional turmoil

Thinking through solutions together

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Quality of Service: Redundant Protections

Beneficence/Nonmaleficence

Additional sources of information or double-checking existing information for a difficult patient

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Redundant Protections

Double-check the data with the patient

Monitor state as mood fluctuates

Routine use of screening or monitoring instruments

Ask concerned others

Ask other treating professionals

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How do Benefit from Consultations and Redundant Protections

Have an attitude of humility (a willingness to strive to see oneself accurately)

Seek out and accept feedback

Have healthy self-doubt

> "love yourself as a person, doubt yourself as a therapist"

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Ensuring Resources: Competence Constellation

A network of colleagues who help provide continual feedback and monitoring (Johnson et al., 2012).

How do others help improve the quality of your services?

What do you do to improve the quality of services of other psychologists?

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Who Is In Your Competence Constellation? (SJK)

Ethics Committee

Colleague Assistance Committee

Writing Group

Informal network of "ethics" friends

Various list-servs and organizations

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How to Build Yours?

1. Journal club, supervision group.
2. Keep up with friends from graduate school.
3. Volunteer or low-paying job with a community agency.
4. Join and participate in a PPA committee or the committee of another professional organization.
5. Attend live or interactive CE programs

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Empowered Collaboration

Respect for Patient Autonomy

Evidence-based relationship-

agreement on treatment goal

accommodating reasonable preferences

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Empowered Collaboration-2

Empowered collaboration builds upon informed consent and attempts to maximize patient involvement in treatment

The patients become more actively involved in the process of psychotherapy. Greater commitment leads to better outcomes.

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Documentation: Legal Purposes

Beneficence/ Nonmaleficence

Required by insurers, State Board of Psychology, APA Ethics Code, etc.

A record of treatment for future providers

Useful risk management tool

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Documentation: Quality Enhancing

Dialogue with self and patient regarding process and goals of treatment

Means to identify pertinent clinical issues

A procedure to document response to treatment

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Take a Moment

From what has been presented so far, please take a moment and reflect on at least two (2) ideas that you believe will help you to improve the quality of your services to suicidal patients.

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Put Into Practice

On a scale of 1 to 5, how easy would it be for you to implement this change?

1– I can easily make this change.

5- I would have great difficulty making this change.

(do this for each change idea)

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Impact

How big an impact would this change make?

1– This change could reduce the number of patient suicide attempts.

5- this change will never make any difference to any patient ever.

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Questions

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