

Taking the Guesswork Out of Suicide Assessment and Documentation

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Why Don't We Know More About Reducing Suicide?

Lack of rigorous research in this area

Disease	Ranking	Number of Trials
Suicide	11 th	46
Liver Disease	12 th	582
Hypertension	13 th	1,392
Parkinson's	14 th	198
AIDS	Lower than 15 th	662

Mental Illness	Number of Studies
Depression	1,989
Bi-Polar Disorder	214
Anxiety Disorders	904

Routine exclusion of suicidal individuals from clinical trials.

Even in clinical trials where they are included, there is routine exclusion of those who present the highest risk of suicide, including those who have:

- made multiple attempts
- drug dependence
- depression
- or other co-occurring diagnoses

Reluctance of clinicians to treat suicidal individuals:

--It's stressful!

--Fear of liability

While ethical caution is merited, our traditional approaches (involuntary hospitalization, termination/referral, and written suicide contracts have no evidence that they are effective in reducing risk.

University of Washington

Researching suicide behavior for 35 years

- ◉ Six clinical trials with suicidal clients
- ◉ Three ongoing trials targeting suicidal behaviors
- ◉ Five experimental or epidemiological studies with suicidal clients
- ◉ Developed two instruments to assess and document suicide risk and intervention:
 - LRAMP—for individual providers of treatment
 - LRAP—for blind assessment

Goals of the Instruments

- Reduce malpractice anxiety.
- Provide an instrument that allows blind assessors to follow suicide protocols even independent of a treatment condition.
- To instruct and induce good clinical care.
- Increase the likelihood that providers would treat suicidal individuals.

Clinical Benefits of the LRAP and LRAMP

Both instruments have been used extensively in clinical trials of Dialectical Behavior Therapy, a treatment shown to reduce suicide attempts, non-suicidal self-injuries, and suicide ideation across four randomized trials.

Both are recommended by NIMH as suicide risk management tools.

Linehan Risk Assessment Protocol (LRAP)

- Designed for use with individuals who are not currently in treatment with the assessor, thus, little information is known about the individual.
- Is a structured, wrap-around method for assessing and managing suicide risk with individuals.
- Most effectively used prior to any other assessment instruments are administered, and for clinical trials or emergency care.
- Training in use of the instrument takes 2-3 hours and include detailed training in the instrument itself, suicide risk assessment, and training each crisis suicide strategy suggested by the LRAP debriefing.

The Linehan Risk Assessment and Management Protocol (LRAMP)

- A treatment form for Clinicians to fill out after treatment sessions.
- Designed for adult clients entering treatment at risk for suicide.
- Documents:
 - Clinician's risk assessment
 - Interventions provided
 - Interventions not provided (and reasons)

Indications for Use of the LRAMP

- At the start of treatment
- Any time the individual:
 - > Makes a suicide attempt
 - > Engages in intentional self-injury
 - > Makes a suicidal threat
 - > Reports a clinically significant increase in urges to commit suicide.

Process of Using the LRAMP

- Identify the risk situation
- Clinician is to provide a reason for not continuing the instrument, if that is indicated
- If continued, a risk assessment is conducted
- The clinician is guided through a series of clinical interventions with documentation of what is or is not done

Training in Use of the LRAMP

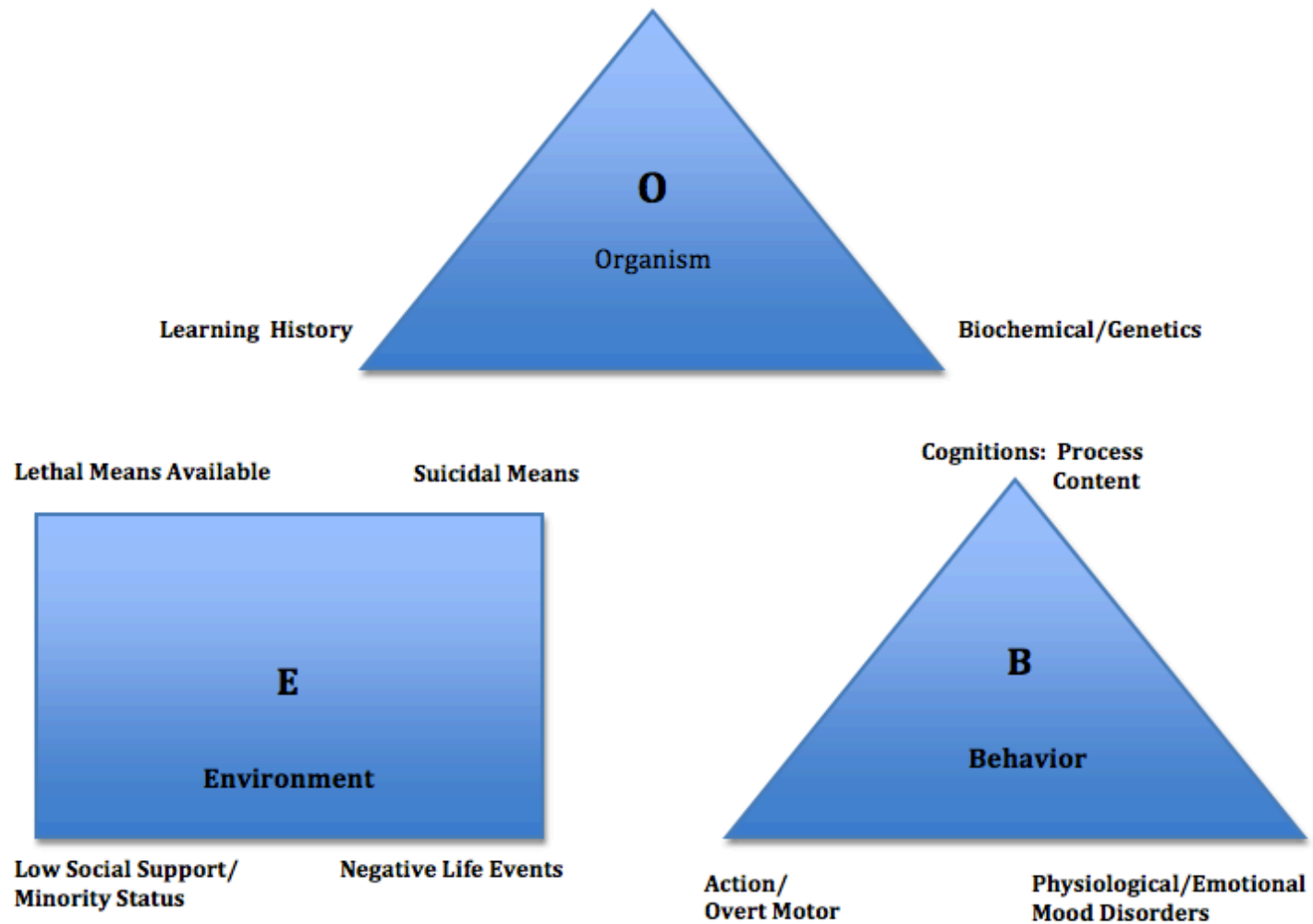
- Takes 20-30 minutes to train providers in the use of the form itself.
- Providers who do not have a solid background in suicide risk assessment and intervention require additional, and longer training in those areas—this is typically a standard 2 Day Training.

Assessing Risk:

Social-Behavioral Model of Suicidal Behavior: An Environment-Person System

|

Demographic Factors: Gender, Race, Age, Nationality



Linehan (1981) pg. 252

Brief Review of the LRAMP

Current Risk

M. M. Linehan, 2009

University of Washington Risk Assessment and Management Protocol

1. **CURRENT, SINCE LAST CONTACT or HISTORY** at intake of suicidal ideation, impulses, and/or behavior or urges to self-injure or commit suicide are:

(This note is not required if suicide ideation or urges to harm are usual and consistent and have not changed substantially since last note.)

- ☐ **HISTORY** of suicide ideation, suicide attempt, or intentional self-injury at intake
- ☐ **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 of Current Suicide Risk was

☐ Conducted (**Must be conducted at first session**)

☐ Not conducted, because (check one)

☐ Clinical reasons: (check all that apply)

☐ USUAL "BACKGROUND" ideation/urges to harm not ordinarily associated with increased imminent risk for 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

☐ OTHER REASON:

☐ FORGOT or distracted by other issues, PLAN FOR FOLLOW UP:

Imminent Risk Factors

3. IMMINENT suicide risk factors

Not reported /observed	No	Somewhat	Yes	Suicide Risk Factor	Comment Required If "Somewhat" Checked
<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 self-injury/ 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"/> 1st night of INCARCERATION; 1st week psychiatric INPATIENT, 1st 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 DEPRESSION 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:	

Imminent Risk Protective Factors

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 this 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"/>	Client MOTIVATED TO OVER-REPORT risk Comment REQUIRED if YES	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Other: <input type="text"/>	

Treatment Actions

5. Treatment actions aimed at suicidal/self-injurious behaviors

- | | | |
|-----------|--------------------------|--|
| A. | <input type="checkbox"/> | Suicidal ideation and behavior NOT EXPLICITLY TARGETED in session (Check reasons) |
| | <input type="checkbox"/> | Client is NOT IMMINENTLY DANGEROUS (see Q6 for documentation) |
| | <input type="checkbox"/> | Same reasons as for not conducting structured formal suicide risk assessment (Q2 above) |
| | <input type="checkbox"/> | Risk Assessment of suicide history was sufficiently therapeutic. |
| | <input type="checkbox"/> | Other: |
| B. | <input type="checkbox"/> | Did COMPREHENSIVE ANALYSIS of previous suicidal ideation and behaviors |
| C. | <input type="checkbox"/> | Did ANALYSIS of chain of events leading to and consequences of current suicidal ideation and behaviors. |
| D. | <input type="checkbox"/> | Focused on CRISIS INTERVENTION and/or PROBLEM SOLVING (Check those used) |
| | <input type="checkbox"/> | VALIDATED current emotions and wish to escape or die (emotional support). |
| | <input type="checkbox"/> | Worked to remove, remediate PROMPTING EVENTS |
| | <input type="checkbox"/> | Gave advice and instructed in use of COPING SKILLS to reduce suicidality |
| | <input type="checkbox"/> | Generated HOPE and reasons for living |
| | <input type="checkbox"/> | Other: |
| E. | <input type="checkbox"/> | Developed or reviewed existing CRISIS PLAN (Check also in Q6) |
| F. | <input type="checkbox"/> | Committed to a PLAN OF ACTION. |

☐ Client made credible **AGREEMENT** for crisis plan and no self-injury or suicide 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 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 or school which are important for this client.
- ☐ Violate already agreed to plan.
- ☐ Cause undue financial burden which is an important issue for this client.

K. ☐ OTHER:

Disposition

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:
(Check All that apply)

☐

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?

☐

12 hrs. How?

☐

48-72 hrs. How?

☐

Next individual session

☐

Next group session

☐

Next pharmacotherapy session

☐

Other:

Practice

Where to Find the LRAMP

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Assessment Instruments

SUPPORT THE BRTC

Help out with Campaign BRTC:
Building Knowledge to Challenge

References

- Linehan, M. M., Comtois, K. A., & Ward-Ciesielski (2012). Assessing and Managing Risk with Suicidal Individuals. *Cognitive and Behavioral Practice*, 19, 218-232.
- Linehan, M. M. (1993). *Cognitive Behavioral Treatment of Borderline Personality Disorder*. Guilford Press: NY.

(Chapter 15 has a complete listing of suicide protocols used in DBT).