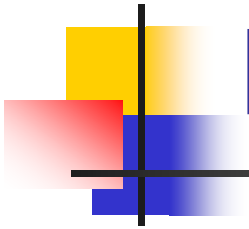
Overcoming patient nondisclosure

Patients at risk of suicide & violence to others



Logistics

- Copies of slides
- Questions
- Recording

Summary

- Legal challenges
- Hypothetical patient
- Patient data reliability
- Questions to increase reliability

Summary

- Trust building
- Self-report measures
- Critical but less loaded questions
- Multiple sources of information

Legal challenges

- Risk assessment inadequate
  - Did not access reasonably available information needed for the assessment
  - Inadequate history (not enough questions)
  - Failure to adequately evaluate risk at transitions
    - Structured risk assessment instruments

Legal challenges

- Treatment, supervision & placement decisions
  - Inadequate based on the level of risk identified or which should have been identified
    - Quality of risk assessment critical

Legal challenges

- Inadequate efforts to provide a safe environment
  - Lethal means
- Failure to involve family & support system
  - Medication compliance monitoring

Hypothetical patient

- Alice, 23-year-old female patient
- Diagnoses:
  - Borderline personality disorder (V & S)
  - Anorexia nervosa (S)
  - Alcohol use disorder (V)

Hypothetical patient

- Referred by ER
  - Brought into the ER by police
    - She seemed intoxicated & confused
    - A full bottle of Tylenol in her pocket
  - Police comments to ER nurse
    - Alice physically resisted being taken in by the police

Hypothetical patient

- ER nurse called the patient's mother
  - She overheard her daughter talking about suicide
  - Alice recently broke up with her boyfriend
  - Alice is living on the streets, but she is welcome back home
  - Mother told Alice to leave the house after a fight

Hypothetical patient

- Disclosed to ER nurse that she made a suicide attempt 6 months ago
  - Ingested the Tylenol she had, 14 tablets
  - Taken under a bridge overpass in the dark
    - Homeless
    - Alone when she took the pills
  - Someone called the police who took her to the ER

Hypothetical patient

- ER records
  - Denies other attempts
  - Difficulty sleeping for 3 weeks
  - Denies fights

Hypothetical patient

- Intake assessment
  - Patient observed to be significantly agitated
  - I'm not thinking about suicide now
  - I often think about wanting to be dead

Hypothetical patient

- Intake assessment
  - I’m not planning a suicide
  - I’m not afraid of suicide at all
  - Denies homicidal thoughts
  - High school dropout
  - Employed at McDonald’s 2 years ago for 2 months

Hypothetical patient

- 4 sources of information
  - Patient
  - ER nurses notes
  - Mother
  - Police

Patient data reliability

- Significant limitations with reliance on the patient's self-report
  - Patient's stigma against help seeking for suicidal thoughts
  - Past negative experiences with disclosure
  - Uncertainty or ambivalence about suicidal thoughts

Patient data reliability

- Significant limitations with reliance on the patient's self-report
  - Lack of perceived need for services
  - Preference for self-management
  - Fear of hospitalization
  - Suicidal ambivalence, uncertainty and temporal instability

Patient data reliability

- Promote inaccurate or deceptive self reporting of suicide risk
  - Selective disclosure – withholding information from unknown individuals until they are trusted
    - Suicidal individuals are much more likely to report thoughts and behaviors to close family and friends over medical providers
      - Podlogar & Joiner, *Allowing for Nondisclosure in High Suicide Risk Groups,* Assessment 1-13, 2019

Patient data reliability

- "… nondisclosure in suicide risk screening – is likely often occurring among those at higher suicide risk [and] may be driven by
  - …predictors of suicide risk itself,…
  - mistrust, avoidance of stigmatized consequences, & not wanting to be misunderstood."
    - Podlogar & Joiner, *Allowing for Nondisclosure in High Suicide Risk Groups,* Assessment 1-13, 2019

Patient data reliability

- "A recent study found that 78% of patients who died by suicide explicitly deny suicidal thoughts in their last verbal communications before killing themselves."
  - Measuring the Suicidal Mind: Implicit Cognition Predicts Suicidal Behavior, *Psychological Science* 21 (4)
    - Citing Clinical Correlates of Inpatient Suicide. *Journal of Clinical Psychiatry, 64, 14-19*

Patient data reliability

- "Study findings indicated that hospitalized patients who did not disclose suicidal intent following a self-inflicted gunshot wound often denied their injuries were due to suicide attempt..."

  - McClay, *Many Self-Inflicted Gunshot Wound Survivors Deny Suicide Attempt as Cause*, Psychiatr Serv, 2018

Patient data reliability

- …[but] psychiatric examination revealed that 43% of these patients present under circumstances suspicious of suicide.”
  - McClay, *Many Self-Inflicted Gunshot Wound Survivors Deny Suicide Attempt as Cause*, Psychiatr Serv, 2018

Patient data reliability

- Vast majority of clients admitted to lying in therapy – 93%
  - "Our initial survey of 547 clients showed large percentages of clients concealing therapy relevant information, such as suicidal thoughts."
  - "I wanted to be polite," "I wanted to avoid upsetting my therapist."

- Farber & Blanchard, *Lying in psychotherapy: Why and what clients don't tell their therapist about therapy and their relationship*, September 23, 2015

Patient data reliability

- "Regardless of who is reporting, overreporting and underreporting are common. People may overreport or underreport on purpose when they are hoping for benefits associated with diagnosis… or fear the consequences of diagnosis, including stigma or adverse effects of medication."
  - Pavlova & Uher, *Assessment of Psychopathology, Is Asking Questions Good Enough,* JAMA Psychiatry, June, 2020

Patient data reliability

- "Unintentional over reporting and under reporting are even more common. Many diagnoses rely on recalling duration and frequency of multiple symptoms, which is prone to memory bias…."

  - Pavlova & Uher, *Assessment of Psychopathology, Is Asking Questions Good Enough,* JAMA Psychiatry, June, 2020

Patient data reliability

- "What is being reported by others is also influenced by the reporters' mental state. For example, mothers experiencing depression and anxiety report more severe symptoms in their children than the children themselves…."
  - Pavlova & Uher, *Assessment of Psychopathology, Is Asking Questions Good Enough,* JAMA Psychiatry, June, 2020

Patient data reliability

- "Because violent patients easily disclaim their violent propensities even when confronted with overwhelming data and documentation, therapists can find themselves colluding with the patient's denial…."
  - Lion, Psychotherapeutic Interventions ch. 16, Violence Assessment and Management, American Psychiatric Publishing, 2008

Patient data reliability

- "Thus it is vital to review the violent act. If a police report exists, an attempt should be made to procure it…"
  - Lion, Psychotherapeutic Interventions ch. 16, Violence Assessment and Management, American Psychiatric Publishing, 2008

Patient interview reliability

- Patients the most intent on suicide may be the most likely to deceive
- Cognitive and emotional deficits
- Intent to avoid hospitalization
- Shame

Question techniques

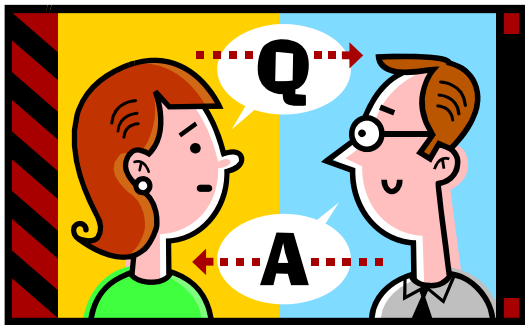
- Send unspoken but reassuring messages

Patient interview reliability

- Normalization: People who are depressed have told me they think about suicide. Do you think about it?
- Shame: As much pain as you are in, have you thought about suicide?
- Specifics: Did you think about overdosing? Not just "Do you or did you have a plan?"

Patient interview reliability

- Open-ended questions: What happened next?
- No leading questions: You didn't think about killing yourself, did you?



Patient interview reliability

- Ask about suicidal thoughts more than once
  - "…one point you made pretty quickly but has been emphasized by some suicide attempt survivors: To get full, accurate information about suicidal ideation, we need to find a way to ask ***twice***."

Patient interview reliability

- Assumptions: Other than an overdose what other ways have you thought about?

- Exaggeration: When you are thinking about suicide, how much of the day do you think about it? 50%, 75%, all the time?

Violence risk - Screening checklist

1. Violent behavior – physically hurt someone?
2. Violent threats

Violence risk - Screening checklist

3. Violent thoughts (the loaded question)

4. Have you felt that you are not in control of your own ideas or thoughts?

- Unspoken message

- Brucato et. al. *A Longitudinal Study of Violent Behavior in a Psychosis-Risk Cohort,* Neuropsychopharmacology, 43, 264-271 (2018)

Violence risk - Screening checklist

5. Hospitalizations related to hurting someone?
6. Fights?
7. Arrests or orders of protection related to threatening or violent behavior?

Violence risk - Screening checklist

8. Current or recent thoughts or behaviors that others have interpreted as threatening

9. Could someone hurt you?

Other indications…..

Trust building

- [1] "…allowing for sufficient time and attention paid to inviting respondents to describe their risk in their own words…

  - Podlogar & Joiner, *Allowing for Nondisclosure in High Suicide Risk Groups,* Assessment 1-13, 2019

Trust building

- [2]…providing hope, reassurance and de-stigmatization before conducting risk assessment, and
- [3] affirming the participant's agency in outcomes as best as possible."

  - Podlogar & Joiner, *Allowing for Nondisclosure in High Suicide Risk Groups,* Assessment 1-13, 2019

- Written self-report measures
- Ask the less emotionally loaded questions than:
  - Thoughts of suicide
  - Thoughts of violence or hurting someone

Suicide risk

Why do people die by suicide?

- "Because they can, and because they want to - because they develop both the desire and capability to do so."

  - Joiner, Van Orden, Witte, & Rudd, *The Interpersonal Theory of Suicide*, American Psychological Association, 2009

Why do people die by suicide? - acquired capability

- Few people are capable because lethal self injury is associated with so much fear and pain
- Instinct for self-preservation

Acquired capability

- Lowered fear of death and increased tolerance of physical pain
  - Acquired Capability for Suicide Scale (ACSS)
    - Self-report measure
  - Painful and Provocative Events Scale
    - Self-report measure

Acquired capability

- Self-inflicted lethal knife wounds
  - Associated with hesitation wounds, minor knife cuts
    - Demonstrating the difficulty of overcoming the instinct to survive

Acquired capability

- Sufficient past pain and provocation
  - Habituated to fear and pain of self injury

Acquired capability

- Clear association in the literature with past and future suicidality

Acquired capability

- Lower fear & tolerance of self harm
  - These patients require closer attention because of the suicide risk

Acquired capability

- Habituation experiences
  - Previous self injury with an intent to die
  - Fear or pain inducing experiences
    - Injury
    - Accidents
    - Violence
    - Combat
- Painful & provocative events scale

Acquired capability

- Those with past suicide attempts habituate to pain more than others

Acquired capability

- Anorexia
  - Habituates to pain & fear
  - Fearlessness in fighting with the instinct to survive

Risk = Acquired capability +

- Acquired capability alone does not create risk
- Acquired capability by itself is not a risk factor
- Acquired capability + desire creates risk

Desire

- Sustained
  - Perceived burdensomeness +
  - Failed belongingness

Desire

- Perceived burdensomeness
  - "a mental state characterized by apperceptions that others would "be better off if I were gone"
  - Which manifests when the need for social competence… is unmet
    - Family discord
    - Unemployment
    - Functional impairment

Desire

- Thwarted belongingness
  - Psychologically painful mental state that results when the fundamental need for connectedness… is unmet
    - loneliness
    - Living alone
    - Low social support

Failed belongingness

- Social isolation has the clearest support in the literature as a risk factor for suicidal behavior

Combining factors

- "And so I am prepared to defend the view that 100% of suicides are characterized by the combination of learned fearlessness, perceived burdensomeness, and profound alienation from others…"
  - Joiner, *Myths about Suicide*, Harvard University Press, 2010, p.193

Therapy approach – failed belongingness

- Therapist's attention to a patient's needs for
  - Social connection
  - Social competence (lack of burdensomeness)

Document detail

- Be specific
  - "Long term risk factors:… Family relational problems…"
    - How do we know about "failed belongingness?"

Therapy approach – perceived burdensomeness

- Identify and correct erroneous thoughts that the patient's death would be a benefit to others

Therapy approach

- Use “we” & “us” to enhance belonging
- The therapeutic relationship is a starting point to evaluate thoughts about the benefit of death
  - The patient’s life is worth more to the therapist
- List of pleasant activities that enhance belonging

Therapy approach

- Caring contacts
  - Reduce deaths

Therapy approach

- Emphasize belongingness
  - The therapeutic relationship as a source of belongingness
  - “We’re in this together.”
  - “We’ll work through this together.”

Therapy approach

- Emphasize belongingness
  - Belongingness related homework
  - Marsha Linehan 225 pleasant events list
    - Linehan, DBT *Skills Training Manual (Second Edition)*, Guilford Press, 2015. List available at Guilford.com/dbt-manual *Emotion regulation Handout 16*

Therapy approach

- Provide counseling to avoid activities which may continue to habituate to injury & fear
- Explore the function of past activities and other ways to accomplish the function

Borderline personality disorder

- 60-70% with the disorder attempt suicide
- 4.21%-4.80% suicide rate
  - 400 times that of the general population

Borderline personality disorder

- Acquired capability from repeated self injury + impulsive behaviors

Borderline personality disorder

- Failed belongingness
  - Stormy interpersonal relationships
- Perceived burdensomeness
  - Strain on family resources
  - Mental illness places a burden on loved ones

Borderline personality disorder

- "… identity disturbance, chronic feelings of emptiness, and frantic efforts to avoid abandonment were significantly associated with suicide attempts… [and] may be clinically overlooked features of BPD in context of suicide risk assessment."
  - Yen et al., *Association of Borderline Personality Disorder Criteria with Suicide Attempts*, JAMA Psychiatry, November 18, 2020

Risk assessment

- Assess
  - Desire
    - Thwarted belongingness
    - Perceived burdensomeness
      - Hopelessness about either condition
  - Capability

Risk assessment

- Non-suicidal self injury
- Precipitating stressors occurring within the past year (e.g., death of a loved one, termination from employment)

Risk assessment

- Psychopathology
  - "Although problematic alcohol use increases risk of suicide… death by suicide when intoxicated is quite infrequent."
- Impulsivity
  - "… Although impulsive individuals engage in suicidal behavior at an elevated rate, they do so with substantial forethought and planning."

Risk assessment

- "Although the assessment of desire, plans, preparations, and intent is essential, evidence suggests that a significant percentage of suicide decedents deny suicidal ideation at their final mental health encounter."
  - Chu, Joiner et al. *Routinized Assessment of Suicide Risk in Clinical Practice: An Empirically Informed Update*, Journal of clinical psychology 1-15 (2015)

Risk assessment

- "Additionally, reliance on chronic risk factors (e.g. psychopathology, past suicidal behavior, family history of suicide) limits our ability to determine whether an individual is at imminent risk."
  - Chu, Joiner et al. *Routinized Assessment of Suicide Risk in Clinical Practice: An Empirically Informed Update*, Journal of clinical psychology 1-15 (2015)

Risk assessment

- "Therefore, it is imperative to assess acute and objective risk factors, which are time-limited and associated with an increased risk for suicide over a period of hours to days, not months or years."
  - Chu, Joiner et al. *Routinized Assessment of Suicide Risk in Clinical Practice: An Empirically Informed Update*, Journal of clinical psychology 1-15 (2015)

Risk assessment

- Danger signs/acute symptoms
  - Agitation
    - Consider symptoms of anxiety?
  - Social withdrawal
  - Severe weight loss
  - Marked irritability
  - Nightmares/insomnia
  - Severe affective states
  - Talking about suicide

SUICIDE RISK ASSESSMENT

DANGER SIGNS

Talking about Suicide Social withdrawal	Agitation Weight loss	Insomnia Marked Irritability	Nightmares Extreme emotional states (e.g. rage)

Assess Suicidal DESIRE and IDEATION	Assess RESOLVED PLANS and PREPARATIONS	Assess OTHER SIGNIFICANT FINDINGS
• Have you been having thoughts or images of suicide (thoughts of images of killing yourself)? Tell me about that. • Do you think about wanting to be dead? • **THWARTED BELONGINGNESS**: Do you feel connected to other people? Do you live alone? Do you have someone you can call when you are feeling bad? (Are supporting relationships completely absent?) • **PERCEIVED BURDENSOMENESS**: Sometimes people think, "The people in my life would be better off if I were gone." Do you think that?	• **Duration** (look for pre-occupation): When you have these thoughts, how long do they last? • **Intensity**: How strong is your intent to kill yourself? 0 = not intense at all, 10 = very intense. • **Past suicidal behavior**: Have you attempted suicide in the past? How many times? Methods used? What happened (e.g., admitted to hospital?). Non-suicidal self-injury? Family history? • **Specified plan** (look for vividness, detail): Do you have a plan for how you would kill yourself? • **Means and opportunity**: Do you have the pills (or a gun, etc.)? Do you think you'll have an opportunity to do this? • Have you made preparations for a suicide attempt (e.g., buying pills) • Do you know when you expect to use your plan? • **Fearlessness**: **Thinking about suicide, do you feel afraid**? 0 = very afraid; 10 = not afraid at all	• **Precipitant Stressors**: HIas anything especially stressful happened to you recently? (e.g., death of a loved one, divorce, major break-up, job loss)? • **Hopelessness**: Do you feel hopeless? • **Impulsivity**: When you are feeling badly, how do you cope? Sometimes when people feel badly, they do impulsive things to feel better. Has this ever happened to you? (e.g., cutting your skin, drinking alcohol, running away, binge eating, promiscuous sex, physical aggression, or shoplifting)? • **Presence of psychopathology:** (rated by interviewer)

Depressive Symptom Index – Suicidality Subscale
Acquired Capability Scale (ACSS) **Interpersonal Needs Questionnaire (INQ)**

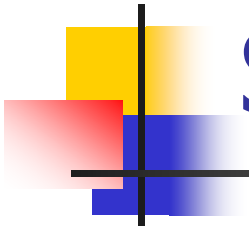
RISK CATEGORY

LOW	MODERATE	SEVERE	EXTREME

ACTIONS TAKEN:

- Continue to monitor regularly
- Given Emergency numbers
- Scheduled mid-week phone check-in
- Provided info about adjunctive treatment
- Coping Card/Safety Plan
- Consulted Supervisor
- Other

Form Provided by Dr. Thomas Joiner, Florida State University, Dept. of Psychology



Self-report measures

- Google “Joiner lab”
- Less pressure than face-to-face interaction

Acquired Capability for Suicide Scale

ACSS (fearlessness) – coding

item 1 + item 4 + item 6 + item 7 + (4 - item 2) + (4 – item 3) + (4 – item 5). Score range: 0 - 28

ACSS-FAD

Please read each item below and indicate to what extent you feel the statement describes you. Rate each statement using the scale below and indicate your responses on your answer sheet.

		0 Not at all like me	1	2	3	4 Very much like me
1	The fact that I am going to die does not affect me.	0	1	2	3	4
2	The pain involved in dying frightens me.	0	1	2	3	4
3	I am very much afraid to die.	0	1	2	3	4
4	It does not make me nervous when people talk about death.	0	1	2	3	4
5	The prospect of my own death arouses anxiety in me.	0	1	2	3	4
6	I am not disturbed by death being the end of life as I know it.	0	1	2	3	4
7	I am not at all afraid to die.	0	1	2	3	4

Painful and Provocative Events Scale

- Acquired capability

PPES

Please answer the following questions for any time in the past. **For each question circle ONE answer.**

		Never	Once	2-3 times	4-20 times	More than 20 times
1.	Have you gone skydiving?	1	2	3	4	5
2.	Have you gone rockclimbing?	1	2	3	4	5
3.	Have you participated in contact sports (e.g., tackle football, hockey, wrestling, judo)?	1	2	3	4	5
4.	Did you get a tattoo?	1	2	3	4	5
5.	Did you get a piercing?	1	2	3	4	5
6.	Have you been a victim of physical abuse?	1	2	3	4	5
7.	Have you been a victim of sexual abuse?	1	2	3	4	5
8.	Have you been a witness to physical abuse?	1	2	3	4	5
9.	Have you been a witness to sexual abuse?	1	2	3	4	5
10.	Have you gone on a motorcycle?	1	2	3	4	5
11.	Have you shot a gun?	1	2	3	4	5
12.	Have you tied a noose?	1	2	3	4	5
13.	Have you had surgery?	1	2	3	4	5
14.	Have you used intravenous drugs?	1	2	3	4	5
15.	Have you broken a bone?	1	2	3	4	5
16.	Have you intentionally hurt animals?	1	2	3	4	5
17.	Have you dissected animals?	1	2	3	4	5
18.	Have you gone bungee jumping?	1	2	3	4	5
19.	Have you been in a car accident?	1	2	3	4	5
20.	Have you had contact with the police because of criminal behavior?	1	2	3	4	5
21.	Have you been in physical fights?	1	2	3	4	5
22.	Have you jumped from high places (e.g., cliffs, roofs, balconies)?	1	2	3	4	5
23.	Have you had injuries requiring medical attention?	1	2	3	4	5
24.	Have you been stabbed?	1	2	3	4	5
25.	Have you been shot?	1	2	3	4	5
26.	I have stopped myself right before attempting suicide and did not carry out the attempt (e.g., standing on a bridge but not jumping, loading a gun but not pulling the trigger).	1	2	3	4	5

Interpersonal Needs Questionnaire (INQ)

- Self-report measure of thwarted belongingness and perceived burdensomeness

INQ

The following questions ask you to think about yourself and other people. Please respond to each question by using your own current beliefs and experiences, NOT what you think is true in general, or what might be true for other people. Please base your responses on how you've been feeling recently. Use the rating scale to find the number that best matches how you feel and circle that number. There are no right or wrong answers: we are interested in what you think and feel.

		Not at all true for me			Somewhat true for me			Very true for me
1.	These days, the people in my life would be better off if I were gone	1	2	3	4	5	6	7
2.	These days, the people in my life would be happier without me	1	2	3	4	5	6	7
3.	These days, I think I am a burden on society	1	2	3	4	5	6	7
4.	These days, I think my death would be a relief to the people in my life	1	2	3	4	5	6	7
5.	These days, I think the people in my life wish they could be rid of me	1	2	3	4	5	6	7
6.	These days, I think I make things worse for the people in my life	1	2	3	4	5	6	7
7.	These days, other people care about me	1	2	3	4	5	6	7
8.	These days, I feel like I belong	1	2	3	4	5	6	7
9.	These days, I rarely interact with people who care about me	1	2	3	4	5	6	7
10.	These days, I am fortunate to have many caring and supportive friends	1	2	3	4	5	6	7
11.	These days, I feel disconnected from other people	1	2	3	4	5	6	7
12.	These days, I often feel like an outsider in social gatherings	1	2	3	4	5	6	7
13.	These days, I feel that there are people I can turn to in times of need	1	2	3	4	5	6	7
14.	These days, I am close to other people	1	2	3	4	5	6	7
15.	These days, I have at least one satisfying interaction every day	1	2	3	4	5	6	7

Note: Items 7, 8, 10, 13, 14, and 15 are reverse coded.

Van Orden, K. A., Cukrowicz, K. C., Witte, T. K., & Joiner, T. E. (2012). Thwarted belongingness and perceived burdensomeness: Construct validity and psychometric properties of the Interpersonal Needs Questionnaire. *Psychological Assessment, 24*(1), 197-215.

Depressive Symptom Index – Suicidality Subscale

- Thoughts

Name_____ Date_____

Depressive Symptom Index – Suicidality Subscale

Instructions: On this questionnaire are groups of statements. Please read all of the statements in a given group. Pick out and circle the one statement in each group that describes you best for the past TWO WEEKS. If several statements in a group seem to apply to you, pick the one with the higher number. BE SURE TO READ ALL OF THE STATEMENTS IN EACH GROUP BEFORE MAKING YOUR CHOICE.

A)
0 I do not have thoughts of killing myself.
1 Sometimes I have thoughts of killing myself.
2 Most of the time I have thoughts of killing myself.
3 I always have thoughts of killing myself.

B)
0 I am not having thoughts about suicide.
1 I am having thoughts about suicide but have not formulated any plans.
2 I am having thoughts about suicide and am considering possible ways of doing it.
3 I am having thoughts about suicide and have formulated a definite plan.

C)
0 I am not having thoughts about suicide.
1 I am having thoughts about suicide but have these thoughts completely under my control.
2 I am having thoughts about suicide but have these thoughts somewhat under my control.
3 I am having thoughts about suicide but have little or no control over these thoughts.

D)
0 I am not having impulses to kill myself.
1 In some situations I have impulses to kill myself.
2 In most situations I have impulses to kill myself.
3 In all situations I have impulses to kill myself.

Violence risk

HCR-20

Risk factors - H

- History of problems with:
  - Violence
  - Other antisocial behavior
  - Relationships
  - Employment
  - Substance use

Risk factors - H

- History of problems with:
  - Major mental disorder
  - Personality disorder
  - Traumatic experiences
  - Violent attitudes
  - Treatment or supervision response

Risk factors - C

- Recent problems with:
  - Insight
  - Violent ideation or intent
  - Symptoms of major mental disorder
  - Instability
  - Treatment or supervision response

Risk factors - R

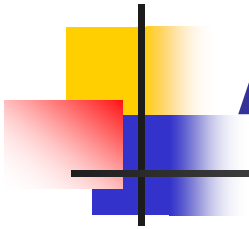
- Future problems with:
  - Professional services and plans
  - Living situation
  - Personal support
  - Treatment or supervision response
  - Stress or coping

Indicators – an example

- Problems with substance use
  - Started in adolescence or childhood
  - Multiple developmental periods
  - Multiple substances
  - Heavy use
  - Chronic use
  - Use of controlled settings
  - Involvement in drug trade

Indicators – an example

- Problems with substance use
  - Lead to dangerous behavior
  - Affected financial status
  - Interfered with education, vocation, relationships
  - Recent past
  - Problems have escalated



A variety of sources

Gather information reasonably necessary

- Patient interview & observation
- Collateral sources – family & others
- Criminal justice records
- Health care records

Sources of information

- Trusted family and friends
- Request availability at intake

Collateral sources

- Ask about danger signs/acute symptoms & risk factors

Supreme Court of Washington

- Volk v Demeerleer, 2016
  - "It is unrealistic to expect perfection in all mental health diagnoses but requiring that mental health professionals use the standards of the mental health profession to arrive at the *informed* assessment of their patient's dangerousness is not an unworkable requirement."

Negligence issues – expert witness

- "Most of the *Tarasoff* like cases on which I have worked have faulted clinicians not for making an inaccurate prediction but for failing to gather information that would have made a reasonable effort at prediction possible."
  - Monahan, Limiting Therapist Exposure to Tarasoff Liability, American Psychologist, 242- 250, 243 March, 1993

Expert recommendations

- Reasonably available past treatment records
- Current hospitalization & other records including
  - **nurses notes**
    - Information about development of day-to-day behavior

- Monahan, Limiting Therapist Exposure to Tarasoff Liability, American Psychologist, 242- 250, 243 March, 1993

Expert recommendations

- Significant others either in person or at least by telephone
  - Ask about violent behavior or threats currently or in the past
  - Ask open ended questions such as, "Are you concerned the patient might hurt someone."
  - Follow-up questions
    - Monahan, Limiting Therapist Exposure to Tarasoff Liability, American Psychologist, 242- 250, 243 March, 1993

Expert recommendations

- "… the clinician should pursue information from other available sources, particularly
  - family members,
  - significant others,
  - and current and past providers of services."
    - New York State Mental Health-Criminal Justice Panel Report and Recommendations, Appendix E: Guidelines for Mental Health Clinic Standards of Care and Sequential Screening of Risk for Violence, 2008

Expert recommendations

- "In practice, evaluators should attempt to gather information that is reasonably necessary to reach an opinion regarding risk in the case, given the context of the evaluation.
  - HCR-20 User Guide, 2013

Expert recommendations

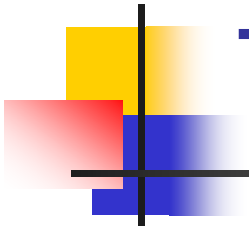
- Sources:
  - Past victims
  - Collateral sources including:
    - Family, friends, professionals
    - Criminal justice records
    - Healthcare records
    - Social service records
    - Psychodiagnostic tests and assessments
      - HCR-20 User Guide, 2013

Expert recommendations

- "Evaluators should recognize that the quantity and quality of information they review sets fundamental limits on the consistency (reliability) and accuracy (validity) of their judgments."
  - HCR-20 User Guide, 2013

By telephone?

- Confidentiality regulations



Treatment activities

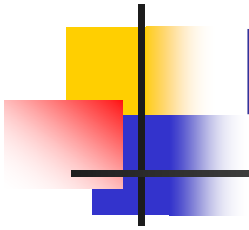
- Healthcare providers

HIPAA in the way?

- 45 CFR 164.506 (c) (2) "A covered entity may disclose protected health information for treatment activities of a healthcare provider."

HIPAA in the way?

- "Generally, the Privacy Rule applies uniformly to all protected health information, without regard to the type of information. One exception to this general rule is for psychotherapy notes, which receive special protections."
  - HIPAA Privacy Rule and Sharing Information Related to Mental Health, OCR Guidance 2017



Part 2 applies to “programs”

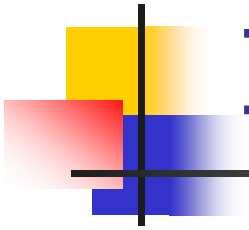
42 CFR part 2 in the way?

- 42 CFR part 2 applies only to "programs" as defined
  - Individual/entity, other than a general medical facility,
    - which holds itself out as providing and provides alcohol/drug diagnosis, treatment or referral for treatment
  - An identified unit within a general medical facility which holds itself out…
  - Medical personnel or the staff in a general medical facility whose primary function is providing alcohol/drug diagnosis, treatment or referral

Talking to family members

HIPAA in the way?

- "..HIPAA in no way prevents healthcare providers from listening to family members or other caregivers who may have concerns about the health and well-being of the patient, so the healthcare provider can factor that information into the patient's care." *OCR February 20, 2014*



Incapacity & emergencies

HIPAA in the way?

- (b) disclosures for involvement in the individual's care
- (3)… if the opportunity to agree or object to the use or disclosure cannot practicably be provided because of the individual's incapacity **or** an emergency circumstance, the covered entity may, in the exercise of professional judgment, determine whether the disclosure is in the best interests of the individual and, if so, disclose only the protected health information that is directly relevant to the person's involvement...

Serious & imminent threats

But what if…..

- Patient diagnosed with schizophrenia attacked mother 6 months ago
  - Agitation
  - Slurred speech
  - Intermittent medication
  - Insomnia
  - Accused mother of controlling him
- Now you see the same symptoms…

Duty to warn/protect

- What if there is a HIPAA "serious and imminent threat"
- **But**
- The patient has not communicated a specific threat?
  - Call the mother?

HIPAA in the way?

- "When a patient poses a serious and imminent **threat** to his own or someone else's health or safety, HIPAA permits a healthcare professional to share the necessary information about the patient with anyone who is in a position to prevent or lessen the threatened harm—including family, friends, and caregivers — without the patient's permission." (emphasis added)
  - OCR, Additional FAQs on Sharing Information Related to Treatment for Mental Health or Substance Use Disorder-Including Opioid Abuse, 12.19.17

HIPAA in the way?

- "HIPAA expressly defers to the professional judgment of health care professionals when they make determinations about the nature and severity of the threat to health or safety. See 45 CFR 164.512 (j) (4)." (emphasis added)
  - OCR, Additional FAQs on Sharing Information Related to Treatment for Mental Health or Substance Use Disorder-Including Opioid Abuse, 12.19.17

Questions & Comments