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Psychiatry and Addictions Case Conference
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SUICIDE RISK ASSESSMENT AND DOCUMENTATION

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UW Medicine
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Integrated Care Training Program
UW Psychiatry & Behavioral Sciences

project ECHO

SPEAKER DISCLOSURES

Nothing to disclose

Planner disclosures

The following series planners have no relevant conflicts of interest to disclose; other disclosures have been mitigated.

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OBJECTIVES

1. Distinguish categories of risk and protective factors for suicide.
2. Identify categories of intervention for management of suicide risk.
3. Describe components of suicide risk assessment and management documentation.

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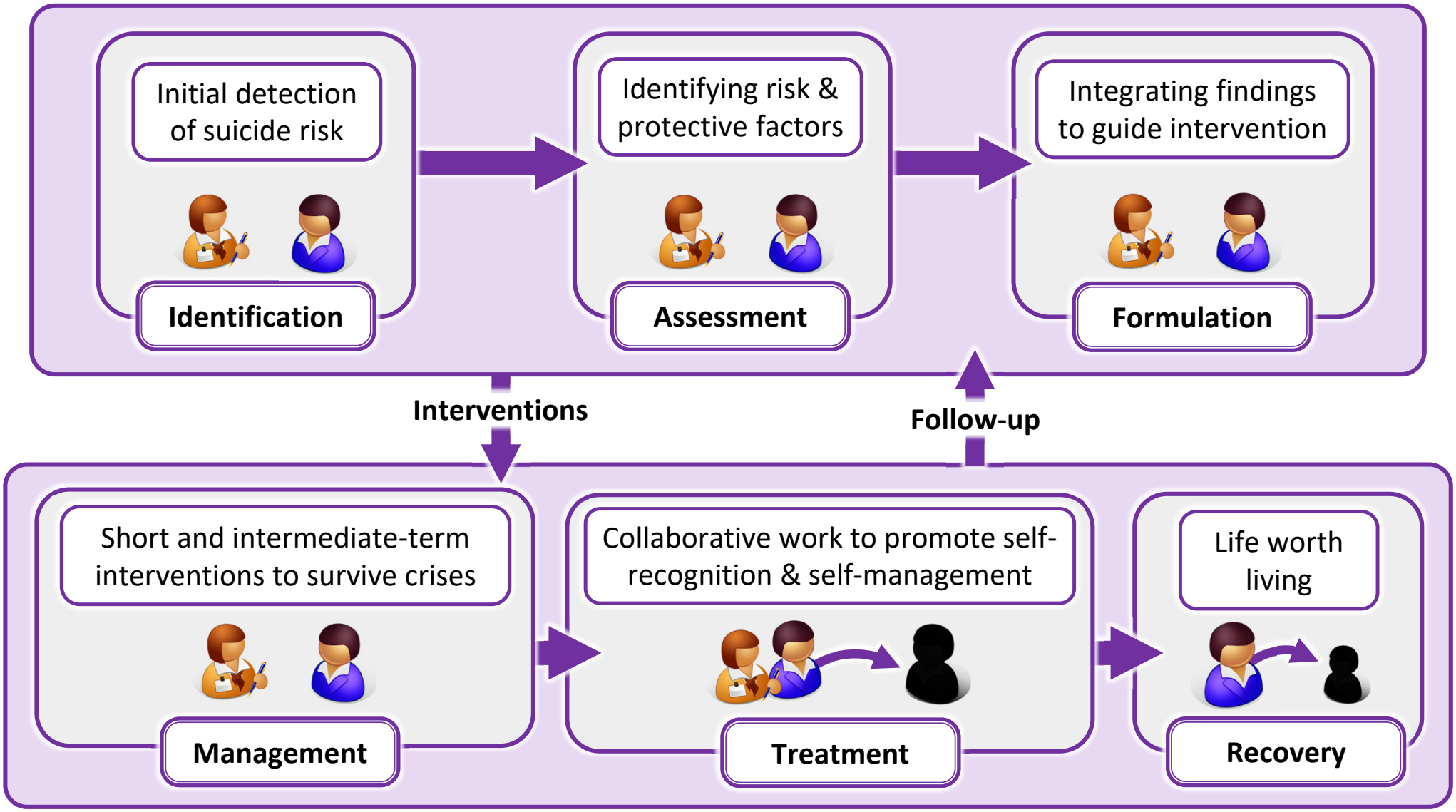
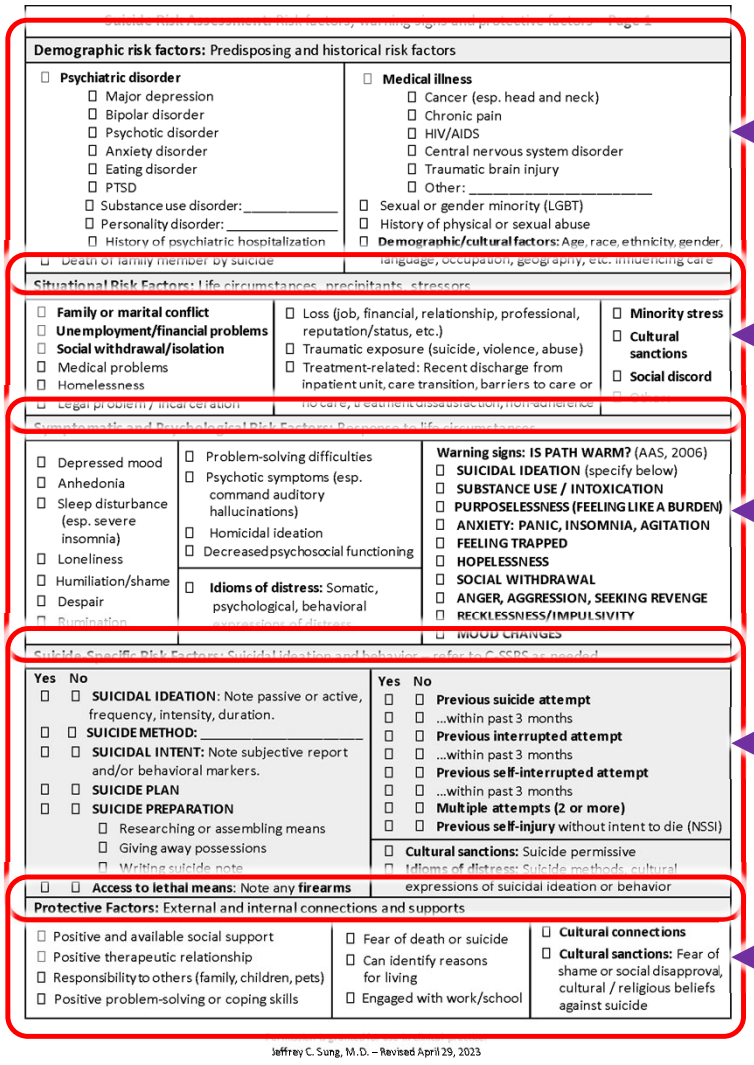

Initial detection of suicide risk
Identifying risk & protective factors
Integrating findings to guide intervention
Identification
Assessment
Formulation
Interventions
Follow-up
Short and intermediate-term interventions to survive crises
Collaborative work to promote self-recognition & self-management
Life worth living
Management
Treatment
Recovery

Assessment



Demographic risk factors: Predisposing and historical risk factors

- ☐ **Psychiatric disorder**
  - ☐ Major depression
  - ☐ Bipolar disorder
  - ☐ Psychotic disorder
  - ☐ Anxiety disorder
  - ☐ Eating disorder
  - ☐ PTSD
  - ☐ Substance use disorder: _____
  - ☐ Personality disorder: _____
  - ☐ History of psychiatric hospitalization
- ☐ **Medical illness**
  - ☐ Cancer (esp. head and neck)
  - ☐ Chronic pain
  - ☐ HIV/AIDS
  - ☐ Central nervous system disorder
  - ☐ Traumatic brain injury
  - ☐ Other: _____
- ☐ Sexual or gender minority (LGBT)
- ☐ History of physical or sexual abuse
- ☐ **Demographic/cultural factors:** Age, race, ethnicity, gender, language, occupation, geography, etc. influencing care
- ☐ Death of family member by suicide

Situational Risk Factors: Life circumstances, precipitants, stressors

- ☐ **Family or marital conflict**
- ☐ **Unemployment/financial problems**
- ☐ **Social withdrawal/isolation**
- ☐ Medical problems
- ☐ Homelessness
- ☐ Legal problem / incarceration
- ☐ Loss (job, financial, relationship, professional, reputation/status, etc.)
- ☐ Traumatic exposure (suicide, violence, abuse)
- ☐ Treatment-related: Recent discharge from inpatient unit, care transition, barriers to care or no care, treatment dissatisfaction, non-adherence
- ☐ **Minority stress**
- ☐ **Cultural sanctions**
- ☐ **Social discord**
- ☐ Other

Symptomatic and Psychological Risk Factors: Response to life circumstances

- ☐ Depressed mood
- ☐ Anhedonia
- ☐ Sleep disturbance (esp. severe insomnia)
- ☐ Loneliness
- ☐ Humiliation/shame
- ☐ Despair
- ☐ Rumination
- ☐ Problem-solving difficulties
- ☐ Psychotic symptoms (esp. command auditory hallucinations)
- ☐ Homicidal ideation
- ☐ Decreased psychosocial functioning
- ☐ **Idioms of distress:** Somatic, psychological, behavioral expressions of distress

Warning signs: IS PATH WARM? (AAS, 2006)

- ☐ **SUICIDAL IDEATION** (specify below)
- ☐ **SUBSTANCE USE / INTOXICATION**
- ☐ **PURPOSELESSNESS (FEELING LIKE A BURDEN)**
- ☐ **ANXIETY: PANIC, INSOMNIA, AGITATION**
- ☐ **FEELING TRAPPED**
- ☐ **HOPELESSNESS**
- ☐ **SOCIAL WITHDRAWAL**
- ☐ **ANGER, AGGRESSION, SEEKING REVENGE**
- ☐ **RECKLESSNESS/IMPULSIVITY**
- ☐ **MOOD CHANGES**

Suicide-Specific Risk Factors: Suicidal ideation and behavior – refer to C-SSRS as needed

Yes	No	
☐	☐	**SUICIDAL IDEATION**: Note passive or active, frequency, intensity, duration.
☐	☐	**SUICIDE METHOD:** _____
☐	☐	**SUICIDAL INTENT:** Note subjective report and/or behavioral markers.
☐	☐	**SUICIDE PLAN**
☐	☐	**SUICIDE PREPARATION**
	☐	Researching or assembling means
	☐	Giving away possessions
	☐	Writing suicide note
☐	☐	**Access to lethal means**: Note any **firearms**

Yes	No	
☐	☐	**Previous suicide attempt**
☐	☐	...within past 3 months
☐	☐	**Previous interrupted attempt**
☐	☐	...within past 3 months
☐	☐	**Previous self-interrupted attempt**
☐	☐	...within past 3 months
☐	☐	**Multiple attempts (2 or more)**
☐	☐	**Previous self-injury** without intent to die (NSSI)

- ☐ **Cultural sanctions:** Suicide permissive
- ☐ **Idioms of distress:** Suicide methods, cultural expressions of suicidal ideation or behavior

Protective Factors: External and internal connections and supports

- ☐ Positive and available social support
- ☐ Positive therapeutic relationship
- ☐ Responsibility to others (family, children, pets)
- ☐ Positive problem-solving or coping skills
- ☐ Fear of death or suicide
- ☐ Can identify reasons for living
- ☐ Engaged with work/school
- ☐ **Cultural connections**
- ☐ **Cultural sanctions:** Fear of shame or social disapproval, cultural / religious beliefs against suicide

Jeffrey C. Sung, M.D. – Revised April 29, 2023

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Demographic: Broad categories of people

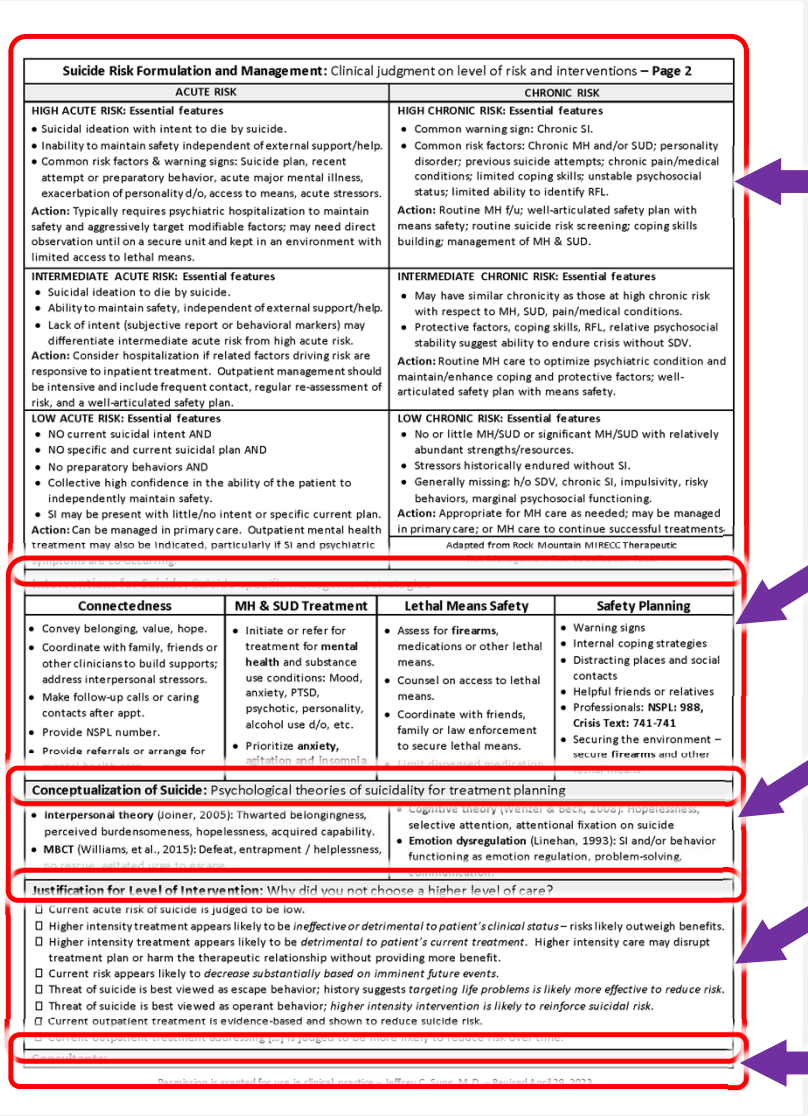
Situational: Stressful life circumstances

Symptomatic: Negative emotional and behavioral responses

Suicide-specific: Suicidal ideation and behavior arising out of life stress and symptomatic responses

Protective factors: Internal and external connections and supports

Formulation & Management



Suicide Risk Formulation and Management: Clinical judgment on level of risk and interventions – **Page 2**

ACUTE RISK	CHRONIC RISK
HIGH ACUTE RISK: Essential features • Suicidal ideation with intent to die by suicide. • Inability to maintain safety independent of external support/help. • Common risk factors & warning signs: Suicide plan, recent attempt or preparatory behavior, acute major mental illness, exacerbation of personality d/o, access to means, acute stressors. **Action:** Typically requires psychiatric hospitalization to maintain safety and aggressively target modifiable factors; may need direct observation until on a secure unit and kept in an environment with limited access to lethal means.	**HIGH CHRONIC RISK: Essential features** • Common warning sign: Chronic SI. • Common risk factors: Chronic MH and/or SUD; personality disorder; previous suicide attempts; chronic pain/medical conditions; limited coping skills; unstable psychosocial status; limited ability to identify RFL. **Action:** Routine MH f/u; well-articulated safety plan with means safety; routine suicide risk screening; coping skills building; management of MH & SUD.
INTERMEDIATE ACUTE RISK: Essential features • Suicidal ideation to die by suicide. • Ability to maintain safety, independent of external support/help. • Lack of intent (subjective report or behavioral markers) may differentiate intermediate acute risk from high acute risk. **Action:** Consider hospitalization if related factors driving risk are responsive to inpatient treatment. Outpatient management should be intensive and include frequent contact, regular re-assessment of risk, and a well-articulated safety plan.	**INTERMEDIATE CHRONIC RISK: Essential features** • May have similar chronicity as those at high chronic risk with respect to MH, SUD, pain/medical conditions. • Protective factors, coping skills, RFL, relative psychosocial stability suggest ability to endure crisis without SDV. **Action:** Routine MH care to optimize psychiatric condition and maintain/enhance coping and protective factors; well-articulated safety plan with means safety.
LOW ACUTE RISK: Essential features • NO current suicidal intent AND • NO specific and current suicidal plan AND • No preparatory behaviors AND • Collective high confidence in the ability of the patient to independently maintain safety. • SI may be present with little/no intent or specific current plan. **Action:** Can be managed in primary care. Outpatient mental health treatment may also be indicated, particularly if SI and psychiatric	**LOW CHRONIC RISK: Essential features** • No or little MH/SUD or significant MH/SUD with relatively abundant strengths/resources. • Stressors historically endured without SI. • Generally missing: h/o SDV, chronic SI, impulsivity, risky behaviors, marginal psychosocial functioning. **Action:** Appropriate for MH care as needed; may be managed in primary care; or MH care to continue successful treatments.

Adapted from Rock Mountain MIRECC Therapeutic

Connectedness	MH & SUD Treatment	Lethal Means Safety	Safety Planning
• Convey belonging, value, hope. • Coordinate with family, friends or other clinicians to build supports; address interpersonal stressors. • Make follow-up calls or caring contacts after appt. • Provide NSPL number. • Provide referrals or arrange for	• Initiate or refer for treatment for **mental health** and substance use conditions: Mood, anxiety, PTSD, psychotic, personality, alcohol use d/o, etc. • Prioritize **anxiety,**	• Assess for **firearms**, medications or other lethal means. • Counsel on access to lethal means. • Coordinate with friends, family or law enforcement to secure lethal means.	• Warning signs • Internal coping strategies • Distracting places and social contacts • Helpful friends or relatives • Professionals: **NSPL: 988, Crisis Text: 741-741** • Securing the environment – secure **firearms** and other

Conceptualization of Suicide: Psychological theories of suicidality for treatment planning

• **Interpersonal theory** (Joiner, 2005): Thwarted belongingness, perceived burdensomeness, hopelessness, acquired capability. • **MBCT** (Williams, et al., 2015): Defeat, entrapment / helplessness,	• **Emotion dysregulation** (Linehan, 1993): SI and/or behavior functioning as emotion regulation, problem-solving,

Justification for Level of Intervention: Why did you not choose a higher level of care?

- ☐ Current acute risk of suicide is judged to be low.
- ☐ Higher intensity treatment appears likely to be *ineffective or detrimental to patient's clinical status* – risks likely outweigh benefits.
- ☐ Higher intensity treatment appears likely to be *detrimental to patient's current treatment.* Higher intensity care may disrupt treatment plan or harm the therapeutic relationship without providing more benefit.
- ☐ Current risk appears likely to *decrease substantially based on imminent future events.*
- ☐ Threat of suicide is best viewed as escape behavior; history suggests *targeting life problems is likely more effective to reduce risk.*
- ☐ Threat of suicide is best viewed as operant behavior; *higher intensity intervention is likely to reinforce suicidal risk.*
- ☐ Current outpatient treatment is evidence-based and shown to reduce suicide risk.

Formulation: Rocky Mountain MIRECC Risk Stratification Table

- Temporality: Acute, chronic
- Severity: Low, intermediate, high

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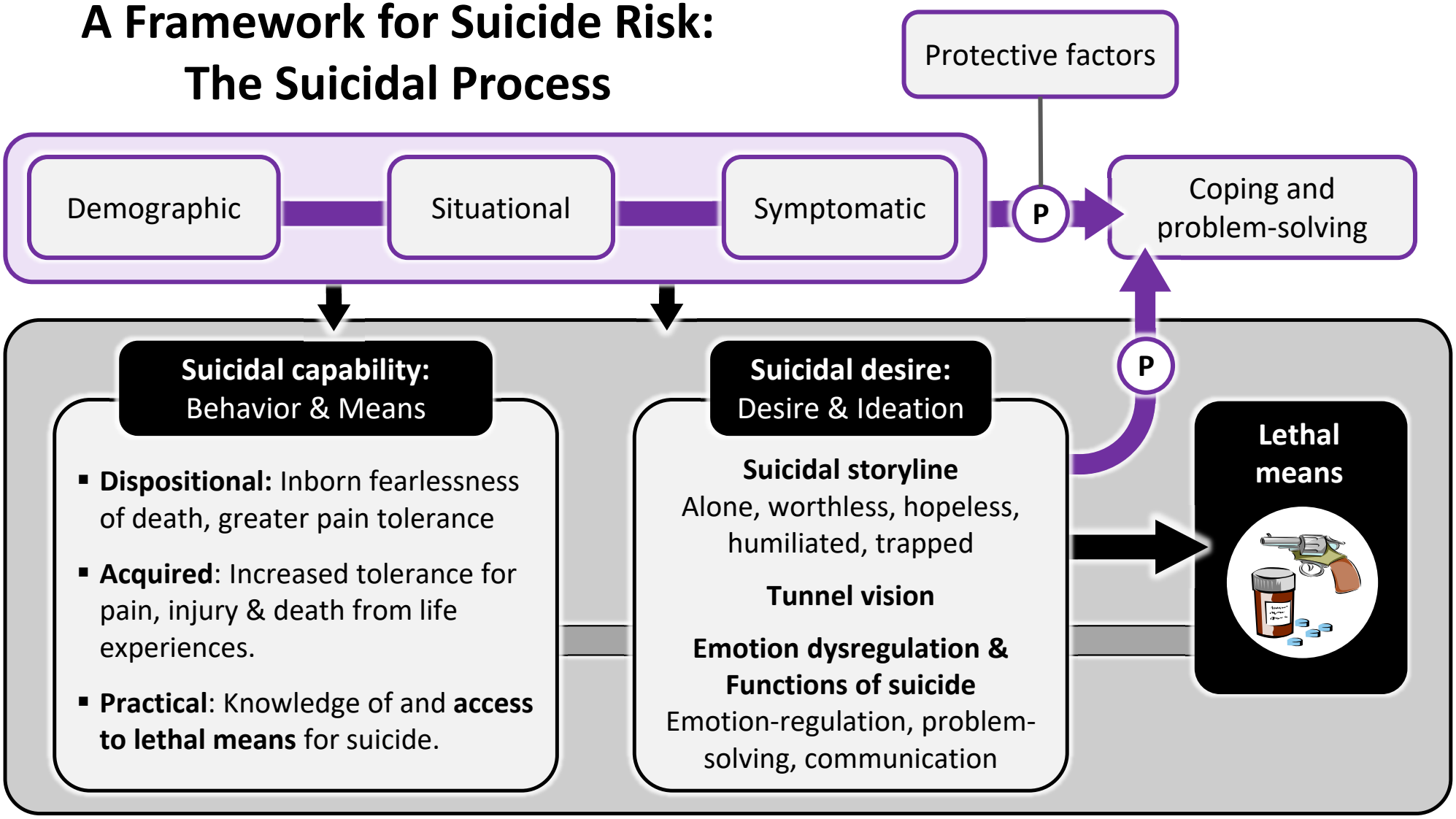
Interventions: Four categories of intervention for management of suicide risk

Conceptualization of suicide: Psychological theories to guide treatment of suicide risk.

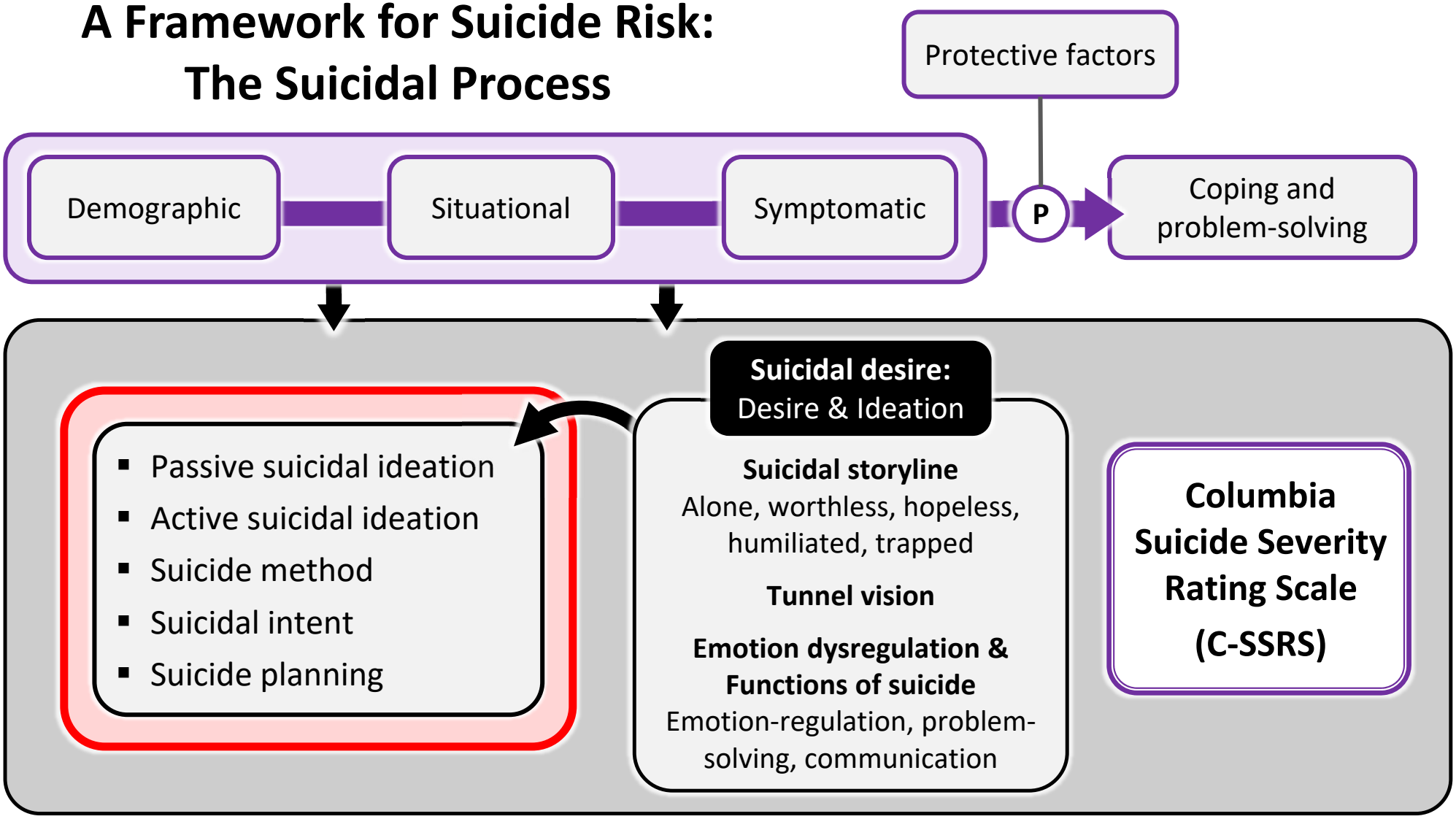
Justification for level of intervention: Rationale to support the level of care

Consultants: Others who provided input on the treatment plan

A Framework for Suicide Risk: The Suicidal Process



A Framework for Suicide Risk: The Suicidal Process



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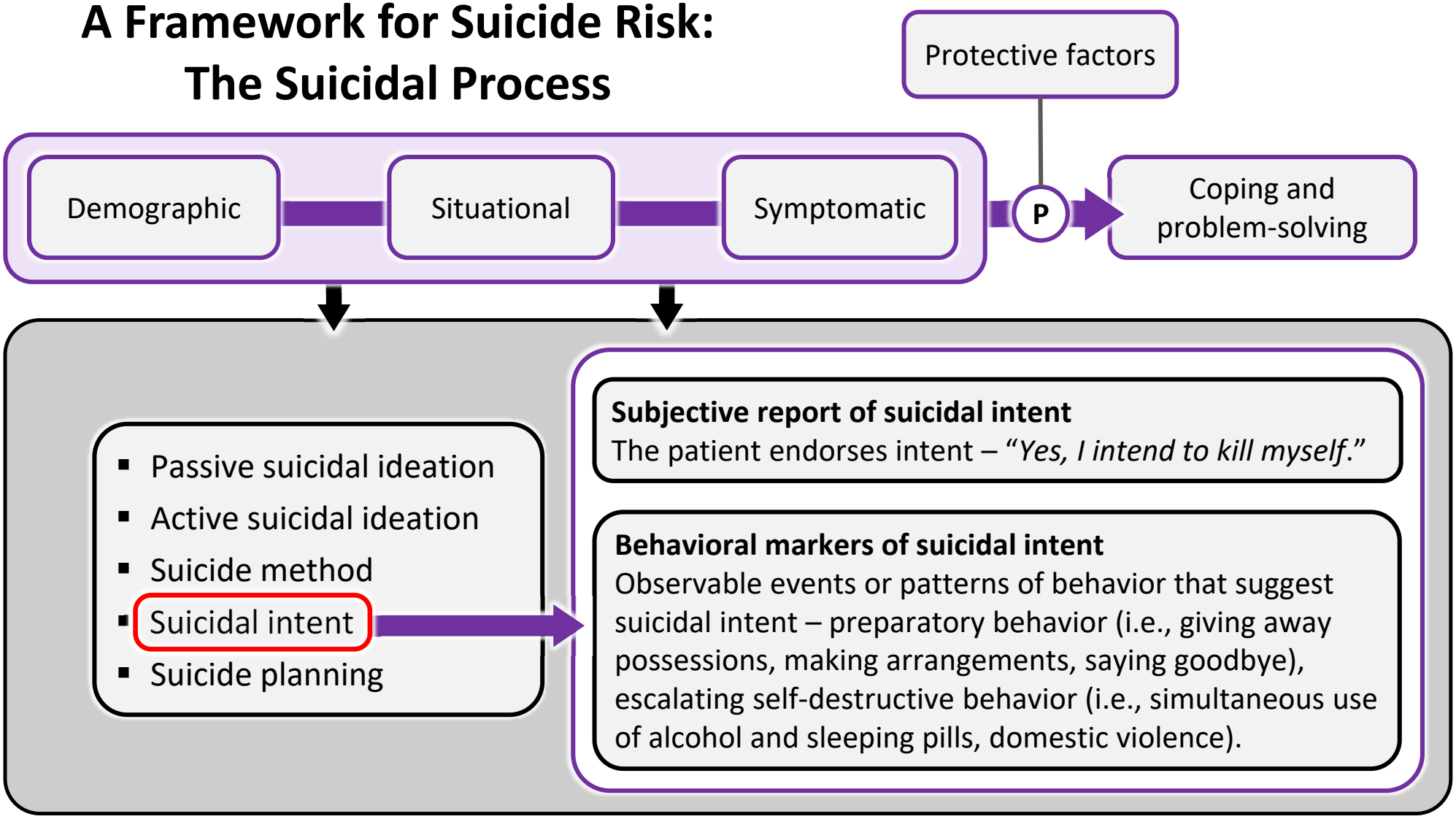

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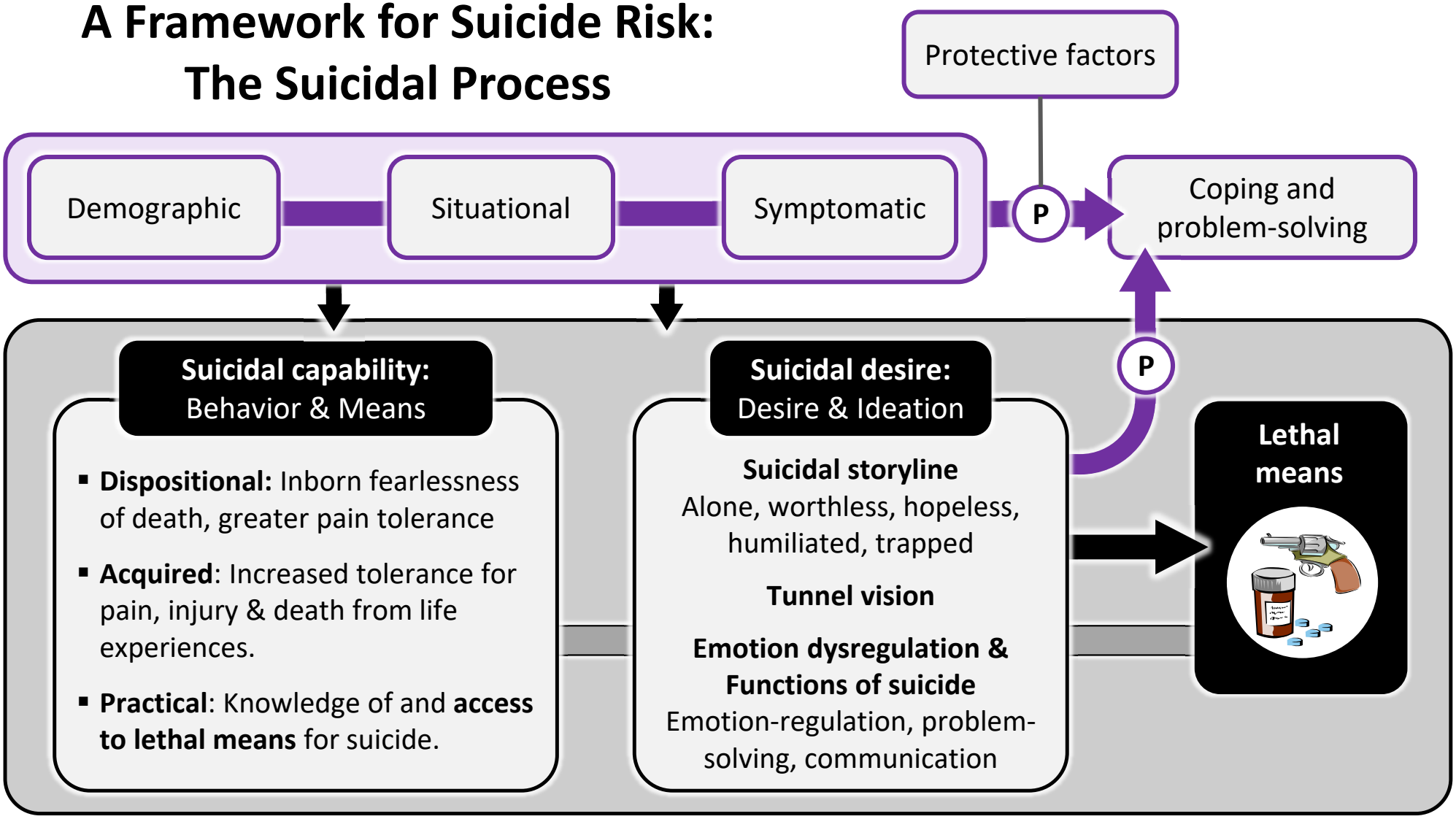


A Framework for Suicide Risk: The Suicidal Process

Protective factors

Demographic

Situational

Symptomatic

P

Coping and problem-solving

Suicidal capability:
Behavior & Means

- **Dispositional:** Inborn fearlessness of death, greater pain tolerance
- **Acquired**: Increased tolerance for pain, injury & death from life experiences.
- **Practical**: Knowledge of and **access to lethal means** for suicide.

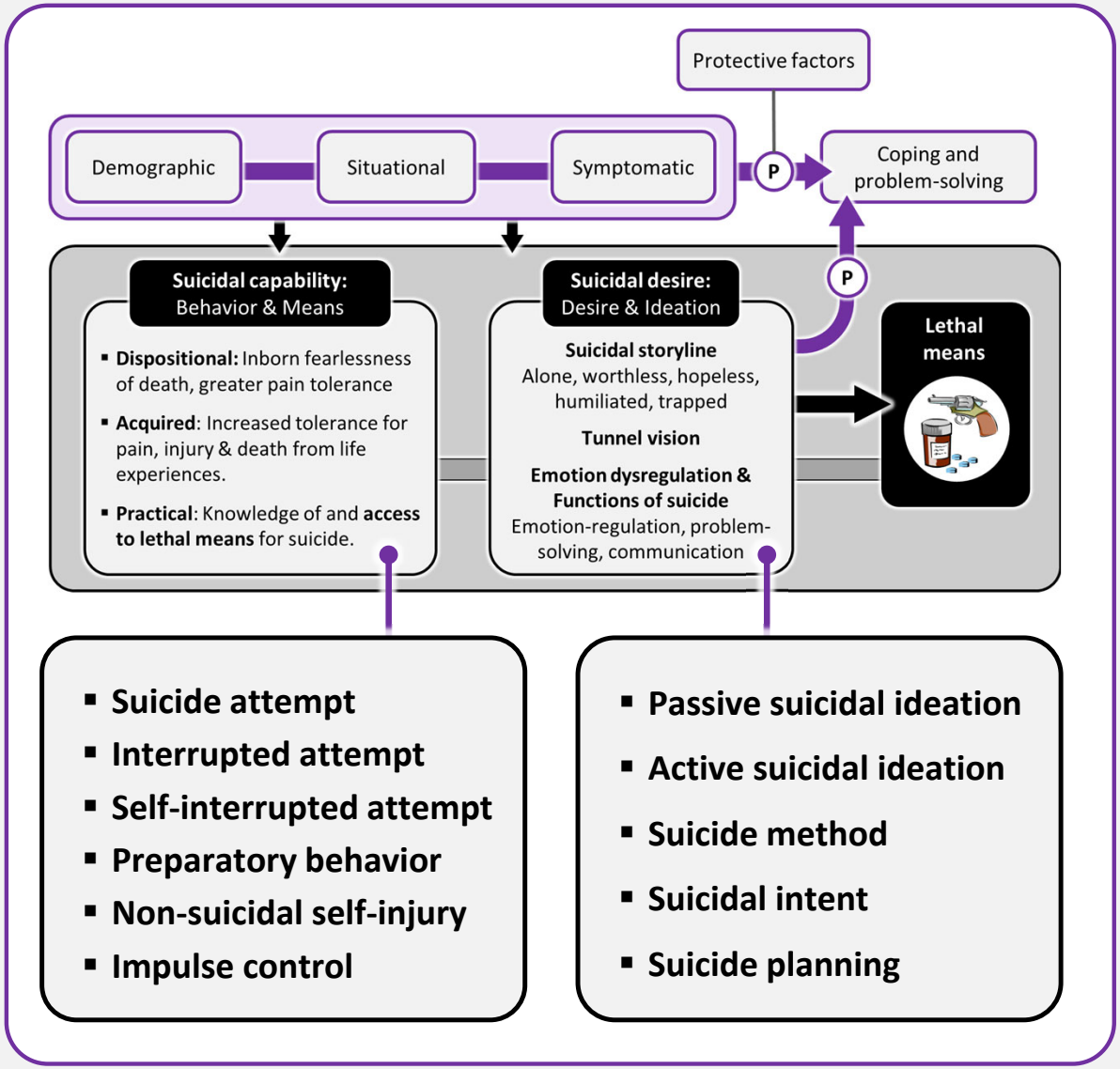
- Suicide attempt
- Interrupted attempt
- Self-interrupted attempt
- Preparatory behavior
- Non-suicidal self-injury
- Impulse control

Lethal means

Suicide Risk Assessment

- Demographic
- Situational
- Symptomatic
- Suicide-specific
- Protective factors

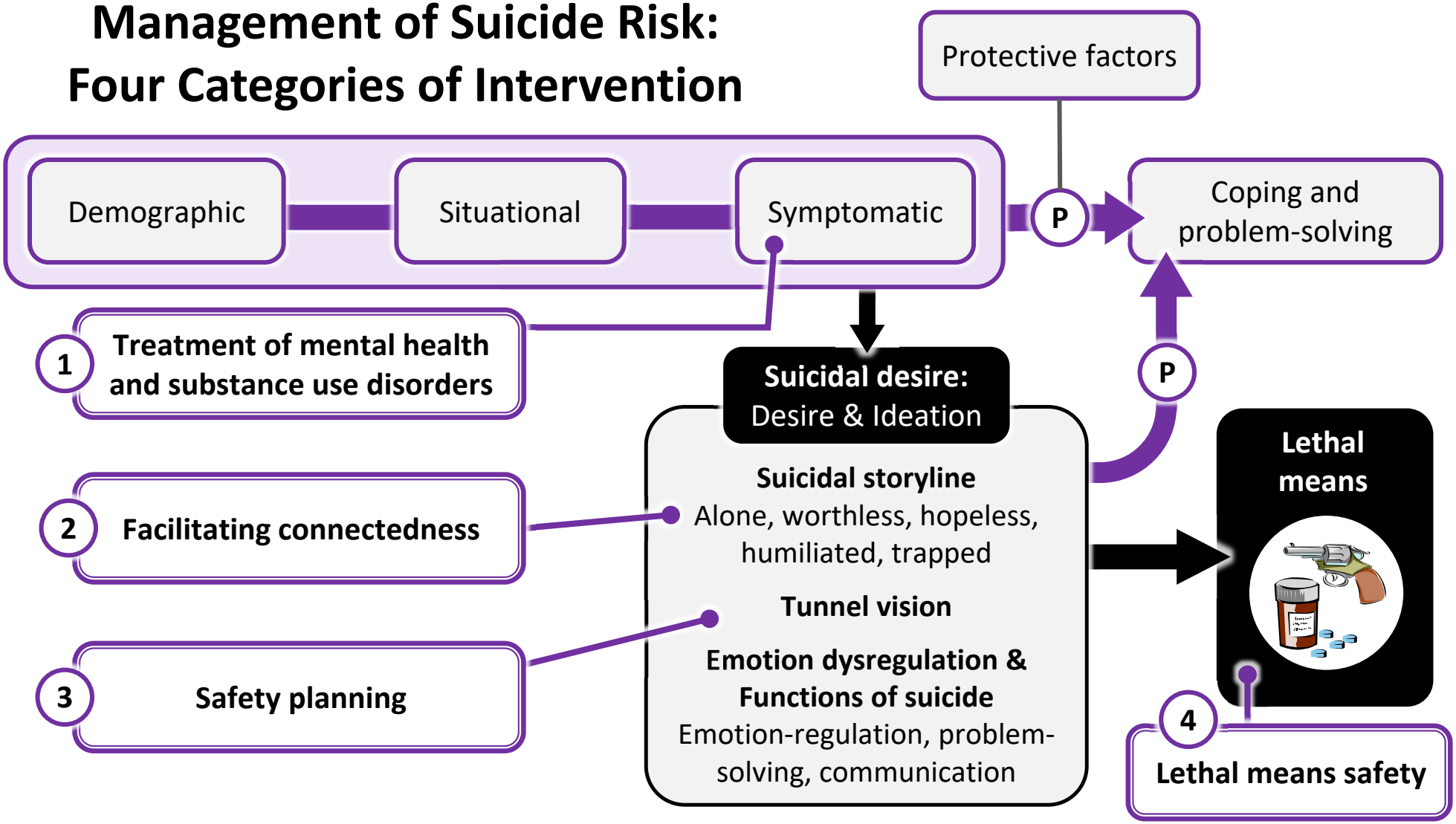
Narrative interview
Supplement with C-SSRS



ACUTE Risk for Suicide	
HIGH ACUTE RISK	
• Suicidal ideation with intent to die by suicide • Inability to maintain safety independent external support/help	Typically requires psychiatric hospitalization to maintain safety and target modifiable factors
INTERMEDIATE ACUTE RISK	
• Suicidal ideation to die by suicide (lack of intent) • Ability to maintain safety, independent of external support/help	• Consider hospitalization • Intensive OP with frequent contact, re-assessment of risk, well-articulated safety plan
LOW ACUTE RISK	
All of the following: • No current suicidal intent • No specific & current plan • No preparatory behavior • Collective high confidence in the ability to independently maintain safety	Can be managed in primary care OP MH treatment if SI and psychiatric conditions are co-occurring

CHRONIC Risk for Suicide	
HIGH CHRONIC RISK	
Common warning sign: Chronic SI **Common risk factors:** Chronic SMI, PD, SUD, previous suicide attempts, medical illness or pain, limited coping skills, unstable psychosocial status, limited reasons for living	Chronic risk of becoming acutely suicidal Typically requires • Routine MH f/u • Safety plan • Means safety • Risk screening • Coping skills
INTERMEDIATE CHRONIC RISK	
Similar to high chronic risk WITH protective factors, coping skills, psychosocial stability	Typically requires • Routine MH f/u • Safety plan with means safety
LOW CHRONIC RISK	
Little in the way of MH or SUD – or MH and SUD problems with abundant strengths/resources	Mental health care on an as-needed basis, potentially in primary care

Management of Suicide Risk: Four Categories of Intervention



Management: Short and intermediate-term interventions intended to survive crisis and keep the patient alive

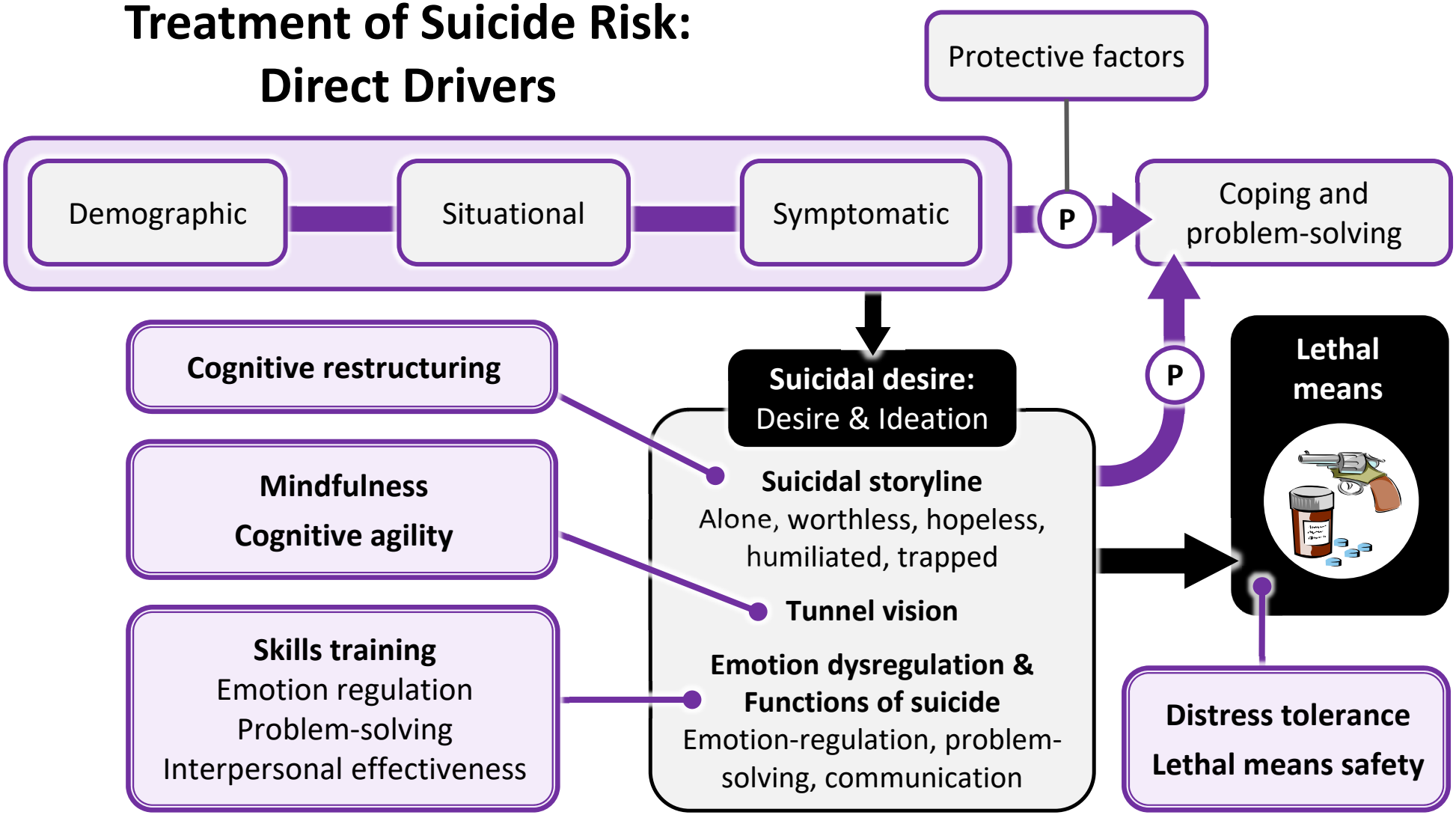
Connectedness **Safety planning**
MH & SUD **Lethal means safety**

Treatment: Longer-term interventions addressing emotional and psychological issues directly linked to suicidality

Consultative and collaborative stance

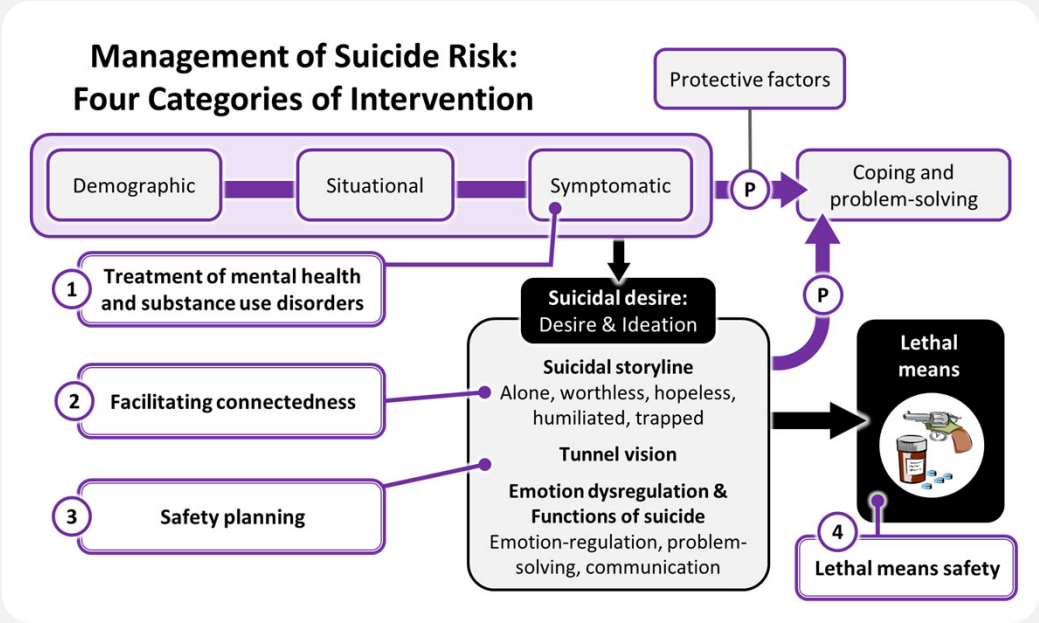
Self-recognition & self-management of suicide risk while building a life worth living

Treatment of Suicide Risk: Direct Drivers



VHA: Make the Connection

Dealing with feelings of hopelessness in therapy



Connectedness	MH & SUD	Lethal Means Safety	Safety Planning
…took me over to the mental health counselor *…every week or two I'd meet with the counselor* *…they listened…made you feel better*	*…started me on some medication* *…Army psychiatrist* *…through private practice*	*…took away my weapon* *…took my bolt away for a while – like a week*	*…if I felt like hurting myself, did I tell anybody* *…I called the crisis hotline*

OBJECTIVES

1. **Distinguish categories of risk and protective factors for suicide.**
   - Demographic
   - Situational
   - Symptomatic
   - Suicide-specific
   - Protective factors
2. **Identify categories of intervention for management of suicide risk.**
   - Facilitating connectedness
   - Addressing mental health and substance use disorders / issues
   - Safety planning
   - Lethal means safety
3. **Describe components of suicide risk assessment and management documentation.**
   - Risk and protective factors
   - Overall risk – acute and chronic
   - Management strategies
   - Treatment strategies
   - Justification for level of intervention
   - Consultants

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Suicide Risk Assessment: Risk factors, warning signs and protective factors **– Page 1**

Demographic risk factors: Predisposing and historical risk factors

- ☐ **Psychiatric disorder**
  - ☐ Major depression
  - ☐ Bipolar disorder
  - ☐ Psychotic disorder
  - ☐ Anxiety disorder
  - ☐ Eating disorder
  - ☐ PTSD
  - ☐ Substance use disorder: _____
  - ☐ Personality disorder: _____
  - ☐ History of psychiatric hospitalization
- ☐ Death of family member by suicide
- ☐ **Medical illness**
  - ☐ Cancer (esp. head and neck)
  - ☐ Chronic pain
  - ☐ HIV/AIDS
  - ☐ Central nervous system disorder
  - ☐ Traumatic brain injury
  - ☐ Other: _____
- ☐ Sexual or gender minority (LGBT)
- ☐ History of physical or sexual abuse
- ☐ **Demographic/cultural factors:** Age, race, ethnicity, gender, language, occupation, geography, etc. influencing care

Situational Risk Factors: Life circumstances, precipitants, stressors

- ☐ **Family or marital conflict**
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- ☐ Medical problems
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- ☐ Legal problem / incarceration
- ☐ Loss (job, financial, relationship, professional, reputation/status, etc.)
- ☐ Traumatic exposure (suicide, violence, abuse)
- ☐ Treatment-related: Recent discharge from inpatient unit, care transition, barriers to care or no care, treatment dissatisfaction, non-adherence
- ☐ **Minority stress**
- ☐ **Cultural sanctions**
- ☐ **Social discord**
- ☐ Other:

Symptomatic and Psychological Risk Factors: Response to life circumstances

- ☐ Depressed mood
- ☐ Anhedonia
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- ☐ Loneliness
- ☐ Humiliation/shame
- ☐ Despair
- ☐ Rumination
- ☐ Problem-solving difficulties
- ☐ Psychotic symptoms (esp. command auditory hallucinations)
- ☐ Homicidal ideation
- ☐ Decreased psychosocial functioning
- ☐ **Idioms of distress:** Somatic, psychological, behavioral expressions of distress

Warning signs: IS PATH WARM? (AAS, 2006)

- ☐ **SUICIDAL IDEATION** (specify below)
- ☐ **SUBSTANCE USE / INTOXICATION**
- ☐ **PURPOSELESSNESS (FEELING LIKE A BURDEN)**
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Suicide-Specific Risk Factors: Suicidal ideation and behavior – refer to C-SSRS as needed

Yes	No	
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☐	☐	**SUICIDE METHOD:** _____
☐	☐	**SUICIDAL INTENT:** Note subjective report and/or behavioral markers.
☐	☐	**SUICIDE PLAN**
☐	☐	**SUICIDE PREPARATION**
		☐ Researching or assembling means
		☐ Giving away possessions
		☐ Writing suicide note
☐	☐	**Access to lethal means**: Note any **firearms**

Yes	No	
☐	☐	**Previous suicide attempt**
☐	☐	…within past 3 months
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☐	☐	**Previous self-interrupted attempt**
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☐	☐	**Previous self-injury** without intent to die (NSSI)

- ☐ **Cultural sanctions:** Suicide permissive
- ☐ **Idioms of distress:** Suicide methods, cultural expressions of suicidal ideation or behavior

Protective Factors: External and internal connections and supports

- ☐ Positive and available social support
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- ☐ Can identify reasons for living
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- ☐ **Cultural sanctions:** Fear of shame or social disapproval, cultural / religious beliefs against suicide

Suicide Risk Formulation and Management: Clinical judgment on level of risk and interventions – **Page 2**

ACUTE RISK	CHRONIC RISK
HIGH ACUTE RISK: Essential features • Suicidal ideation with intent to die by suicide. • Inability to maintain safety independent of external support/help. • Common risk factors & warning signs: Suicide plan, recent attempt or preparatory behavior, acute major mental illness, exacerbation of personality d/o, access to means, acute stressors. **Action:** Typically requires psychiatric hospitalization to maintain safety and aggressively target modifiable factors; may need direct observation until on a secure unit and kept in an environment with limited access to lethal means.	**HIGH CHRONIC RISK: Essential features** • Common warning sign: Chronic SI. • Common risk factors: Chronic MH and/or SUD; personality disorder; previous suicide attempts; chronic pain/medical conditions; limited coping skills; unstable psychosocial status; limited ability to identify RFL. **Action:** Routine MH f/u; well-articulated safety plan with means safety; routine suicide risk screening; coping skills building; management of MH & SUD.
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Interventions for Suicide: Suicide-specific management strategies

Connectedness	MH & SUD Treatment	Lethal Means Safety	Safety Planning
• Convey belonging, value, hope. • Coordinate with family, friends or other clinicians to build supports; address interpersonal stressors. • Make follow-up calls or caring contacts after appt. • Provide NSPL number. • Provide referrals or arrange for mental health care.	• Initiate or refer for treatment for **mental health** and substance use conditions: Mood, anxiety, PTSD, psychotic, personality, alcohol use d/o, etc. • Prioritize **anxiety, agitation and insomnia**.	• Assess for **firearms**, medications or other lethal means. • Counsel on access to lethal means. • Coordinate with friends, family or law enforcement to secure lethal means. • Limit dispensed medication.	• Warning signs • Internal coping strategies • Distracting places and social contacts • Helpful friends or relatives • Professionals: **NSPL: 988, Crisis Text: 741-741** • Securing the environment – secure **firearms** and other lethal means

Conceptualization of Suicide: Psychological theories of suicidality for treatment planning

- **Interpersonal theory** (Joiner, 2005): Thwarted belongingness, perceived burdensomeness, hopelessness, acquired capability.
- **MBCT** (Williams, et al., 2015): Defeat, entrapment / helplessness, no rescue, agitated urge to escape.
- **Cognitive theory** (Wenzel & Beck, 2008): Hopelessness, selective attention, attentional fixation on suicide
- **Emotion dysregulation** (Linehan, 1993): SI and/or behavior functioning as emotion regulation, problem-solving, communication.

Justification for Level of Intervention: Why did you not choose a higher level of care?

☐ Current acute risk of suicide is judged to be low.
☐ Higher intensity treatment appears likely to be *ineffective or detrimental to patient's clinical status* – risks likely outweigh benefits.
☐ Higher intensity treatment appears likely to be *detrimental to patient's current treatment*. Higher intensity care may disrupt treatment plan or harm the therapeutic relationship without providing more benefit.
☐ Current risk appears likely to *decrease substantially based on imminent future events*.
☐ Threat of suicide is best viewed as escape behavior; history suggests *targeting life problems is likely more effective to reduce risk*.
☐ Threat of suicide is best viewed as operant behavior; *higher intensity intervention is likely to reinforce suicidal risk*.
☐ Current outpatient treatment is evidence-based and shown to reduce suicide risk.
☐ Current outpatient treatment addressing […] is judged to be more likely to reduce risk over time.

Consultants: