A Malpractice Context

• Malpractice at an all time high
• Placing blame
• Links to malpractice
Spoiler Alert!!!
The Key to Avoiding Malpractice with Suicidal Clients

- Assess for lethality using an empirically based model
- Use a comprehensive model of suicide assessment
- Document awareness of suicidality throughout treatment
- Consult using known terminology
- Provide mutually agreed upon resources
- Document appropriately
<table>
<thead>
<tr>
<th>Category</th>
<th># Year</th>
<th># Per Day</th>
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<tbody>
<tr>
<td>Nation</td>
<td>41,149</td>
<td>112.7</td>
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<tr>
<td>Males</td>
<td>32,055</td>
<td>87.8</td>
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<tr>
<td>Females</td>
<td>9,094</td>
<td>24.9</td>
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<td>Whites</td>
<td>37,154</td>
<td>101.8</td>
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<td>Non-Whites</td>
<td>3,995</td>
<td>10.9</td>
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<tr>
<td>Black</td>
<td>2,353</td>
<td>6.4</td>
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<tr>
<td>Elderly (65+)</td>
<td>7,215</td>
<td>19.8</td>
</tr>
<tr>
<td>Young (15-24)</td>
<td>4,878</td>
<td>13.4</td>
</tr>
<tr>
<td>Middle Age (45-64)</td>
<td>15,756</td>
<td>43.2</td>
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</tbody>
</table>
2013 USA Suicide Data

- **SUICIDES:**
  - 1 person every 12.8 minutes kill themselves
  - 1 elderly person every 1 hour 13 minutes
  - 1 young person every 1 hour 48 minutes
  - 10\textsuperscript{th} leading cause of death overall
  - 2\textsuperscript{nd} leading cause of death for young people

- **ATTEMPTS:**
  - 1,028,725 annual attempts
  - 3 female attempts for each male attempt
  - 1 attempt every 31 seconds
2013 USA Suicide Data

Methods

- Firearm: 51.5%
- Suffocation / Hanging: 24.5%
- Poisoning: 16.1%
- Cut / Pierce: 1.9%
- Drowning: 1.0%
- Other: 5%
Growing Links to Suicide

- Suicide among abused children:
  - 2-4 times higher among women
  - 4-11 times higher in men
- Depression: some say 2-9% of diagnosed will complete suicide
- Links to Criminal Activity: 29% or more of all deaths in jails
- LGBTQ Youth: twice as likely to attempt
- Questioning: 3.4 times more likely to attempt
- Bully victims are between 2 to 9 times more likely to consider suicide than non-victims
- Insomnia, Caffeine, Sexual Dysfunction
How do we Assess for Suicide?
Risk Model of Suicide Ideation

- **Lowest risk**: No thoughts of death
- **Low risk**: Nonsuicidal thoughts of death
- **Elevated risk**: Suicidal thoughts w/o specific method
- **Highest risk**: Suicidal thoughts with specific method
Lethality Terms

- **Short Term Lethality:**
  - The clinician's determination of a client's suicide lethality for the next 72 hours.

- **Long Term Lethality:**
  - The clinician's determination of a client's suicide lethality beyond 72 hours, but no longer than three months.
When to Formally Assess for Suicide

- At intake
- At termination
- At treatment planning
- When client’s mood significantly changes
- When client talks about suicide
- When your supervisor says so
Lethality Terms

- **Low Lethality:** The client is not suicidal at the time. Client is relatively happy, healthy, and functioning.
  - There is no such thing as “no lethality” because there is always the possibility.

- **Low – Moderate Lethality:** The client has some of the SIMPLE STEPS variables but does not have suicidal ideation or intent.

- **Moderate Lethality:** The client is suicidal and possesses several SIMPLE STEPS variables. Client is either in the ideation or threat phase of the suicidal process. Client has suicidal ideation and intent but can live beyond 72 hours.

- **Moderate – High Lethality:** The client may die within 72 hours unless there is an intervention.

- **High Lethality:** The client is currently in the process of attempting suicide. The client will die without intervention.
Suicide Assessment Mnemonics

- **PIMP:**
  - Plan, Intent, Means, & Prior Attempts

- **PIMP DAD:**
  - Plan, Intent, Means, Prior Attempts, Drugs, Alcohol, & Depression

- **PLAID:**
  - Prior Attempts, Lethality, Access to Means, Intent, & Drugs / Alcohol

- **IS PATH WARM**

- **SIMPLE STEPS**
Ideation
Substance Abuse
Purposelessness
Anger
Trapped
Hopelessness
Withdrawing
Anxiety
Recklessness
Mood Change

IS PATH
WARM
SIMPLE STEPS Model

- **Suicidal?**
  - Suicide Intent
- **Ideation**
  - Thought Process
- **Method**
  - Means & Plan
- **Pain (Perturbation)**
  - Degree of Emotional Pain
- **Loss**
  - Experienced & Perceived
- **Earlier Attempts**

- **Substance Use**
  - Use & Med Compliance
- **(Lack of) Troubleshooting**
  - Problem Solving Abilities
  - Cognitive Constriction
- **Emotion / Diagnosis**
  - Key Emotions & Dx
- **(Lack of) Protective Factors**
  - Also good for Treatment
- **Stressors & Life Events**
  - Current & Past Stressors
Ensuring Safety with the Resource Tree

<table>
<thead>
<tr>
<th>Self</th>
<th>Other</th>
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</thead>
<tbody>
<tr>
<td>1)</td>
<td>1) Name &amp; Number</td>
</tr>
<tr>
<td>2)</td>
<td>2) Name &amp; Number</td>
</tr>
<tr>
<td>3)</td>
<td>3) Name &amp; Number</td>
</tr>
<tr>
<td>4)</td>
<td>4) Maybe You &amp; Number</td>
</tr>
<tr>
<td>5)</td>
<td>5) Hotline Name &amp; Number</td>
</tr>
<tr>
<td>6)</td>
<td>6) 911</td>
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</table>
Calls to a suicide prevention hotline (January 2008 to December 2013)
N = 25,992 total contact sheets reviewed
Nominal vs. ordinal data issues
Eliminated: 3\textsuperscript{rd} Party Calls, Duplicate Calls, Prank Calls, Repeat Callers, Errors in Hand Coding, and Calls with Missing Data
Total Usable N = 13,423
Sex
- Females: 58.7% (N = 7,873)
- Males: 41.3% (N = 5,550)
Known Range: 8 - 89
- 8-14: N = 356 2.6%
- 15-24: N = 2,908 23.8%
- 25-44: N = 3,562 26.6%
- 45-64: N = 2,737 20.4%
- 65+: N = 314 2.2%
- Unknown: N = 3,546 24.4%
SIMPLE STEPS Overall Regression Equation

- N = 13,423
- R = 0.789; R Square = 0.623; Adjusted R Square = 0.622
- \[(\text{Constant}) -2.653 + 0.374 \text{ Suicidal} + 0.164 \text{ Attempt History} + 0.250 \text{ Ideation} + 0.093 \text{ Perturbation} - 0.064 \text{ Means} + 0.141 \text{ Loss} + 0.467 \text{ Lack of Troubleshooting Skills} + 0.140 \text{ Emotions} + 0.238 \text{ Lack of Protective Factors} + 0.047 \text{ Substance Use} + 0.041 \text{ Stress} = \text{Lethality Assessment}\]
## Comparison of Adjusted $R^2$

### PIMP, PLAID, SIMPLE STEPS Regression by Age

<table>
<thead>
<tr>
<th>Age</th>
<th>PIMP</th>
<th>PLAID</th>
<th>SIMPLE STEPS</th>
<th>N</th>
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<tbody>
<tr>
<td>8-20</td>
<td>.275</td>
<td>.290</td>
<td>.572</td>
<td>2,188</td>
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<tr>
<td>31-40</td>
<td>.334</td>
<td>.369</td>
<td>.656</td>
<td>1,822</td>
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<tr>
<td>41-50</td>
<td>.312</td>
<td>.360</td>
<td>.614</td>
<td>2,055</td>
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<tr>
<td>51-60</td>
<td>.377</td>
<td>.434</td>
<td>.644</td>
<td>1,128</td>
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<td>61 +</td>
<td>.346</td>
<td>.432</td>
<td>.607</td>
<td>391</td>
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<tr>
<td>Unknown</td>
<td>.346</td>
<td>.407</td>
<td>.625</td>
<td>3,624</td>
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Comparison of Adjusted $R^2$
PIMP, PLAID, SIMPLE STEPS Regression by Year

*(Missing: $N = 12$)*

<table>
<thead>
<tr>
<th>Year</th>
<th>N</th>
<th>PIMP</th>
<th>PLAID</th>
<th>SIMPLE STEPS</th>
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<tr>
<td>2008</td>
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<td>.316</td>
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<td>2009</td>
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<td>2012</td>
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<td>2013</td>
<td>3,111</td>
<td>.336</td>
<td>.371</td>
<td>.626</td>
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Clinical Implications

- SIMPLE STEPS Model:
  - Stable across years
  - Stable constructs across lethality
  - Stable across ages

- Suggests that the PIMP & PLAID models are not enough

- Plan is still needed for treatment purposes

- Piling Sticks!!!

- Task is to take more sticks off!!!!
Avoiding Malpractice
Overall Malpractice Arises When…

- (1) did not explain the consequences of treatment or the counseling process;
- (2) informed consent was not documented or obtained;
- (3) failed to protect the client (or others) from violent or suicidal actions;
- (4) did not choose a treatment that would have been more helpful;
- (5) the clinician used techniques and skills that they were not trained to use;
- (6) the treatment / procedure that was used was not accepted by professional standards.
Suicide Malpractice Arises When Clinicians Fail to..

- assess correctly
- maintain the clinician / client relationship
- diagnose the client’s symptoms correctly
- conduct an intake that includes a mental status examination and thorough client history
- establish and follow through with a treatment plan
- appropriately document actions made, clinical judgments, and observations
- provide a safety plan for clients when they are not in the direct supervision of a clinician
- seek out and properly document supervision
- obtain prior records of treatment
- assess for suicide at appropriate times
- hospitalize clients at the appropriate time
What do you do if you get sued?

- First, have your own professional liability insurance coverage.
- Second, continually document clearly and precisely.
- Third, obtain the services of a lawyer that has experience in working with mental health professionals.
When to Document Suicidality

- At admissions or intake
- Any time suicidal behavior or ideation occurs
- Any time there is significant change your client
- Any time clients discuss suicide
- Prior to termination or discharge
- Continuously throughout treatment showing increase / decrease in lethality across all clients
Proper documentation of suicide risk should first include a determination of the level of the client’s lethality.

Clinicians should develop a common and standard language of client lethality.

Proper suicide documentation should also include both objective and subjective data of the suicide assessment.

Provide a working and differential diagnosis of the client.

Provide short and long term goals addressing suicide.

Justification for suicide assessment via the SIMPLE STEPS model.
Never write “is suicidal” when client is not actively attempting suicide
Use the client’s own verbatim words
Document as soon as you determine it is important to document.
You do not want to ever say “boy, I wish I documented that”
  If you do find yourself saying this, create a new summary of what has happened up to this point in time
Never back date anything
Include as much detail as possible (e.g., dates, exact times, etc.)
Document soon after the interaction with the client so it stays fresh
Tips on Suicide Documentation

- Document suicidal lethality via the SIMPLE STEPS Model
- Document step-by-step what happened
- Consult with a supervisor and document the actions taken by the supervisor
- Document all conversations between you and family members
- Document that you reviewed prior clinical records (even from previous clinicians) and built your treatment off of their work
- Document all follow-up procedures and make sure you follow through with them. Document the time and day each procedures was accomplished
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