PRACTICAL POINTERS FOR MANAGING RISK WHEN TREATING PATIENTS WITH SUICIDAL BEHAVIORS

1. Include specific exploration of suicidal potential in examinations at the outset of treatment and at other points of decision during treatment. Suicidal potential should be re-assessed at least: 1) whenever there is an incidence of suicidal or self-destructive ideation or behavior; 2) when significant clinical changes occur; 3) when any modification in supervision or observation level is ordered; and 4) at the time of discharge or transfer from one level of care to another. Based on these reassessments, make adjustments to the treatment plan as needed.

2. Explore past treatment. Obtain treatment records where possible for new or returning patients. Record attempts to obtain records if they cannot be obtained.

3. Review patient records prior to lifting precautions or otherwise reducing the nature or intensity of treatment. Review the entries of other professionals as well as your own.

4. Conduct follow-up discussions with staff members whose record entries may be inconsistent with treatment options under consideration. Include the basis for resolution of the inconsistency in a record entry of the decision.

5. Instruct staff to notify you immediately if they are concerned about a patient's potential for suicide.

6. Communicate with other treaters, especially when the patient is being treated in a split or collaborative treatment arrangement.

7. At the outset of treatment, or after breaks in treatment, consult family members or others close to the patient, as appropriate, for information about the patient's history, presenting condition, and life circumstances.

8. Address the need for a safe environment for patients with suicidal behaviors. The accessibility of firearms or other weapons should be assessed and an appropriate plan for safety should be instituted, including getting information from and instructing family/significant others about this issue.

9. Record all potentially relevant information provided by family and close friends.

10. Know the criteria and procedures for involuntary hospitalization in your state.

11. Do not rely solely on "no-harm" contracts as a guarantee of patient safety. These "contracts" have no legal force and cannot take the place of an adequate suicide risk assessment. It may be appropriate for a "no-harm" contract to be *one part* of a comprehensive treatment plan but it is the clinician's responsibility to evaluate the patient's overall suicide risk and ability to participate in the overall treatment plan.

12. Be alert for - and respond to - developments in a patient's life that may increase the risk of suicide.

13. Address financial constraints directly. If recommended treatment is not financially possible, then attempt to find equivalent alternatives. Document the adequacy of the alternative that is ultimately chosen.

14. Document all relevant information about a patient's condition, treatment options considered, risk/benefit analysis performed, and the rationales for choosing or rejecting each option.

15. Never alter or destroy a patient record after an adverse incident.

16. Develop a follow-up treatment plan for discharge or for transfer from one level of care to another that is consistent with a patient's situation and abilities. You may need to take steps to monitor patient compliance if another psychiatrist or professional has not yet assumed care.

17. Familiarize yourself with the policies of all hospitals or other institutions/organizations where you provide treatment. Practice accordingly.

18. The decision about type and amount of medication given to a suicidal patient - and the resulting record entry - should reflect the extent of your experience with the patient, your knowledge of the patient, the severity of the patient's suicidality, and the extent to which physician prescribed medications may be of significance to the patient.

19. Refill prescriptions for other psychiatrists' patients with care. Review such refills with the psychiatrist if possible. Where such review is not possible, consider prescribing only enough medication to cover the patient until the psychiatrist returns or can be consulted.

20. Terminate treatment with potentially suicidal patients with extreme care. Avoid terminating during periods of crisis. Consider termination during inpatient treatment, if termination is necessary.

21. Prepare patients for scheduled absences and make provisions for coverage.

22. Consider alerting family members to the risk of outpatient suicide when:
    - the risk is significant,
    - the family members do not seem to be aware of the risk, and
    - the family might contribute to the patient's safety.

23. Consistently use an authoritative guideline to assess the level of suicide risk and facilitate the development of a reasonable intervention and treatment plan based on the assessed risk level.

Compliments of:

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