

Risk Formulation

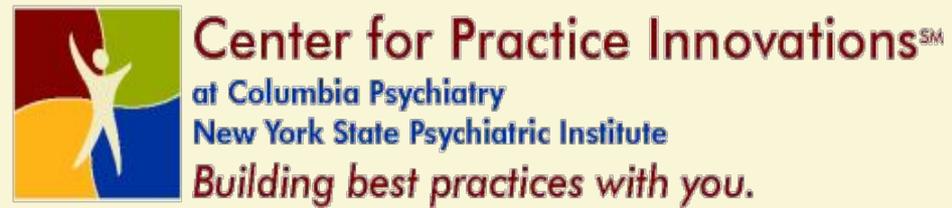
Using Case Studies to Examine Best Practices in Formulation of Risk

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Welcome and Introductions

Learning Objectives

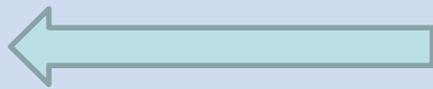
- Understand the role of risk assessment and formulation in the NYASSC protocols
- Know how to assess and weigh suicide risk factors and protective factors to arrive at a risk formulation
- Differences in risk assessment and formulation according to treatment setting – CPEP, inpatient, outpatient, SUD
- Learn how to overcome obstacles to risk formulation
- How risk formulation informs treatment decisions
- Know when to balance the protocol with clinical judgment

Agenda

- Role of Risk Assessment and formulation in the NYASSC Zero Suicide Assess, Intervene and Monitor Protocols in the various treatment settings: Inpatient, Outpatient, CPEP and SUD
- Common obstacles to Risk Formulation in the various settings
- Overview of Comprehensive Risk Assessment
- When/how to use clinical judgment
- When/how to factor in other sources of information
- Break-out groups
- Discussion

Discussion: Questions about Risk Formulation

- How many of you have experienced the loss of a patient to suicide?
- What are your concerns about risk assessment?
- What are your questions about risk formulation?
- What challenges/obstacles have you been coming across?



Patient and Family Engagement

(Throughout episode of care)



ASSESS

INTERVENE

MONITOR

Suicide Care Management Plan

UNIVERSAL SUICIDE SCREENING
All patients screened with the C-SSRS SCREEN version

UNIVERSAL PRECAUTIONS
Psychoeducation regarding suicide warning signs, Lifeline and GOT5 Crisis Text Line numbers

STRUCTURED FOLLOW-UP PHONE CALL
Within 48-72 Hours of discharge

COMPREHENSIVE SUICIDE RISK ASSESSMENT including Risk & Protective Factors and Access to Lethal Means

TREATMENT PLAN
with goals and objectives that specifically target suicide, including a plan for the identified foreseeable change

OUTPATIENT APPOINTMENT
Scheduled within 5 days of discharge

STANLEY-BROWN SAFETY PLAN
(with lethal means reduction counseling)

WARM HAND-OFF OF RECORDS
Forward records prior to first visit, including discharge summary including 2 foreseeable changes and safety plan

CARING CONTACTS
Send within 2 weeks and 3 months of inpatient discharge

Note: Items in **BLUE** represent procedures for all patients, and items in **PINK** for those assessed to be at higher risk



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Challenges and Obstacles to Risk Formulation

- Cases of conflicting information from collaterals/medical record and client self-report
- Minimizing history of suicidal crisis or attempt (e.g., only happened because I was drunk but now I'm sober; I was just upset but now I'm fine, etc.)
- When does clinical judgment override the “formula”

Common questions/challenges

- Very high and low risk seems to be the easiest to understand; what do we do with moderate-to-high-risk individuals?
- How do I know when to hospitalize?
- How do I decide to NOT hospitalize someone with moderate risk?
- When to place moderate risk individuals on suicide care management plan
- Ongoing risk assessment - when to enter people or take them off the care plan

Using risk assessment/formulation to inform treatment plan

- Some information from the risk assessment to be incorporated into safety planning and means reduction counseling
 - i.e., warning signs, 2 foreseeable changes, access to means, support network
- Other information informs suicide-specific treatment targets in ongoing treatment plan
 - i.e., psychiatric diagnoses and symptoms, modifiable risk and protective factors suicide specific trauma history, monitoring suicidal ideation, hopelessness

To summarize so far...

- NYASSC protocols provide a “formula” for risk assessment to arrive at a “risk level” formulation
- Conflicting information/reporting can present a challenge to arrive at an accurate risk level
- And, once arriving at a risk level formulation, how does this inform treatment? In particular, how to proceed with those deemed at “moderate risk”?
- When does clinical judgment override the “formula”, for formulation and treatment decisions?

First a review –

Goals of Risk Assessment:

- To guide in determining overall suicide risk
- To inform a triage decision and treatment plan that is responsive to modifiable suicide risk factors
- To guide treatment recommendations and help determine the most appropriate level of care or follow-up action to be taken
- To provide a framework for documenting a suicide risk formulation based on all risk and protective factors using clinical judgment

Features of a Comprehensive Suicide Risk Assessment

- Never based on any one risk factor (or set of risk factors)
- All suicide risk and protective factors are assessed together to provide an overall picture
- Identifies factors that are modifiable with intervention
- Identifies and distinguishes between Acute/ Proximal risk factors and warning signs from the ongoing, Chronic/ Distal risk factors
- Identifies changes in protective factors
- A process that generates specific individual data to guide clinical judgment
- In an ongoing care situation, risk assessment is not a single event; it must be evaluated over time; risk fluctuates
- Risk assessment aids, but does not replace, clinician decision-making

Quality of the Suicide Risk Assessment

Depends upon:

1. Individual's willingness or ability to accurately disclose information
2. Amount of available time
3. Clinician's style of inquiry
4. Access to the medical record, especially the most recent hospitalization
5. Contact with the individual's family, friends or clinicians

Note: 4-5 above are particularly important if the suicidal individual is not forthcoming

Overview of Assessing Suicide Risk

- Review 7 categories of general risk factors
- Determine protective factors
- Weigh risk/protective factors in making a risk assessment
- Distinguish acute, “proximal” risk factors from more chronic, “distal” risk factors, and identify warning signs
- Use general risk/protective factors to identify an individual’s particular risk/protective factors
- Identify modifiable risk and protective factors
- Assign a risk level that will inform triage and level and type of intervention

7 Categories of Risk Factors

1. Suicide-specific characteristics
2. Demographic risk factors
3. Psychiatric diagnosis and symptoms
4. Family and social factors
5. Precipitants
6. Treatment history difficulties
7. Access to means

Proximal/Distal Risk Factors/Warning Signs

Distal (chronic, background) risk factors

- Ongoing general characteristics or factors that are known to be associated with an elevated longer term risk for suicide; they exist in the individual's background
- Example: Suicide attempt 10 years ago

Proximal (acute) risk factors

- Recent events or exacerbations of ongoing characteristics that can indicate imminent risk
- Example: Suicide attempt within the last 3 months

Warning Signs (most acute risk factors)

- Individualized behaviors that are directly related to those that precede a spike in suicide risk in a particular individual, according to individual's history; time frames varies from individual to individual from minutes to days
- Example: Active, escalating suicidal ideation that is similar to the type of ideation present directly preceding a previous suicide attempt

Past History of Suicide Attempt

- The most known risk factor for a future suicide attempt is a past suicide attempt
- Obtaining details about past suicidal behavior can help create an individualized risk profile
- Identify circumstances and context surrounding one past behavior (preferably the most recent)
- Precipitant, mood state, recent life change, method, medical lethality, intent, extent of planning
- Compare current presentation with the past situation to help determine current risk for this individual

Weighing the Risk Factors

The highest risk factors are those that are most proximal (acute):

- Current presentation of suicidal ideation or recent suicidal behavior
- Current mood or psychiatric state
 - Agitation, mania, psychosis, aggression, mixed mood state
- Recent high risk precipitants
- Changes in treatment or situation that are stressful
 - Discharge from inpatient hospitalization
 - Discharge from Emergency Department
 - Impending incarceration or homelessness
 - Loss of social support
 - Job or financial loss
 - Severe medical diagnosis

Proximal (Acute)

- Acute symptoms, such as:
 - Mania
 - Agitation
 - Psychosis
 - Impulsivity/Aggression
 - Sleep disturbance
 - Active suicidal ideation
 - Non-suicidal self-injury
 - Depressed mood, hopelessness
 - Mood instability
 - Perceived burdensomeness
 - Social isolation/alienation
 - Active substance abuse
- Recent loss
- Access to lethal means
- Trauma trigger
- Change in treatment status

Distal

(Chronic, Background)

- History of suicidal behavior
- High risk psychiatric diagnosis
- Difficult treatment course, non-adherence
- History of abuse / trauma / neglect
- Long standing traits of aggression / impulsivity
- History of substance abuse
- Demographics
- Military Service

Protective Factors

- Expression of hope for the future
- Identification of reasons for living
- Sense of responsibility to family or others; living with family
- Children in the home; pregnancy
- Supportive social network or family
- Fear of death or dying due to pain and suffering
- Belief that suicide is immoral, high spirituality, religious prohibition
- Positive coping or problem-solving skills
- Positive current therapeutic relationship
- Engaged in work or school
- Protective factors may become operationally not relevant – this then adds to risk

Example of an Individualized Profile

- Mr. G is a 35 year old single man who lives alone and works as a graphic artist. History of 3 highly lethal suicide attempts, most of them impulsive overdoses precipitated by job losses or interpersonal altercations with supervisors and coworkers.
- **Distal risk factors:** Dx borderline personality disorder, history of severe sexual abuse in childhood, history of impulsive/aggressive behaviors, history of INSSI (cutting) and interpersonal problems interfering with keeping a job
- **Proximal risk factors** –interpersonal stressors at his current job, financial instability, current substance abuse
- **Past suicidal behavior:** Last suicide attempt one year ago, overdose of 100+ pills – mix of antidepressants and benzodiazepines. Lost consciousness for a day or two and never sought medical treatment
- **Precipitant:** Placed on probation by his supervisor at work
- **Current suicidal ideation:** Thoughts of wanting to OD on his medication
- **Current mood:** anger, shame, some agitation
- **Access to means:** Has some medications at home that he never used because he stopped taking it and switched to a new medication
- **Protective Factors:** Has a good relationship with his girlfriend and caring family

Risk Formulation

- Risk factors are general population derived characteristics associated with increased suicide risk
- A clinician's risk formulation weighs population-based risk factors and the individual presentation to ascribe a level of risk
- Risk formulation shows clinicians' rationale behind assigning a level of risk and supports the treatment plan
- Always clearly document your risk formulation

Assigning a Risk Level

- Assigning a risk level helps with triage
- Helps with longer range intervention planning
- To be used **ONLY** along with clinical judgment – **NOT** a rigid formula
- Guidelines for taking into account risk factors to determine risk level are suggestions not mandates

Assign Level of Risk

- High Risk – Acute, imminent, proximal risk factors, protective factors clearly outweighed by risk factors; suicidal intent/plan/recent suicidal behavior
- Moderate Risk – More distal than proximal risk, protective factors present but not as prominent, no immediate suicidal intent
- Low Risk – No acute, proximal risk factors, strong protective factors, no suicide intent

Risk Level: MODERATE

- Risk/Protective Factors
 - Multiple risk factors, more distal than proximal (suicide attempt in distant past, psychiatric diagnosis, trauma history)
 - Can anticipate a precipitant in the near future
 - No immediate access to means
 - Few protective factors
- Suicide-specific Factors
 - Suicidal ideation with plan, but no intent or behavior

Using clinical judgment to decide when moderate risk is lower or higher

Increase to high if:

- Conflicting collateral information
- Little support network
- Not able to fully engage in safety planning
- History of low treatment engagement
- Acute psychiatric symptoms are interfering with subjective reporting and you suspect minimizing

Decrease to low if:

- Clinical knowledge of patient that indicates lower risk
- Supports in place
- Treatment adherence
- Acute psychiatric symptoms are interfering with subjective reporting and you suspect over reporting or malingering
- You determine that acute symptoms will subside soon and lower imminent risk

Assessment Informs Intervention

High Risk – Enter into Suicide Care Management Plan

- Inpatient psychiatric admission or Intensive outpatient care followed by outpatient treatment
- Other suicide precautions such as involving friends and family to create a social support safety net for close monitoring as outpatient
- Safety Plan Intervention
- Structured Follow-up and Monitoring

Moderate Risk – Enter into Suicide Care Management Plan

- Possible inpatient admission
- Safety Plan Intervention with emergency and crisis plan
- Structured Follow-up and Monitoring
- Outpatient treatment

Low Risk – No entry into Suicide Care Management Plan

- Consider outpatient treatment
- Safety Plan Intervention including an emergency and crisis plan

Site Specific Decisions Informed by Risk Formulation

- **Outpatient and SUD:**
 - When to enter an individual into the Suicide Care Management Plan
 - When to hospitalize
- **CPEP:** Hospitalize yes or no? Follow up?
- **Inpatient:** Monitoring status, privileges. When to discharge. Follow up?

Let's revisit Mr. G – what do we need to know to determine moderate vs. high risk?

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Incorporating risk assessment into treatment planning

Safety planning:

- Identify warning signs – increased feelings of anger and shame, thoughts of feeling not good enough, not appreciated at work
- Reduce access to excess medication; assess and reduce access to other potential means

Ongoing suicide specific treatment targets:

- Monitor job situation, anticipate possible aversive interactions and cope ahead
- Monitor financial situation, substance use
- Monitor impulsive/risk taking behaviors
- Monitor any possible medication stockpiling
- Target dysfunctional thought patterns related to childhood trauma

Break Out Groups

- Groups divided by treatment setting
- Each will review a case
- Use the risk formulation sheet to determine risk level and treatment decisions

Suicide Risk Formulation Worksheet

Risk/Protective Factors summary

Chronic Risks:

Proximal Risks:

Warning signs:

Protective factors:

Suicidality Factors:

Worst lifetime ideation

Current/Recent ideation

Wish to die

Active ideation

Plan

Current intent (to act on plan)

Access to means

Past suicide attempt (remote)

Past suicide attempt (within last 6 months)

NSSI

Choose one past suicide attempt and identify the following:

Method

Medical lethality

Intent to die

Subjective report

Objective factors

Precipitant

Impulsive/pre-meditated

Risk Level:

Level of intervention recommendation:

How does risk assessment/formulation inform:

Safety Planning:

Ongoing treatment plan:

Obstacles/Challenges/Questions

Resources

<http://practiceinnovations.org>

<http://zerosuicide.actionallianceforsuicideprevention.org>

<http://www.sprc.org>

<http://www.preventsuicideny.org>

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