

## Assessing and Managing Risk With Suicidal Individuals

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*The University of Washington Risk Assessment Protocol (UWRAP) and Risk Assessment and Management Protocol (UWRAMP) have been used in numerous clinical trials treating high-risk suicidal individuals over several years. These protocols structure assessors and treatment providers to provide a thorough suicide risk assessment, review standards of care recommendations for action, and allow for subsequent documentation of information gathered and actions taken. As such, it is a resource for providers treating high-risk populations across multiple contexts (e.g., primary care, outpatient psychotherapy, emergency department). This article describes both the UWRAP and UWRAMP. Taken together, these assessment and risk management tools include (a) assessment questions for gathering information to determine the level of risk, (b) action steps that can be taken to ensure safety, and (c) a companion therapist note where providers document their assessment and actions.*

THERE is little question that suicide is an important public health problem. The rates of suicide worldwide have not decreased in the last 100 years (Centers for Disease Control and Prevention, 2009). One undoubtedly important factor is the astounding lack of rigorous clinical trials for suicidal individuals. Forty-six randomized, controlled trials have been published to date that evaluate treatment interventions targeted at reducing suicidal behaviors, with suicide currently ranked as the 11th leading cause of death (Centers for Disease Control and Prevention; see Appendix A for the complete list of studies). This is in comparison to large numbers of randomized clinical trials listed in the Cochrane Central Register of Controlled Trials (2009) for other disorders, including 582 trials for liver disease (ranked 12th in 2006), 1,398 for hypertension (ranked 13th), 198 for Parkinson's disease (ranked 14th), and 662 trials listed for AIDS (ranked lower than 15th). When compared to clinical trials for depression (1,989 trials), schizophrenia (396 trials), bipolar disorder (214 trials), and anxiety disorders (904 trials), the number of clinical trials focusing on reduction of suicidal behavior is amazingly low.

Exclusion of suicidal individuals from clinical trials is a second factor that has arguably crippled the field of suicide intervention research. Because they are consistently excluded, we cannot confidently confirm

evidence-based practices for a diagnosis will benefit suicidal individuals with that diagnosis. Even intervention studies targeting suicidal behaviors routinely exclude those at the highest risk for death by suicide (e.g., those with multiple suicide attempts, drug dependence diagnoses, depression, or other co-occurring mental health diagnoses; e.g., Hawton et al., 1987; McLeavey, Daly, Ludgate, & Murray, 1994; Tyrer et al., 2003). Suicidal individuals, like pregnant women, are not only excluded from clinical trials but the ethical costs of not learning how to treat these individuals is rarely discussed.

A third factor that impedes effective interventions for suicidal individuals is the unwillingness of many mental health care providers to treat suicidal individuals. Of all of the undesired outcomes in clinical practice, a client's suicide is perhaps both the most stressful and the most feared. To avoid this, many clinicians refuse to accept suicidal clients or refer clients that become suicidal. Some clinicians even terminate care with clients who attempt suicide after agreeing not to do so.

The reluctance to treat suicidal individuals, either in clinical practice or in research settings, is likely due to many factors. In the United States, many clinicians are clearly afraid of the liability risk in such care and practice defensively. Although some defensive measures are clearly indicated with suicidal individuals, many others—such as treatment termination or referral, involuntary hospitalization, or requiring written suicide contracts—have no evidence that they are effective in reducing risk. Among researchers, common difficulties include risk-averse universities that prohibit suicide treatment research,

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difficulties getting suicide research approved by IRBs, and a lack of training among researchers in suicide crisis intervention.

Our research group has been conducting clinical trials with highly suicidal individuals for over 35 years. Taken together, Linehan and Comtois have conducted or supervised six clinical trials with suicidal clients (Bartman, 1976; Ivanoff, 1985; Linehan et al., 2006; Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; Rizvi & Linehan, 2005) and have three ongoing trials targeting suicidal behaviors. We have also conducted or supervised five experimental or epidemiological studies with suicidal clients (e.g., Brown, 2003; Kuo & Linehan, 2009; Welch, 2005). In the course of our research, we have developed a number of protocols to provide both guidance and documentation for clinical assessors and treatment providers.

We developed two instruments, the University of Washington Risk Assessment Protocol (UWRAP for assessors; Linehan et al., 2000) and the University of Washington Risk Assessment and Management Protocol and Note (UWRAMP for treatment providers) to manage several important tasks when working with suicidal individuals. First, we wanted our protocols to reduce malpractice anxiety of both assessors and providers by prompting them to both follow and document standards of care in their assessment and management of suicide risk. Second, we wanted standardized protocols so that management of suicide risk during clinical research assessments could be both documented and applied by blinded assessors independent of treatment condition. Third, we wanted a generic crisis protocol that would both instruct and induce good clinical care applicable across treatment conditions in clinical trials. Our major hope here was that we could develop an online treatment note that when filled out would both improve clinical skill with suicidal clients and provide sufficient documentation of care.

We also hope that dissemination of these protocols to other clinicians and researchers will increase the likelihood that clinicians will treat suicidal individuals and that clinical trials will not exclude highly suicidal individuals. As noted by many others, a defensive measure that benefits both the care provider and the client is careful documentation of suicide risk assessment, interventions taken, and of the rationale for steps not taken (Simon & Shuman, 2009). The UWRAP has been used in 10 clinical trials to date. The UWRAMP is currently being used in 5 ongoing clinical trials and in the graduate student training clinic in the Psychology Department's Behavioral Research and Therapy Clinics. Of note for the wary clinician and/or researcher, the protocols have been used in studies of dialectical behavior therapy (DBT), an intervention that has

been shown to reduce suicide attempts, nonsuicidal self-injuries, and suicide ideation across four randomized trials (Koons et al., 2001; Linehan et al., 1991; Linehan et al., 2006; Linehan, Heard, & Armstrong, 1993; Verheul et al., 2003) and are recommended by the NIMH as suicide risk management tools (Pearson, Stanley, King, & Fisher, 2001).

### The UWRAP for Assessors

The UWRAP for assessors provides a structured, wrap-around method for assessing and managing suicide risk with individuals who are not currently in treatment or are not in treatment with the person conducting the assessment. It is likely to be most useful for research trial assessment and for screening interviews for clinical treatment programs before clinical responsibility for the case is accepted. When clients become distressed during an interview or when the interview is over and they want to leave, they are less willing to generate coping strategies. For this reason, the UWRAP starts before all other assessment measures and/or interviews.

The UWRAP provides a complete, step-by-step protocol for evaluating suicidality and, if necessary, implementing appropriate strategies for responding to suicide risk (see Appendix B). Prior to the start of each session, clients are asked to rate their level of stress, urges to self-harm, urges to commit suicide, and to use drugs or alcohol. In the first session of an assessment, the assessor next completes a "mood improvement" protocol. This protocol directs the assessor and client to make plans in the event that the client becomes distressed during the assessment or after leaving the office. If the client experiences distress during that interview (or subsequent sessions of that assessment), the assessor is able to draw upon these prepared strategies.

The UWRAP continues after completion of the assessment interview when the client is asked to make the four risk ratings again. By comparing these second ratings to the ones given at the start of the assessment, the assessor can determine if there has been a significant change in the client's stress level or urges to engage in self-destructive behaviors.

If, at postassessment, clients (a) rate suicidality higher than a 4 on a 7-point scale, (b) report being unsure about their ability to control suicidal urges, or (c) if the assessor's judgment indicates that the client is at high risk for suicide, the assessor conducts the Suicide Risk Assessment. The goal is for the assessor to have considered and documented each of the standard risk factors. If information is known, it is not reassessed. Unknown information is clarified until there is a full understanding of suicide risk. This assessment guides the

assessor in choosing the level of intervention, as described below.

Suicide urges and ideation often come and go throughout the day or the week and are brought on by stressful circumstances or negative self-evaluation or hopeless thoughts. Research and screening assessments carry the potential to elicit these urges if clients are already unhappy with areas in their life that are covered by the assessment. However, these “darkest moments” are often reduced by positive circumstances, validation, and activating positive and hopeful self-statements. By contrast, many clients are not suicidal at the time of the interview but continue to have life difficulties and subsequently low mood. Whether or not they are suicidal, it is important to improve a client's mood and develop coping strategies to keep this mood going when they return home. To do this, the assessor conducts a debriefing after each session using the coping strategies identified in the mood improvement protocol (from the start of the assessment) and a list of intervention strategies to develop a crisis response plan. Suggested interventions range from low-level interventions (e.g., reminding clients of positive things in their lives) to high-level interventions (e.g., accompanying a client to the emergency room). The assessor begins with the lowest-level intervention that is appropriate based on the Suicide Risk Assessment and moves toward the high-level interventions if the lower levels are not successful in improving the client's mood or ability to cope independently. The assessor also works with the client to find a fun activity to do after the assessment is completed so that any distress from the assessment does not drag on throughout the day. The goal is to develop a crisis response plan that the client can take home or to facilitate the client receiving help from his or her treatment provider or crisis services.

Regardless of suicide risk, the UWRAP ends with second half of the mood improvement protocol. The assessor attempts to improve the client's mood with activities like chatting about common positive interests, validating the client's strengths, watching a comedy video, taking a walk, or getting a cup of coffee together. The time and effort involved is proportional to the client's level of stress, with most clients needing little or no mood improvement activities and a minority benefiting from 5 to 30 minutes of these activities prior to leaving. After the client leaves, the assessor makes a rating of whether these mood improvement activities appeared to have changed the client's four ratings. (The client is not asked to re-rate at this point because this can often undo the benefit of the mood improvement activities. If ratings were high, this was previously addressed in developing the crisis response plan.)

To illustrate, consider a man who was suicidal at the screening interview for a study but has since improved and reports a 2 (out of a possible 7) on stress and a 1 on urges to self-harm, kill himself, and use drugs. The assessor and client agree that they will take a break during the assessment if he becomes distressed and he will go hang out at his brother's house later if distressed. After the assessment he responds with a 1 (out of 7) on all ratings, confirms he'll go to his brother's if he is distressed later and agrees that reading his new book is fun and he'll do that later too. After chatting a few minutes about a sports team to lighten his mood the client goes home. By contrast, a client comes for a screening assessment and reports a score of 7 (out of 7) for stress and 5 for urges to self-harm, 4 on his intent to die, and 3 on urges to use. He and the assessor plan to take a break if he finds the assessment difficult and, if needed, he will call his current case manager for help and the assessment can be completed on another day. They agree that after the assessment he will call his case manager to let her know he's feeling this badly, go to an AA meeting where there are other people, and avoid alcohol. The client is able to complete the interview with a brief break for a glass of water and afterward reports his stress is 4 (out of 7) but urges to harm and kill himself are still 4 and urge to use is still a 3. The assessor conducts the Suicide Risk Assessment, which identifies several risk factors but not all, and the client does not have access to lethal means. They agree the best next step is to contact the client's case manager and see what she suggests. The client is reluctant to bother her but agrees. The case manager is not available but a coverage provider speaks with the client by speakerphone in the assessor's office and they review some coping strategies and agree to a plan for him to come to the clinic the next day. Afterward, the assessor augments this with some suggestions for improving his mood later that day and spends 20 minutes with the client talking about the good things in his life, expressing hope for his future, and other cheerful topics. Client expresses appreciation for the support, agrees to check in tomorrow to confirm he saw someone at the clinic, and leaves.

Using a sample of one of our treatment research studies in which we used the UWRAP with women meeting criteria for borderline personality disorder and current suicidality, Reynolds, Lindenboim, Comtois, Murray, and Linehan (2006) found that changes in suicidal urges following long, intensive research assessments were infrequent (16.4% of all assessment sessions) and, when they did occur, were small (mean increase between .04 and .14 on a 7-point scale across all seven study assessment points). Interestingly, while the majority of subjects reported no change in their ratings of suicidality when preassessment and postassessment

ratings were compared, the authors found that a similar number of subjects rated their suicidality lower following the assessments (17.6%).

Further, for those subjects who reported increases in suicidality ratings, assessors recorded the interventions selected from the provided list (see [Appendix B](#)). [Reynolds et al. \(2006\)](#) looked at the 15 highest risk participants (i.e., those who had a high-risk session where the subject rated her intent to kill herself as 5 or greater on a 7-point scale or based on the assessor's clinical judgment) and the interventions implemented by the assessors to reduce suicide risk. The interventions that were most commonly used were those at the lower level (e.g., troubleshoot about feelings, refer to positive things in the client's life, validate feelings). Higher-intensity interventions were rarely implemented. Thus, the authors concluded that "research with highly suicidal individuals can be done safely with the use of well-trained assessors and a reasonable crisis management protocol" (p. 30).

Training in the UWRAP is provided by an experienced assessor with clinical experience and skill in working with suicidal clients. This includes not only step-by-step training in the UWRAP, but suicide risk assessment and training in each suicide crisis strategy suggested in the UWRAP debriefing (total of 2 to 3 hours). It is important to assure that the assessor understands the nature and how to use each resource, including clinician contact information, crisis services, transport to the emergency room, etc. In addition, the assessor needs to be clear when and how to contact his or her supervisor in the case of a high-risk client and how to document this supervision. New assessors role-play the UWRAP with the trainer, who plays suicidal clients at different levels of risk. When competent at this, the assessor is observed administering the UWRAP correctly at least once before doing so independently and discusses risk with the trainer after independent assessments until the trainers is confident of the assessor's judgment.

### **The UWRAMP for Treatment Providers**

The UWRAMP is a treatment form for therapists to fill out following treatment sessions (see [Appendix C](#)). The instrument was designed for adult clients entering treatment at risk for subsequent suicidality. (An adolescent form is under construction.) The UWRAMP documents both the clinician's risk assessment as well as interventions provided, those not provided, and the reasons for not providing specific interventions. The UWRAMP is not filled out after every single treatment session. Instead, it is designed for very specific situations: (a) at the start of treatment, and any time that an individual (b) makes a suicide attempt, (c) engages in

intentional self-injury, (d) makes a suicidal threat, or (e) reports a clinically significant increase in urges to commit suicide. For example, in DBT where suicide ideation and urges are assessed every week, an increase of 3 points on a 6-point scale requires use of the UWRAMP. After identifying the risk situation, the UWRAMP asks the clinician to provide a reason for not completing the rest of the note (e.g., the risk is negligible, resolved by the end of the treatment session, or likely to be reinforced by the attention of the risk assessment and intervention). Thus, the treatment note guides providers to address not only what they did, but also why they did not do things that other providers might consider the standard of care for suicidal crises (e.g., [Joiner, Walker, Rudd, & Jobes, 1999](#)). In our experience, even suicide experts have improved their suicide clinical skills by using the UWRAMP.

If there is not a reason to stop, the UWRAMP continues with a risk assessment. The information selected to be a part of the UWRAMP reflects the extensive literature on risk factors for suicide (e.g., [American Association of Suicidology, 2010](#); [International Association for Suicide Prevention, 2010](#); [Linehan, 1981](#); [Miller, Azrael, Hepburn, Hemenway, & Lippmann, 2006](#); [Móscicki, 2001](#); [National Institute of Mental Health, 2009](#)). More specifically, the assessment of risk and protective factors includes an abbreviated array of short- and long-term factors. It is important to note that the risk and protective factors included are but a subset of factors that may predict adult suicide risk. Revisions can be easily made, however, to provide risk and protective factors for specialized populations, such as individuals with specific mental and physical disorders, from specific countries or cultural backgrounds, or of various ages. We expect that we will be developing other versions. (See our website at <http://depts.washington.edu/btrc/> for updates on both UWRAP and UWRAMP versions.)

Following the risk assessment, the UWRAMP directs the clinician through a series of clinical interventions. Again, if options aren't chosen, the UWRAMP provides the opportunity to clarify why not or to note a follow-up plan to do so. Finally, steps for receiving consultation on the case and follow-up with the patient are documented. In summary, this note assures that the clinician did not fail to do something that would reasonably be expected and if they did so to provide justification. This process provides assurance to the clinician that he or she has done what there is to do and the liability protection that they are at or above standard of care.

Training in the UWRAMP follows one of two paths. For providers who have already received adequate training in suicide assessment and management, in addition to their training in providing general mental

health services, UWRAMP training is focused primarily on orienting providers to the format and the content included in the assessment. In our research trials, this orientation has been provided to therapists conducting DBT and to those outside of DBT. Minimally reviewing the content, explaining the structure of documentation, and answering providers' questions takes approximately 20 to 30 minutes. However, if the therapist does not have prior training in suicide risk assessment and management, a standard 2-day workshop is indicated. This workshop training is similar to that provided in crisis clinics and follows standard guidelines for crisis management.

### Supportive Data for UWRAP and UWRAMP

The only available data on the UWRAP and UWRAMP are the outcomes of our clinical trials in which the protocols have been used. The UWRAP has been used in all of our trials with experimental and control conditions alike. Although we have had a very low rate of suicide in our clinical trials (e.g., Linehan et al., 2006; two unpublished studies, each with no suicides in any treatment condition), it is impossible to attribute this to the use of the UWRAP. In addition to using the UWRAP, we have also met with clients every 4 months for assessments and provided 1 year of treatment to most. In the follow-up years we have sent caring greeting cards and cards for various other reasons to clients. It is impossible to ascertain why our suicide rates have been as low as they have been as well as to determine which of these procedures are related to decreased suicide rates and which are not.

The UWRAMP has also been used across several trials. In our current trials we have used it across both experimental and control conditions, which makes it difficult for us to evaluate its specific efficacy. The protocol is based on the DBT suicide intervention protocol that has been part of DBT since its creation. The effectiveness of DBT in reducing suicidal behaviors compared to control treatments not using such a protocol suggests that the protocol itself is likely effective. At a minimum, there is no evidence that it is ineffective. To date, no interrater reliability assessment has been conducted on the UWRAP or UWRAMP. This is an important area for future study.

Clearly, the next step is to research the effects of using the protocol both on clinicians and on client outcomes. Because our protocols represent what we would view as minimum standards of care, such research will be high risk and will require, in our opinion, courageous researchers and equally courageous funding agencies. It is important to remember, however, that our belief that we know how to treat suicidal behavior has been the central

enemy of finding out how to provide effective treatment. It is time that we address this question.

## Appendix A Randomized Clinical Trials Targeting Reduction in Suicidal Behaviors

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**Appendix B**

UNIVERSITY OF WASHINGTON  
 RISK ASSESSMENT PROTOCOL (UWRAP) FOR ASSESSORS  
 (Copyright Marsha M. Linehan, 2006. Adapted with permission)

REVIEW THE FOLLOWING WITH INDIVIDUAL AT START OF ASSESSMENT

1. On a scale of 1 to 7, what is your level of stress right now?  
 Low 1 2 3 4 5 6 7 High
2. On a scale of 1 to 7, what is your urge to harm yourself now?  
 Low 1 2 3 4 5 6 7 High
3. On a scale of 1 to 7, what is your intent to kill yourself right now?  
 Low 1 2 3 4 5 6 7 High
4. On a scale of 1 to 7, what is your urge to use drugs or alcohol right now?  
 Low 1 2 3 4 5 6 7 High

MOOD IMPROVEMENT PROTOCOL

(As you know,) these assessment interviews can be very stressful. We ask a lot of personal questions, and often these questions remind you of things you too, but we want to be sure the interview goes as smoothly as possible. What I'd like to do before we start the interview is to act *as if* the interview will be stressful, and figure out how to handle the stress before it happens.

1. Let's first talk about what might help during the interview. [pause] Is there anything you could do or I could do that might make it easier if you got upset? (DESCRIBE BELOW)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. What about after the interview is over? [pause] Is there anything you or I could do to make managing negative emotions later more tolerable? (DESCRIBE BELOW)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3. At the end of each session, after the debrief, offer mood induction activity (check all used and specify exactly what you did)

- |                                               |                |
|-----------------------------------------------|----------------|
| a. _____ TV comedy                            | Specify: _____ |
| b. _____ Music                                | Specify: _____ |
| c. _____ Chit chat                            | Specify: _____ |
| d. _____ Went for a walk                      | Specify: _____ |
| e. _____ Scents                               | Specify: _____ |
| f. _____ Food                                 | Specify: _____ |
| g. _____ Client not stressed, needed to leave |                |
| h. _____ Client refused, insisted on leaving  |                |

4. Rate effect of mood induction activities on client's mood (please circle):

	Much worse		No change		Much better		
a. Overall stress level:	---	--	-	○	+	++	+++
b. Urge to self-harm:	---	--	-	○	+	++	+++
c. Intent to die/suicide ideation:	---	--	-	○	+	++	+++
d. Urge to use drugs:	---	--	-	○	+	++	+++

\_\_\_\_\_



DEBRIEF

REVIEW THE FOLLOWING WITH INDIVIDUAL AT END OF ASSESSMENT

- 1. Ask for feedback on her/his experience during this assessment and other experiences she/he has had with the clinic (i.e., other assessments -- how did this one compare? How was it different? What made the difference?) (DESCRIBE)

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- 2. On a scale of 1 to 7, what is your level of stress right now?  
 Low    1    2    3    4    5    6    7    High

- 3. On a scale of 1 to 7, what is your urge to harm yourself now?  
 Low    1    2    3    4    5    6    7    High

- 4. On a scale of 1 to 7, what is your intent to kill yourself right now?  
 Low    1    2    3    4    5    6    7    High

- 5. On a scale of 1 to 7, what is your urge to use drugs or alcohol right now?  
 Low    1    2    3    4    5    6    7    High

- 6. How will you cope with any negative feelings or suicidal impulses generated by the assessment? (DESCRIBE BELOW)

---



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- 7. Do you have any fun activities planned for the rest of the day? (DESCRIBE BELOW)

---



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- 8. Is Client either suicidal (higher than 4 on Question 4) or stating that she/he is uncertain about being able to control suicidal impulses? (1=Yes, 0=No)
  - 8a. Was a Suicide Risk Assessment Worksheet completed? (Required if 8 =Yes) (1=Yes, 0=No. If no, explain): \_\_\_\_\_

*If risk is high, implement suicidal behavior strategies:*

- 9. Refer clients to their primary treatment provider (if they have one). Assist client in making contact, if necessary.
- 10. Remain with client until risk is lowered, using crisis response strategies as may seem necessary (please check which actions taken):
  - a. Referred to positive thing(s) in subject's life;
  - b. Suggested going for a walk together/getting food or coffee to help the client regulate their mood and "shake off" the stress of the assessment
  - c. Validated subject's feelings, i.e. "That was really long. I'm tired too." "Seems like it was difficult to stick with the assessment today given how you've been feeling", "What have you done with feelings like this in the past?"
  - d. Focused on what coping strategies he/she can use from mood improvement protocol and assessor suggestions;
  - e. Made sure she/he had a card with our emergency numbers;
  - f. Ask client to commit not to engage in suicidal acts
  - g. Called people in client support network
  - h. Asked people in client support network to come & pick her/him up, waited with client until they came
  - i. Accompanied client to Emergency Room;
  - j. Evaluated or arranged for evaluation for involuntary treat if danger to life is imminent and client refuses help.
  - k. Other Interventions and Notes:

---



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SUICIDE RISK ASSESSMENT WORKSHEET

- Y N 1. History of suicide attempts/self-injury.
- Y N 2. Current suicide intent.
- Y N 3. Methods available or easily available.
- Y N 4. Suicide planning and/or preparation.
- Y N 5. Precautions against discovery or intervention; deception or concealment about timing, place, etc.
- Y N 6. Current substance abuse (including alcohol or prescription medications)
- Y N 7. Isolation.
- Y N 8. Prompting events for previous suicide attempts/self-injury.
- Y N 9. Recent disruption or loss of interpersonal relationship; negative environmental changes in past month
- Y N 10. Abrupt clinical change, either negative or positive.
- Y N 11. Indifference to or dissatisfaction with therapy; elopements and early pass returns by a hospitalized patient.
- Y N 12. First four weeks after psychiatric inpatient discharge
- Y N 13. Current hopelessness, anger, or both.
- Y N 14. Depressive turmoil, severe anxiety, panic attacks, severe mood cycling.
- Y N 15. Current psychosis.
- Y N 16. Chronic physical pain.
- Y N 17. Usually or currently highly impulsive

ASSESSOR

If any client seems actively suicidal during assessments, or you either suspect or know she/he is engaging in any self-inflicted injury, or client displays considerable/significant distress, stop the assessment.

(Indicate below if you needed to stop the assessment for SELF-INFLICTED behavior or suicidal ideation and which option(s) were taken).

Stopped for:

- 11. Self-Self-inflicted injury/impulses
- 12. Suicidal ideation/behavior
- 13. Significant distress (DESCRIBE): \_\_\_\_\_
- 14. Other reasons (DESCRIBE): \_\_\_\_\_

Action(s) taken were:

- 15. Stopped the assessment without scheduling future session as client was too distressed.
- 16. Stopped the assessment and rescheduled with plan for frequent breaks now that difficulties have been detected.
- 17. Took a break and continued when client improved, taking frequent breaks now that difficulties have been detected.

**Appendix C**  
**University of Washington Risk Assessment and Management Protocol (UWRAMP)**  
*(Copyright Marsha M. Linehan, 2009. Adapted with permission)*

**University of Washington Risk Assessment and Management Protocol**

**Client Name:** \_\_\_\_\_

**Contact Date:** \_\_\_\_\_

**Therapist Name:** \_\_\_\_\_

**Today's Date:** \_\_\_\_\_

**REASON FOR IMMINENT RISK AND TREATMENT ACTION NOTE**

**1) CURRENT, SINCE LAST SESSION or HISTORY of suicidal ideation, impulses, and/or behavior or urges to self-injury or commit suicide are (check all that apply):**

- HISTORY** of suicide ideation, suicide attempt, or intentional self-injury at intake **(Check only if 1<sup>st</sup> session)**
- NEW (or first report of) suicide ideation/urges to harm**
  - Fleeting**
  - Frequent**
  - Continual**
- INCREASED** suicide ideation/urges to harm, describe: \_\_\_\_\_
- THREAT** or other behavior indicating **IMMINENT SUICIDE RISK SINCE LAST CONTACT**
- ATTEMPT/SELF-INJURY** since last contact
- CURRENT** suicide attempt/self-injury, describe: \_\_\_\_\_
- USUAL "BACKGROUND"** suicide ideation/urges to harm occurring

**2) Structured Formal Assessment<sup>1</sup> of Current Suicide Risk was \_\_\_\_\_ (CHECK ONE)**

- CONDUCTED (Must be conducted at first session)**
- NOT CONDUCTED**, because \_\_\_\_\_ **(CHECK ONE) (GO TO QUESTION 5)**
  - Clinical reasons: (check all that apply)**

- USUAL "BACKGROUND"** ideation/urges to harm not ordinarily associated with increased risk for imminent suicide or medically serious self-injury
- NO** or negligible **SUICIDE INTENT BY TIME OF CONTACT**, impulse control appears acceptable, no new risk factors
- NO** or negligible **SUICIDE INTENT BY CONTACT END**, impulse control appears acceptable, no new risk factors apparent, risk assessment done previously
- Self-injury that occurred **NOT SUICIDAL AND SUPERFICIAL/MINOR** (e.g., scratch, took three extra of medication). Determined by: \_\_\_\_\_
- Threat or suicide ideation best viewed as **ESCAPE BEHAVIOR** and treatment aims best accomplished by targeting precipitants and vulnerability factors rather than formal risk assessment
- Threat or suicide ideation best viewed as **OPERANT** behavior; formal risk assessment may reinforce suicide ideation

- PRIMARY THERAPIST** recently or soon will assess suicide risk. Not of value to have two clinicians treating the same behavior.
- REFERRED CLIENT** to other responsible clinician for evaluation. (see Q5)
- OTHER REASON:** \_\_\_\_\_

**FORGOT** or distracted by other issues, **PLAN FOR FOLLOW UP:** \_\_\_\_\_

**3) IMMINENT suicide risk factors**

Comment required if “somewhat” is selected.

Not reported/observed	No	Somewhat	Yes	Suicide Risk Factor	Comment <sup>2</sup>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	HISTORY of suicide attempts/self-injury	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	CURRENT suicide intent, including client belief that he/she is going to commit suicide or hurt self	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Preferred METHOD CURRENTLY or easily AVAILABLE	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	LETHAL MEANS (of any sort) CURRENTLY or easily available	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	CURRENT PLAN and/or preparation (including specific method and time)	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	CURRENT PRECAUTIONS against discovery; deception about timing, place, etc.	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	CURRENT SUBSTANCE USE, including ETOH and Rx meds (last 3 hours)	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Currently or will be ISOLATED or ALONE	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PROMPTING EVENTS for previous selfinjury/suicide attempt	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	RECENT LOSS, other negative event	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	ABRUPT CLINICAL CHANGE, either negative or positive	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	INDIFFERENCE/DISSATISFACTION with therapy	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	1 <sup>st</sup> night of INCARCERATION; 1 <sup>st</sup> week psychiatric INPATIENT; 1 <sup>st</sup> four weeks after psychiatric INPATIENT DISCHARGE	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Current Severe HOPELESSNESS	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Current MAJOR DEPRSSION PLUS:	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Current Severe TURMOIL, ANXIETY, PANIC attacks, mood CYCLING	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Current Severe GLOBAL INSOMNIA	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Current Severe ANHEDONIA	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Current Inability to CONCENTRATE, INDECISION	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Current PSYCHOSIS, voices telling client to commit suicide	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	CHRONIC PHYSICAL pain	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	USUALLY OR CURRENTLY HIGHLY IMPULSIVE	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Client MOTIVATED TO UNDER-REPORT/LIE about risk Comment REQUIRED if NO.	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	OTHER:	

**4) IMMINENT suicide protective factors**

Not reported/observed	No	Yes	Protective Factor	Comment:
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	HOPE for the future	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SELF-EFFICACY in problem area	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	ATTACHMENT to life	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	RESPONSIBILITY to children, family or others, including pets, who client would not abandon	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	ATTACHED to therapy and at least one provider	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PROVIDER attached, will stay in contact	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Embedded in PROTECTIVE SOCIAL NETWORK or family	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	FEAR of act of suicide, death and dying or no acceptable method available	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Fear of SOCIAL DISAPPROVAL for suicide	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Belief that suicide is IMMORAL or that it will be punished; HIGH spirituality	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	COMMITMENT to live and history of taking commitments seriously or reason to trust the commitment	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Client WILLING TO FOLLOW CRISIS PLAN	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Belief that suicide is IMMORAL or that it will be punished; HIGH spirituality	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Client MOTIVATED TO OVER-REPORT risk Comment REQUIRED if YES	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Other:	

### 5) Treatment actions aimed at suicidal/self-injurious behaviors

- A.  Suicide ideation and behavior NOT EXPLICITLY TARGETED in session (Check reasons)
- Client is **NOT IMMINENTLY DANGEROUS** (see Q6 for documentation)
  - Same reasons as for not conducting structured formal suicide risk assessment (Q2 above)
  - Risk Assessment of suicide history was sufficiently therapeutic
  - Other: \_\_\_\_\_
- B.  Did COMPREHENSIVE ANALYSIS of previous suicidal ideation and behaviors
- C.  Did ANALYSIS of chain of events leading to and consequences of current suicidal ideation and behaviors
- D.  Focused on CRISIS INTERVENTION and/or PROBLEM SOLVING (Check those used)
- VALIDATED current emotions and wish to escape or die (emotional support)
  - Worked to remove, remediate PROMPTING EVENTS: \_\_\_\_\_
  - Gave advice and instructed in use of COPING SKILLS to reduce suicidality
  - Generated HOPE and reasons for living:
  - Gave advice and instructed in use of COPING SKILLS to reduce suicidality
  - Other: \_\_\_\_\_
- E.  Developed or reviewed existing CRISIS PLAN (Check also in Q6)
- F.  Committed to a PLAN OR ACTION
- Client made credible AGREEMENT for crisis plan and no self-injury or attempts until \_\_\_\_\_
  - Client agreed TO REMOVE LETHAL implements (drugs, knife) \_\_\_\_\_
- G.  Did TROUBLESHOOTING of factors that might interfere with effective action:
- H.  Increased SOCIAL SUPPORT
- Planned for client to contact SOCIAL SUPPORT:
  - ALERTED NETWORK to risk (describe):
  - Planned for a FOLLOW-UP CALL for:
- I.  REFERRED:
- To Primary Therapist: \_\_\_\_\_
  - To Clinician-On-Call at \_\_\_\_\_
  - To Crisis Line \_\_\_\_\_
  - For medication evaluation at \_\_\_\_\_
  - Other: \_\_\_\_\_
- J.  HOSPITALIZATION CONSIDERED; did not recommend because (check all that apply):
- Client is **NOT IMMINENTLY DANGEROUS** (see Q6 for documentation)
  - Other environmental support available
  - Client can easily contact me if condition worsens
  - Client previously hospitalized, benefit not apparent
  - No bed available
  - Client refused
  - Client refused even with persistent argument by me in favor
  - Client does not meet criteria for involuntary commitment
- And/or it would (check all that apply)
- Increase stigma and isolation which are important issues for this client
  - Interfere with work of school which are important for this client
  - Cause undue financial burden which is an important issue for this client
- K.  Other: \_\_\_\_\_

**6) I believe, based on information currently available to me (Check all that apply)**

A.  Client is **NOT IMMINENTLY DANGEROUS** to self and will be safe from serious self-injury or suicide until next contact with me or with primary therapist for the following reasons: (Check all that apply)

- Problems that contribute to suicide risk are being resolved
- Suicide ideation and/or intent reduced by end of contact
- Credible agreement for crisis plan and no self-injury or suicide
- Adequate crisis plan in place
- Suicidality being actively addressed by primary therapist
- Protective factors outweigh risk factors
- Other: \_\_\_\_\_

B.  There is some **IMMINENT DANGER** of serious self-injury or suicide (See Q5). However, emergency interventions likely to exacerbate rather than resolve long-term risk.

C.  Emergency intervention is needed to prevent **IMMINENT DANGER** of medically serious self-injury or suicide (Check all that apply)

- Took to ER at \_\_\_\_\_
- Arranged for outreach evaluation for INVOLUNTARY COMMITMENT (Describe): \_\_\_\_\_
- Arranged for a WELLNESS CHECK \_\_\_\_\_
- CALLED 911 for medical aid \_\_\_\_\_
- HOSPITALIZATION ARRANGED (describe): \_\_\_\_\_

Comments on emergency intervention: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

D.  Significant **UNCERTAINTY EXISTS** as to imminent risk. I **will get** a second opinion from<sup>3</sup>:

- SUPERVISOR: \_\_\_\_\_
- CRISIS CLINIC SUPERVISOR: \_\_\_\_\_
- TEAM MEMBER or COLLEAGUE: \_\_\_\_\_
- MEDICAL EXPERT: \_\_\_\_\_
- PRIMARY THERAPIST: \_\_\_\_\_
- Other: \_\_\_\_\_

I **have received** a second opinion from:

- SUPERVISOR: \_\_\_\_\_
- CRISIS CLINIC SUPERVISOR: \_\_\_\_\_
- TEAM MEMBER or COLLEAGUE: \_\_\_\_\_
- MEDICAL EXPERT: \_\_\_\_\_
- PRIMARY THERAPIST: \_\_\_\_\_
- Other: \_\_\_\_\_

**7) Client will be REEVALUATED for suicide risk no later than**

- 12 hrs. How? \_\_\_\_\_
- 24 hrs. How? \_\_\_\_\_
- 48-72 hrs. How? \_\_\_\_\_
- Next individual session
- Next group session
- Next pharmacotherapy session
- Other: \_\_\_\_\_

<sup>1</sup> A structural formal assessment involves asking the client about every item, rather than relying on previous knowledge of the individual.

<sup>2</sup> The comment field expands to allow for explanatin in the electronic version.

<sup>3</sup> In the event that the provider has not consulted a second opinion at the time when this section of documentation is completed, he or she can come back and update this item under "I have received a second opinion."

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