Suicide Risk Factors:

Protective Factors and Ongoing Assessment

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Suicide Statistics

- 1 million people die worldwide due to suicide every year (2020)-1 suicide every 40 seconds
- Suicide rates are highest among middle aged adults 45-64 (19.6%)
- 19.4% occur in the elderly (85 or older)
- Males are 3.5 times more likely to commit suicide, but more females attempt suicide by less lethal means (overdose)

Suicide Statistics

- Suicide is the 2nd leading cause of death among people aged 10-34 and the 10th leading cause of death in all age groups (2020)
- Implicated in many disorders to include MDD, BPD, schizophrenia, and Bipolar Disorder
- In people with MDD suicide risk rate is 15%
- MDD and anxiety disorders have a synergistic role in increasing suicidal risk

Suicide Statistics

- LGBT youth are more likely to have suicidal ideation and attempt suicide than their heterosexual counterparts (4-6 times more likely)
- 1 out of every 15 high school students report a suicide attempt every year
- In 2017, Caucasians and American-Indians/Alaskans were 2.5 times more likely to commit suicide than Hispanics, Asians/Pacific Islanders, and African-Americans
- For male and female youth aged 15-24, suicide rates were higher among American-Indian/Alaskans and white youths relative to Black youth, Asian/Pacific Islander, and Hispanic youth

Suicide Statistics

- But, there was a decrease in suicide rates between 2018 and 2019 for White and American-Indian/Alaskans
- And there was an increase in suicide rates during this time for Black and Asian/Pacific Islanders
- Between 2014-2019, the suicide rate increased by 30% for Black individuals and 16% for Asian/Pacific-Islanders
- The suicide rate increased for Black youth by 47% in 2019 and Asian/Pacific Islander youth by 40% in contrast to a decrease in white youth this age
- Data is still pending on the impact of suicide rates attributable to COVID-19 and the differential impact of it on minorities

COVID-19 and Suicide Risk

- During Covid, people with pre-existing psychiatric conditions, as well as COVID-19 patients and their families, frontline healthcare workers, older people, prisoners, and LGBTQ populations showed increased suicide risk
- Risk factors increased due to Covid:
  - Fear and worry about health and health of loved ones
  - Excessive media exposure about the pandemic
  - Physical distancing, remote working, school closures
  - Sleep disturbances-lockdown affected circadian rhythms
  - Family conflicts and IPV, DV
  - Economic crisis-unemployment
  - Low SES-socioeconomic impact of pandemic unequal
  - Increased drug and alcohol use

COVID-19 and Suicide Protective Factors

- Social Support: talk about physical distancing, not social distancing, remote ways of connecting
- Higher perceived control over the infection - adequate and reliable info about the pandemic
- Resiliency; resilient people have 7 xs higher odds of flourishing mental health, 9.3 xs lower odds of stress
- Continuing to work
- Less social media
- Exercise and access to the outdoors
- Uninterrupted mental health treatment
- Perceived social and organizational support
- Extra free/family time

Suicidal Ideation

- Suicidal Ideation (SI): Thoughts, fantasies, and wishes about ending one’s life
- If SI is present, ask about:
  - Active vs. passive wishes for death
  - Planning or not?
  - Duration of SI
  - Frequency of SI
  - Intensity of SI
  - Controllable or not?
  - Expectations about death (escape, harm to others before death, punish others, reunite with lost loved ones)

Suicide Threat (ST)

- Thoughts of engaging in self-injurious behavior that are verbalized and intended to lead others to think one wants to die despite no intention of dying

- If ST is present, ask:
  - Are there non-suicidal self-injurious thoughts such as deliberate destruction of body tissues in the absence of any intent to die or not

Suicide Plan (SP)

- Having plans on how to end one's life
- If patient has Suicidal Ideation (SI) carefully investigate presence and characteristics of SP:
  - Plan formulated/implemented? Method, place, and time
  - Anticipated outcome of plan?
  - Means accessible?
  - Does patient know how to use the means?
  - Lethality of plan
  - Likelihood of rescue
  - Preparations performed/How close came to completing plan?
  - Practiced suicidal act or attempt made?
  - History of impulsive behaviors or SUD
  - Patient's ability to control impulsivity

Suicide Attempt (SA)

- Self-destructive act with intent to end one’s own life, even though is not fatal
- If SA is present, ask:
  - Is self-injurious behavior accompanied by intent to die? If yes, it’s a real SA
  - Is it a non-suicidal self-injurious behavior without intent to die?
  - Has the patient had a previous SA and or a family history of a SA or Completed Suicide (CS)
  - Manage the patient through medical stabilization, inpatient hospitalization or other Intensive Outpatient Program if possible

Completed Suicide (CS)

- Self-injurious behavior with intent to end one’s own life and is fatal
- Apply post-suicide interventions such as helping family, friends and co-workers understand why suicide victims killed themselves and decreasing the assumption of inappropriate guilt for the death
- Identify survivors at risk for suicide
- Prevent PTSD, complicated grief, and depressive symptoms

Risk Factors for Suicide - *Demographic & Individual Risk Factors (mostly static)*

- Male gender
- Younger and/or older age
- Personal history of attempted suicide
- Positive family history of suicide
- Marital isolation
- Chronic physical illness
- Parental loss through death before age 11
- Child history of physical or sexual abuse
- Corporal punishment in adolescence

Risk Factors for Suicide - *Symptom Risk Profile Risks (mostly dynamic)*

- Presence of hopelessness
- Presence of low self-esteem
- Feelings of worthlessness
- Feelings of helplessness
- Feelings of entrapment
- Anhedonia
- Cognitive rigidity

Risk Factors for Suicide - *Symptom Risk Profile Risks (mostly dynamic) cont.*

- Impaired problem-solving and/or decision-making
- Impulsive aggressive personality trait
- Early onset of Major Depressive Disorder (MDD)
- First episode of MDD
- Comorbid substance or alcohol use disorder
- Comorbid Borderline Personality Disorder

Suicide Risk Factors as Triggers - *Demographic & Individual Risk Factors (mostly dynamic)*

- Social crisis or loss
- Financial crisis or loss
- Family crisis or loss
- Contagion or recent exposure to suicide
- Social support lacking

Suicide Risk Factors as Triggers - *Symptom Risk Profile Risks (mostly dynamic)*

- Comorbid anxiety symptoms
- Comorbid panic disorder
- Acute alcohol and/or substance intoxication
- Severity of depressive episode of Major Depressive Disorder
- Post-partum

Suicide Risk Factors as Triggers - *Circumstantial Risk Profile Risks (mostly dynamic)*

- Reduced or absent desire to live
- Active Suicidal Ideation (SI)
- Presence of a Suicide Plan (SP)
- Presence of suicidal behavior or self-harm behavior
- Acute alcohol and/or substance intoxication
- Unresolvable problems
- Presence of auditory command hallucinations to kill oneself

Protective Factors - *Demographic & Individual Factors (both static and dynamic)*

- No personal history of attempted suicide
- No family history of suicide and/or attempted suicide
- No personal and/or family history for psychotic symptoms and/or disorders
- Religious or moral constraints
- Concern about social disapproval
- Better coping skills

Protective Factors - *Demographic and Individual Factors (mostly dynamic)-cont.*

- Feelings of responsibility toward family
- Living with children under 18
- Supportive relationships
- Positive and valid therapeutic alliance
- Better impulsivity control
- Better emotional regulation

Protective Factors - *Symptom Protective Risks (mostly dynamic)*

- Good self-esteem
- Self-efficacy
- Good problem-solving skills
- Willingness to seek help
- Positive coping skills
- Emotional stability
- Responsibility to family
- Developed self-identity
- Healthy life-style choices

Protective Factors - *Circumstantial Risk Profiles (mostly dynamic)*

- Absence of suicidal ideation, suicide planning, suicidal behavior, or self-harm behavior
- No feelings of hopelessness or desire to die
- Good connectedness
- Good therapeutic adherence
- Positive therapeutic relationship and alliance

Protective Factors - ***Circumstantial Risk Profiles (mostly dynamic)-cont.***

- Good future planning
- Solving of previous critical problems
- Positive social support
- Moral objections toward suicidal behavior
- Fear of social disapproval towards suicidal behavior

Suicide Risk Stratification - *White Code (No Risk)*

- Absence of suicidal ideation
- Negative personal and/or family history of suicide, previous suicidal attempts
- Symptomatological stability
- Absence of specific suicide risk-no suicidal ideation, suicide threats, suicide plan, suicide attempt

Suicide Risk - *White Code* →*Recommended Interventions*

- Clinical observation
- Periodic suicide risk evaluation (including the occurrence of new situations, e.g. the presence of suicide risks not present previously)

Suicide Risk Stratification - *Green Code (Low Suicide Risk)*

- Presence of suicidal ideation (occasional, inconstant, fleeting, reported to clinician with scarce credence/conviction e.g. with aim of requesting attention/help or present but criticized by patient in a credible manner)
- Acute depressive episode in MDD, mild severity (not stable or remitted without comorbid anxiety)
- Positive family history of suicide or suicide attempt during MDD episode
- Positive personal history of self harm behavior and/or suicide threat

Suicide Risk-Green Code →Recommended Interventions

- Careful/periodic clinical observation by treatment team, especially if patient is silent or doesn't ask for help
- Actively listen and support inviting atmosphere that reinforces asking for help in event of negative thoughts
- Develop good therapeutic alliance/relationship
- Encourage expression of thoughts/feelings
- Provide info/support to patient and family about management of emotional crisis and adaptive coping

Suicide Risk-Green Code →Recommended Interventions-cont.

- Carefully observe family, personal, group dynamics to ID potential triggers
- Monitor/alert about occurrence of potential symptoms/risks (e.g. anxiety, agitation, irritability, hypervigilance, mood)
- Reduce patient being alone/isolated
- Ensure medication compliance with caregivers if permitted

Suicide Risk Stratification - *Yellow Code (Moderate Suicide Risk)*

- Presence of suicidal ideation (constant - low intensity)
- Presence of suicidal ideation (partially and credibly criticized by patient)
- Positive and recent personal history of suicide attempt without current suicidal ideation
- Acute depressive episode in Major Depressive Disorder (not stable, not remitted, with comorbid anxiety and/or mixed symptoms, without psychotic symptomatology)

Suicide Risk - Yellow Code → Recommended Interventions

- All of the interventions recommended for Green Code PLUS…
- Inform and involve family members
- Provide personalized supervision and vigilance
- Reconsider access to and use of risky items
- Increase observation and consider higher level of care
- Address cognitive distortions/misperceptions without belittling or judgment
- Limit frustrating situations

Suicide Risk-Yellow Code → Recommended Interventions-cont.

- Facilitate expression of anger in more functional manner
- Stimulate and discuss values/reasons for living
- Encourage change is possible
- Involve patient in positive activity/socialization
- Encourage patient to communicate thoughts of self-harm or suicidal ideation
- Identify and address agitation, anxiety, irritability and/or impulsivity

Suicide Risk Stratification - Red Code (Severe Suicide Risk)

- Positive and recent personal history of suicide attempt with active, current and intensive suicidal ideation
- Presence of suicidal ideation (constant with high intensity and not credibly criticized by patient)
- Acute depressive episode in Major Depressive Disorder (not stable, not remitted, with and/or without psychotic symptomatology, e.g. guilt or ruin delusion, with intense psychomotor agitation, impulsivity, with mixed symptoms, higher introversion levels, with auditory command hallucinations of self-harm)

Suicide Risk-Red Code →Recommended Interventions

- All of the interventions for green and yellow codes PLUS
- Greater, more frequent and intensive clinical supervision and vigilance
- Consideration of voluntary or involuntary hospitalization

"PSYCHACHE" - Shneidman

"In most cases, suicide stems from psychological pain, and the psychache itself arises from frustrated psychological needs"

- All suicidal behavior according to Shneidman is preceded by psycache
- Psychache = a state of intense disturbance that has also been described as mental pain, psychological pain, and psychic pain by different authors
- Psychache serves as a mediator between circumstance, risk factors, and suicidal behavior

“PSYCHACHE” - Shneidman-cont.

- Assess the general condition of the patient with psychache in mind without restricting the assessment to exclusively or only what the patient says when assessing suicide risk
- Consider that many who commit suicide do so on impulse, without manifesting ideation or awareness of the risk
- Lesson: Don’t expect your patient to be only one to alert you to their risk of suicide

Psychache

- One of the most important proximal predictors of suicidal risk well beyond depression

- An acute state of psychological pain associated with negative cognitive and emotional aspects of the self such as thoughts of self-disappointment or inadequacies and feelings of guilt, anguish, fear, panic, angst, loneliness, and helplessness often accompanied by a sense of disconnection, loss or incompleteness of the self

Psychache

- Its central aspects are related to connectedness and impulsivity
- Non-connectedness
  - Socially excluded
  - Loneliness even when around others
  - No mutually and satisfactory interpersonal relationships
  - Perception of being a burden to others
- Impulsivity
  - Out of control expressions of aggression
  - Trait anger
  - Risk-taking in the face of the intolerable
  - Unable to communicate experiences when requesting help

Interventions related to Psychache

- Address issues of connectedness
- Manage reactive impulsivity
- Manage the gap between the ideal and the actual perception of the self
- Manage emotional pain
- Help devise solutions to manage the pain of the gap between the ideal and the actual perception of the self
- Manage depression, anxiety, and hopelessness with medications, coping mechanisms, and problem-solving

Factors that Shape Personality Leading to Problems in Coping with Life

- Genetic load from family biology
- Learning to deal problematically with emotions and interpersonal relationships in childhood
- Life events that cause prolonged stress
- Traumatic childhood experiences such as abuse, neglect, loss of caregivers, and bullying
- Dysfunctionalities can be increased or decreased, depending on history and context, leading to states of greater or lesser emotional well-being and impacting the relationship with oneself, interpersonal relationships, and quality of life

Psychological States in Suicide - most commonly referenced in meta-analyses of suicide studies (dynamic)

- Anxiety Disorder
- Chronic Illness
- Comorbidity
- Dependence Disorders
- Major Depression
- Medically Severe Conditions

Psychological States in Suicide-most commonly referenced in meta-analyses of suicide studies (dynamic)-cont.

- Mental Illness
- Personality Disorders
- Psychopathology
- Posttraumatic Stress Disorder
- Substance Abuse

Psychological Traits in Suicide - most commonly referenced in meta-analyses of suicide studies (mostly static)

- Alexithymia
- Inability to Communicate Stress/Painful Feelings/Thoughts
- Lack of Control
- Persistence Intolerance of Psychological Distress
- Sustained Emotional Dysregulation
- Rule Learning Problems
- Problems with Seeking Help

Psychological Traits in Suicide - most commonly referenced in meta-analyses of suicide studies-continued (mostly static)

- Insecure Attachment Style
- Difficulties with Interpersonal Abilities
- Schizoid Traits
- Impulsivity and Difficulty Delaying Rewards
- Decision-Making Issues
- Impaired Cognitive Rule Learning
- Rigid Conceptual Reasoning

Static versus Dynamic Risk Factors

- Try to differentiate between transitory and stable variables
- There are historic (static/trait) variables on the one hand and diagnostic and subjective, experiential variables on the other (dynamic)
- Dynamic, symptomatic, and experiential variables are amenable to change, historic/trait variables may not be
- Static/historical variables can be assessed in the first interview and rarely change (with some exceptions, (e.g. age)
- What contributes to psychache/mental pain, is closest in time to a suicidal event and is transitory, variable, dynamic and amenable to change potentially
- These factors should be assessed in real-time and in on-going assessments because they can change rapidly

O’Connor’s Motivational-Volitional Model of Suicidal Behavior

- Suicidal behavior has a pre-motivational phase including background factors and triggering events in which ideation and intention regarding suicide build up
  - Diathesis
  - Environment
  - Life events
- Suicidal behavior also has a motivational and a volitional phase or the moment when the behavior is enacted

O’Connor’s Motivational-Volitional Model of Suicidal Behavior – cont.

- Psychache or mental pain occurs in the motivational phase where diverse factors lead a person to experience humiliation, defeat, or entrapment that leads someone to believe suicide is the only way to alleviate the pain

- It’s in the motivational phase that the presence or absence of factors may show a risk or protective role and it is within that limited timeframe that interventions can play a critical role

The Big Four

1. **Unbearable Psychological Suffering, Hopelessness and Loneliness** → in DBT addressed with Distress Tolerance
2. **Emotional Dysregulation and Impairment in Recognizing and Communicating Emotions** → in DBT addressed with Emotional Regulation
3. **Troubled Interpersonal Relationships** → in DBT addressed with Interpersonal Effectiveness
4. **Impulsivity in Distorted Reasoning** → In DBT addressed with Mindfulness

Unbearable Psychological Suffering, feelings of Hopelessness, Loneliness

- Unbearable suffering combined with depression, hopelessness, and impulsivity is the most frequent hallmark of psychache
- Suicidal behavior most frequently occurs in the presence of psychological pain, hopelessness, a lack of feeling connected to others, and suicide capacity or means
- Any effort to prevent suicide should target one or more of these factors
- Feeling connected to others is a great protective factor for those high in pain and hopelessness, especially when connectedness exceeds pain

Emotional Dysregulation and Impairment in Recognizing and Communicating Emotions

- Alexithymia is associated with suicidal behavior because those with it have difficulty identifying psychological pain
- When the pain becomes unbearable for people with alexithymia the confusion and emotional overflow can be understood as a call for help
- In treatment it is necessary to help patients name emotions that are usually expressed as physical sensations and emotional storms; this allows for the increase of emotional awareness (diary cards and psych education)
- Help patients understand mental states like beliefs, emotions, intentions, and desires that form the basis of relationships with oneself and others

Troubled Interpersonal Relationships

- Repeated frustrated interpersonal interactions, interpersonal needs being unmet, coupled with a history of victimization such as recurrent experiences of abuse interfere with interpersonal bonds and attachments
- As a result, trust, bonding, and openness in relationships suffers
- Depressive symptoms, psychache, feeling like one does not belong, and feeling as though one is a burden can lead to suicidality
- Therapy in these cases should focus on stimulating relationships for the patient by focusing on their and others' emotions, perspective taking, being flexible, and knowing how to ask for what one wants and how to compromise-treat rigidity

Impulsivity in Distorted Reasoning

- Impulsivity is a major risk factor to suicidal behavior
- Impulsivity is related to suicidal behavior and the fluctuation of suicidal ideation, but it is not related to suicidal ideation itself
- Impulsivity acts as a distal risk factor in that it is culpable for suicide and plays a role in suicidal ideation, but is not the proximal cause
- Impulsivity manifests itself in different stages leading to suicidal behavior from evaluating one’s difficulties, to the options to solve them, and to the decision to engage in suicidal behavior

Impulsivity in Distorted Reasoning - cont.

- Impulsivity must be considered in suicide risk assessment as it is vital in a person's decision to engage in suicidal behavior
- Additionally, executive functioning impairments like difficulty shifting set and negative cognitive biases are associated with suicidal behaviors.
- Cognitive remediation, problem-solving, and mastery are protective factors

Analysis of the Opinions of Adolescents on the Risk Factors of Suicide - (Kielan et al, 2018)

- In 2015, adolescents aged 16-19 from eight public high schools from eight different cities in Poland completed questionnaires
- 37% said lack of understanding from parents was a risk factor to suicide
- 48.6% said conflicts between peers and school related conflicts were risk factors to suicide
- 59.1% felt that being rejected by close and important persons was the main factor related to the feeling of loneliness that could contribute to suicidal acts
- Parental training in understanding and accepting children and classes to develop psychosocial skills for adolescents, especially interpersonal problems, will reduce suicide risk

Race, Ethnicity, and Religion affects suicidality in various populations

- There's a link between a low sense of mastery and Major Depressive Disorder and suicide in Black youth, but this was only found to be present in African-Americans and not Caribbean Blacks
- Malaysian individuals with a strong sense of religion were less likely to attempt suicide than Chinese or Indian individuals with less religious beliefs, and when they did, the means were less lethal
- Race, ethnicity, and culture can alter how depression distorts evaluation of the self, others, and the likelihood of suicide

Risk and Protective Factors in the LGBTQ population

- Sexual minority youth are at a greater risk than their heterosexual peers; twice as likely to report suicidal ideation and three times as likely to make an attempt
- This greater risk is partly explained by the Minority Stress Model which posits prejudice, stigma, social rejection, and internalized homophobia leads to greater risk
- Joiner’s Interpersonal Theory of Suicide posits that perceived burdensomeness and thwarted belongingness could explain this greater risk with perceived burdensomeness, especially to parents, being the stronger risk factor
- Acceptance and connectedness with primary caretakers in the family is an important protective factor against suicide

Risk and Protective Factors in the LGBTQ population – cont.

- Effective and early interventions rooted in parental and family contexts may reduce the risks of suicide associated with perceived burdensomeness and thwarted belongingness
- Additionally, creating a supportive school climate is protective
- Almost all studies suggest generally that victimization of LGBTQ individuals is a major risk factor for suicide
- More specific risk factors included being bullied at school, experiencing sexual assault, depressive symptoms, cannabis use, and being female
- The greater risks in the LGBTQ population persist even after controlling for general suicide risk factors like depression, alcohol abuse, family history of suicide attempts, and prior victimization

Risk and Protective Factors in the LGBTQ population – cont.

- Suicide and self-inflicting injurious behavior in LGBTQ adolescents is associated with a lack of acceptance from peers, discrimination, family rejection, and school failure
- Suicide risk is highest for bisexual women over lesbian women and gay and bisexual men
- Transgender/genderqueer individuals reported greater suicidal ideation than both cisgender men and women
- This represents risk factors unique to this population

Reasons for Living

- Cognitive distortions and dysfunctional beliefs or schemas about the self and others develop throughout life and early maladaptive schemas predict worse outcomes
- Negative schemas to include disconnection and rejection and impaired autonomy and performance, are at the heart of risk for suicide
- Research suggests symptoms of depression and hopelessness do not lead to increased suicidal ideation alone, but rather low levels of protective factors, like reasons for living, leads to suicidality

Reasons for Living

- Suicidal individuals differ from non-suicidal people in the degree to which they attach importance to various reasons for living
- Reasons for living are modifiable factors that can be targeted in treatment
- Treatments aimed at reducing suicidal behavior might be enhanced if the suicidal person can be taught to believe and attach importance to beliefs contained in the Reasons for Living Inventory

Reasons for Living-5 Categories

1. Survival and Coping Beliefs
2. Responsibilities to Family
3. Fear of Suicide
4. Fear of Social Approval
5. Moral Objections
6. Child-related Concerns

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Survival and Coping Beliefs

- Includes positive expectations about the future
- Includes beliefs about one's ability to cope with whatever life has to offer
- Is the opposite of Beck's hopelessness scale
- Individuals in a general population reporting a history of serious suicidal behavior had weaker survival and coping beliefs than individuals reporting no or minimal suicidal behavior
- In a clinical population, individuals hospitalized for suicidal or parasuicidal behavior attach lesser importance to survival and coping beliefs

Responsibility to Family and Child-Related Concerns

- In the general population, individuals who report they never considered suicide attach more importance to family and child concerns
- In psychiatric populations, individuals who were not suicidal at the time of the evaluation or who had no history of parasuicidal behavior attach importance to family and child concerns
- The importance of family and children is negatively related to suicidal ideation for the past year, the prediction of likelihood of future suicide, and ratings of suicide as a solution to life's problems.

Fear of Suicide

- The Fear of Suicide scale of the Reasons for Living measure is the only scale that distinguishes between individuals who report actual parasuicidal behavior in the past and those who report having thought about it seriously at some point but did not engage in the behavior
- In general, people with a history of parasuicide report less fearful expectations than do individuals with a history of serious ideation in the absence of actually carrying out those ideas

Fear of Social Disapproval, and Moral Objections

- Fear of Disapproval and Moral Objections are less successful in distinguishing between suicidal groups
- No significant differences were found in the general population
- But in clinical samples, individuals who endorse few moral concerns about suicide were more likely to have a history of parasuicidal behavior
- Psychiatric patients who attached high importance to expectancies for social disapproval following suicidal behavior were less likely to report communicating suicidal ideation to others → people with high social disapproval scores may need to be monitored more closely because they will be less likely to divulge suicidal thoughts, planning, or behaviors

The University of Washington Risk Assessment and Management Protocol (UWRAMP)

- The UWRAMP is a treatment form for therapists to fill out at treatment sessions and was designed for adult clients at risk for subsequent suicidality
- The form documents the clinician's suicide risk assessment, as well as interventions provided, those not provided, and the reasons interventions were not provided
- Hyperlink: http://depts.washington.edu/uwbrtc/wp-content/uploads/2008-10-10_Imminent_Risk_And_Action_Plan.pdf

UWRAMP – cont.

- It is not filled out at every session but rather is filled out at the start of treatment, if an individual makes a suicide attempt, engages in parasuicidal behavior, or reports urges to commit suicide
- The UWRAMP guides providers to address not only what they did, but also why they did not do things other providers might consider the standard of care for suicidal crises
- The information covered by the UWRAMP reflects the extensive literature on risk factors for suicide and includes both short-term and long-term risk factors that are both static and dynamic

UWRAMP – cont.

- Following the risk assessment, the UWRAMP directs the clinician through a series of clinical interventions
- If various intervention options are not chosen, the form offers the opportunity to clarify why not
- Steps for receiving consultation on the case and follow-up with the patient are documented
- The form assures that the clinician did not fail to do something that would be reasonably expected
- Offers liability protection and helps to ensure the clinician is providing an at or above standard of care

Take Home Messages

- Do a comprehensive baseline assessment-include standardized measures when possible
- Develop and maintain a strong therapeutic alliance
- Recognize assessment and risk management is ongoing and dynamic
- Address and discuss suicidal ideation/protective measures before, during and after they are salient
- Consider individualized and idiosyncratic risk and protective factors of suicide
- Do not expect your patients to be the experts or full informants about risks/protective factors relating to suicide