

## THEORY-GUIDED APPROACH TO SUICIDE RISK ASSESSMENT, DOCUMENTATION, AND SAFETY PLANNING: MOVING BEYOND THE CHECKLIST

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## Objectives

- Suicide Risk Assessment Components
  - Suicide Risk Assessment (SRA)
  - Suicide Risk Formulation (SRF)
    - Documentation
- Theories to inform SRA & SRF
  - Confidence & Comfort
- Safety Planning
- Provider Self-Care
- Resources



## BACKGROUND

Challenges & Consequences

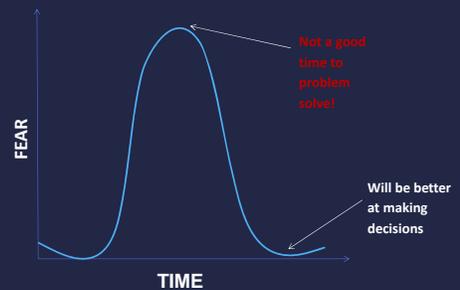
## We assess risk to...

- ...take good care of our patients and to guide our interventions
- ...take care of ourselves



## Consequences?

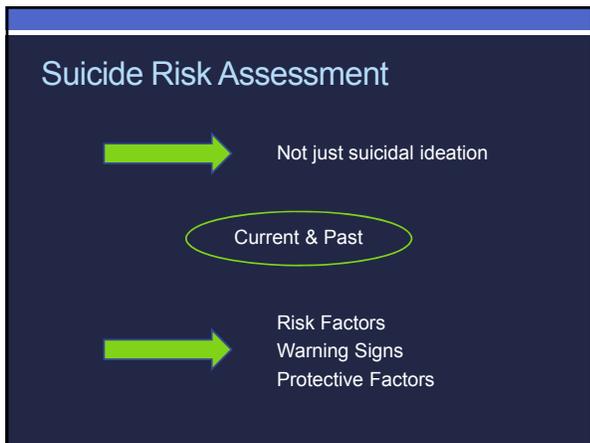
- Defensive practices may compromise:
  - Autonomy and/or non-maleficence
  - Clinical/therapeutic relationships
  - Protective factors
  - Long-term progress



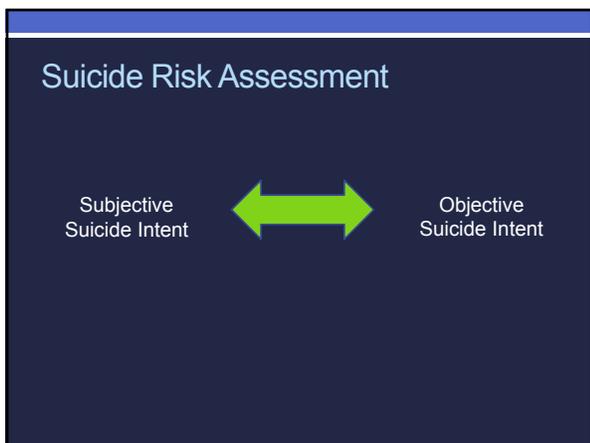


## SUICIDE RISK ASSESSMENT COMPONENTS

Assessment + Formulation



- ### Suicide Risk Assessment
- Ideation → Plan → Intent → Access to Means
- Specific & Direct
    - "Tell me about what you think/what goes through your head"
  - Assess
    - Frequency, duration, severity
  - Plan/Intent
    - Preparatory Behaviors?
      - Access to means, letters, rehearsal, research
    - Willingness to Act/Reasons for Dying
      - How do these size up to barriers to act/reasons for living?



- ### Case Example: What's the Risk?
- 29 y/o female
  - 18 suicide attempts and chronic SI
    - Currently reports below baseline SI & stable mood
  - Numerous psychiatric admissions
  - Family hx of suicide
  - Owns a gun
  - Intermittent homelessness
    - Currently reports having stable housing
  - Alcohol dependence
    - Has sustained sobriety for 6 months
  - Borderline Personality Disorder

### Case Example: What's the Risk?

- Risk factors?
- Warning signs?
- Protective factors?



### Severity

Low

Intermediate

High



Image: www.clerk.com

### Stratify Risk – Severity & Temporality

Low

Intermediate

High

Acute

Chronic

### High Acute Risk

- Essential features:
  - SI with intent to die by suicide **AND**
  - **Inability** to maintain safety independent of external support/help
- Likely to be present:
  - Plan
  - Access to means
  - Recent/ongoing preparatory behaviors and/or SA
  - Acute Axis I illness (e.g., MDD episode, acute mania, acute psychosis, drug relapse)
  - Exacerbation of Axis II condition
  - Acute psychosocial stressor (e.g., job loss, relationship change)
- Action:
  - Psychiatric hospitalization

### Intermediate Acute Risk

- Essential features:
  - **Ability** to maintain safety independent of external support/help
- Likely to be present:
  - May present similarly to those at high acute risk except for:
    - Lack of intent or preparatory behaviors
    - Reasons for living
    - Ability/desire to abide by Safety Plan
- Action:
  - Consider psychiatric hospitalization
  - Intensive outpatient management

### Low Acute Risk

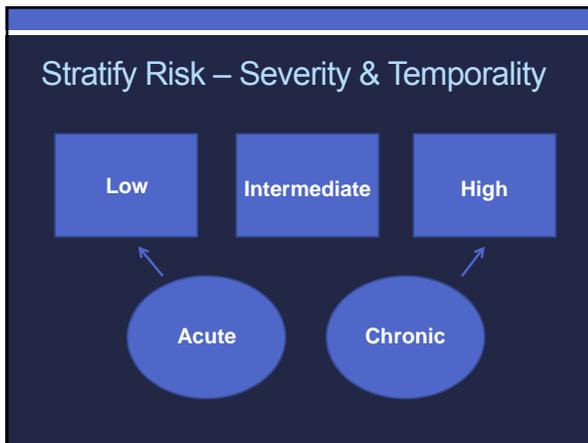
- Essential features:
  - No current intent **AND**
  - No suicidal plan **AND**
  - No preparatory behaviors **AND**
  - Collective high confidence (e.g., patient, care providers, family members) in the ability of the patient to independently maintain safety
- Likely to be present:
  - May have SI but **without** intent/plan
  - If plan is present, it is likely **vague** with **no preparatory behaviors**
  - Capable of using appropriate coping strategies
    - Willing/able to use Safety Plan
- Action:
  - Can be managed in primary care
  - Mental health treatment may be indicated

### Chronic Risk

- High
  - Prior SA, chronic conditions (diagnoses, pain, substance use), limited coping skills, unstable/erratic psychosocial status (housing, rtp), limited reasons for living
  - Can become **acutely suicidal**, often in the context of unpredictable situational contingencies
  - Routine mental health f/up, safety plan, routine screening, means restriction, intervention work on coping skills/augmenting protective factors
- Intermediate
  - **BALANCE** of protective factors, coping skills, reasons for living, and stability suggests **ENHANCED** ability to endure crises without resorting to SDV
  - Routine mental health care to monitor conditions and maintain/enhance coping skills/protective factors, safety plan
- Low
  - History of **managing stressors without resorting to SI**
  - Typically **absent**: history of SDV, chronic SI, tendency toward impulsive/risky behaviors, severe/persistent mental illness, marginal psychosocial functioning

### Case Example: What's the Risk?

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### Documentation

Although patient carries many static risk factors placing her at **high chronic risk** for engaging in suicidal behaviors, her present mood, stable housing, sustained sobriety, and SI below baseline suggest **low acute/imminent risk** for suicidal behavior

Ideation → Plan → Intent → Access to Means

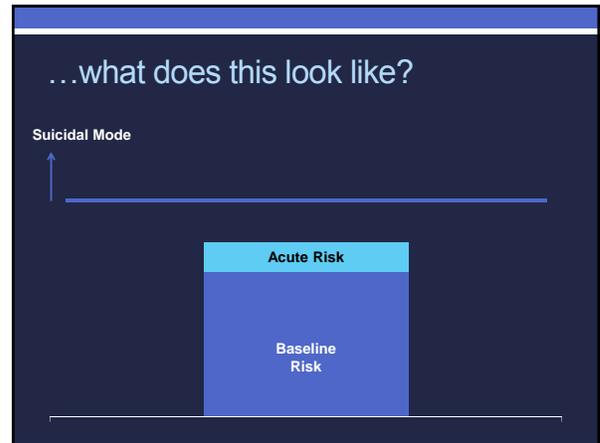
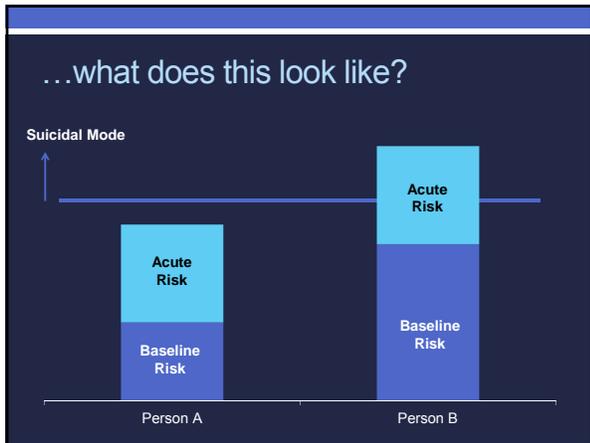
## FLUID VULNERABILITY THEORY

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Rudd, 2006

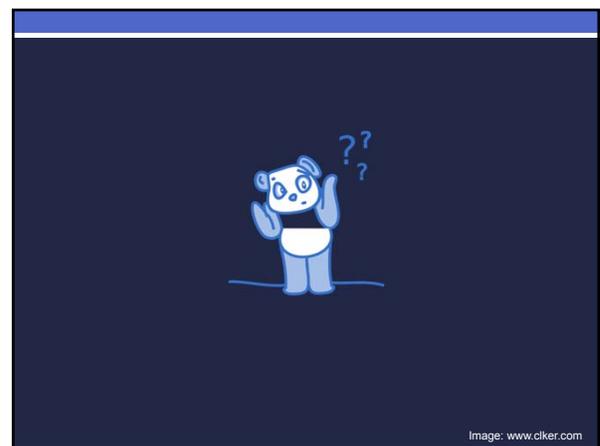
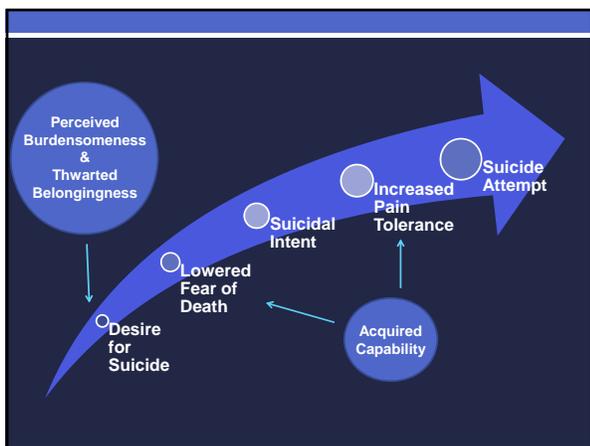
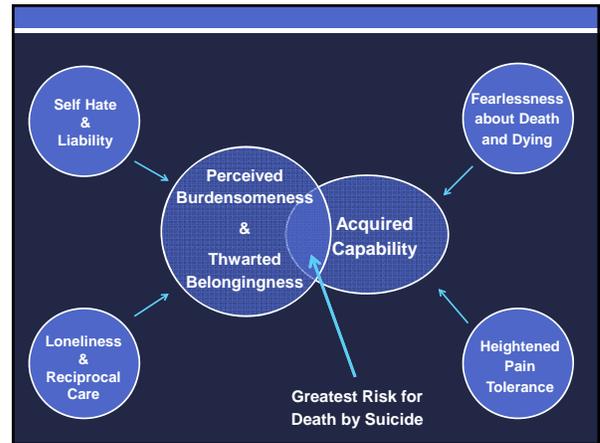
### Core Concepts

- Suicidal episodes are time limited
- Factors that trigger an episode and determine the duration are fluid
- Baseline risk varies person to person



# INTERPERSONAL THEORY OF SUICIDE

Joiner, 2005  
Van Orden et al., 2008  
Van Orden et al., 2010



## ...PULLING IT TOGETHER

### Pulling it Together: Confidence

- Goal 1
  - Complete your Suicide Risk Assessment (SRA)
  - Ideation/Plan/Intent/Access to Means
- Goal 2
  - Determine acute & chronic risk
    - Conceptualize with Fluid Vulnerability Theory
      - If acute = high, what needs to happen right now to reduce risk back to baseline?
- Goal 3
  - Use Interpersonal Theory
    - ...to supplement your risk assessment (desire + capability)
    - ...to guide ongoing conceptualization of risk

### Pulling it Together: Comfort

- No longer a checklist of risk factors
- Make assessment an ongoing dialogue
  - Desire for suicide?
    - Perceived burdensomeness & thwarted belongingness
  - Capability for suicide?
    - Fear of death/dying & ability to tolerate pain?
- Don't be shy – share the theory/conceptualization
  - Work this into intervention ideas
    - Safety Planning
    - Chronic risk factors

## SAFETY PLANNING

### Major Challenges

- How can an individual manage a suicidal crisis in the moment that it happens?
- How can a clinician help the individual do this?



### Safety Planning

- Brief Intervention
- Follows risk assessment
- Hierarchical and prioritized strategies
- Useful preceding or during a suicidal crisis
- Collaborative

Stanley & Brown, 2008

### “No-Suicide Contracts”

- Individuals promise to stay alive without knowing **how** to stay alive
- False sense of assurance to the clinician



### Tips

- Increase collaboration
- Sit side-by-side
- Use a paper form
- Have the individual write
- Provide instructions using the individual's own words
- Address barriers and use problem-solving

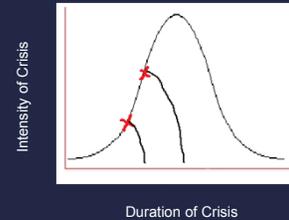


### 6 Steps

1. Warning Signs
2. Internal Coping Strategies
3. Social Contacts and Settings for Distraction
4. Social Contacts for Support
5. Professionals
6. Reducing Access to Lethal Means

### Rationale

- What's your thinking like in a crisis?
  - Flight or fight response
- Stop, Drop, & Roll analogy
- SOP
- Catch it early!



### Step One: Warning Signs

**Purpose: To help the individual identify and pay attention to his/her warning signs**

### Step One: Warning Signs

#### Ask:

- "What do you notice that's different when about you when you are feeling distressed and/or heading for a crisis?"
  - "What do others tell you that's different..."
- Query for situations, thoughts, images, sensations, mood, behavior
- Specific and personalized examples
- Continuum

## Step Two: Coping Strategies

**Purpose: Take the individual's mind off of problems to prevent escalation of suicidal thoughts**

## Step Two: Coping Strategies

### Ask:

- "What types of things have you found helpful when trying to distract yourself?"
- Activities the individual can do **without contacting another person**
- Promotes self-efficacy re: suicidal thoughts

## Step Two: Coping Strategies

### Ask:

- "How likely do you think you would be able to do \_\_\_\_ during a time of crisis?"
- "What might stand in the way of you thinking of these activities or doing them?"
- Consider "preparation" & experience
- Discuss behavioral activation

## Step Three: Social Distraction

**Purpose: To engage with people and social settings that will provide distraction and increases in social connection**

## Step Three: Social Distraction

### Ask:

- Who helps you take your mind off of your problems at least for a little while?"
- "Who do you enjoy socializing with?"
- "Where can you go where you'll have the opportunity to be around people in a safe environment?"
- Not for support! **No disclosure!**
- Include phone numbers and multiple options
- Avoid controversial relationships

## Step Four: Social Support

**Purpose: To explicitly tell a family member or friend that he/she is in crisis and needs support**

## Step Four: Social Support

### Ask:

- “Among your family or friends, who do you think you could contact for help during a crisis?”
- “Who is supportive of you and who do you feel that you can talk with when you’re under stress?”
- Can be the same people as Step 3, but different purpose
- Consider sharing the safety plan
- Better to leave blank than enter bad option

## Step Five: Professionals

**Purpose: List of professionals/services to reach out to if previous steps did not work to resolve the crisis**

## Step Five: Professionals

- Providers
- Urgent care/emergency psychiatric services
- 911
- National Crisis Line
  - Phone, Web Chat, Texting
  - Press 1
  - “Early and Often”

## Step Six: Access to Means

**Purpose: Eliminate or limit access to any potential lethal means**

**Bonus Purpose: Reminders of reasons for living**

## Step Six: Access to Means

### Ask:

- “What means do you have access to and are likely to use to make a suicide attempt or to kill yourself?”
- “How can we go about developing a plan to limit your access to these means?”
- Always inquire about firearms
- Always discuss **options**
- Alcohol/drugs & decision making
- Asking for help
- Reasons for living reminders

## Implementation

- Assess comfort/intention to use plan
  - Problem-solve around barriers

**Difficult to reach out to others  
Don't like the name “Safety Plan”  
Don't remember to use it/will get lost**

## Implementation

### Discuss:

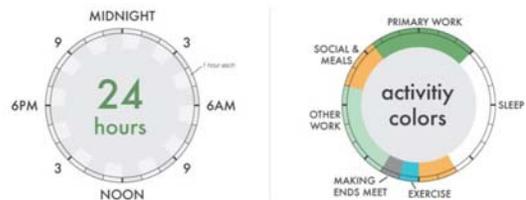
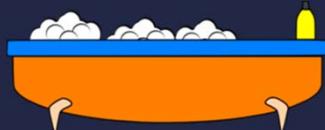
- Sharing the Safety Plan
- Location of the Safety Plan
- Practice, practice, practice!

## The Relationship

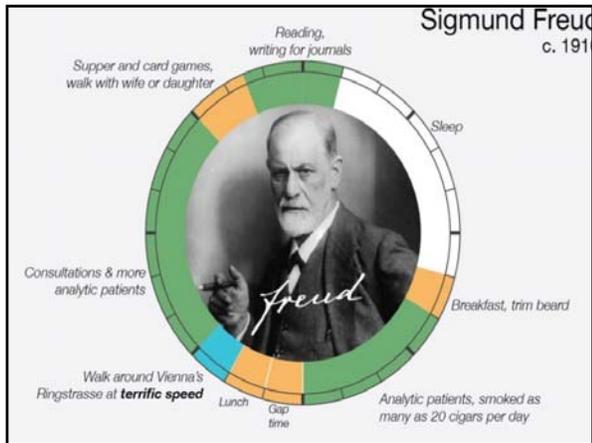
- Be familiar with the steps
- Conversational development of the plan
- Recognize strengths and skills
- Draw on patient's history to support the positive side of the ambivalence
- Bridging this intervention to therapy goals



## PROVIDER SELF-CARE



www.twistedstifter.com



# RESOURCES

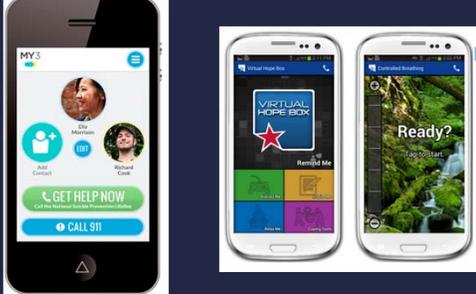
## National Suicide Consultation Service

- Clinician-focused (i.e., do not follow specific Veterans and not meant for acute suicidal crises (that role is most often served by SPCs))
- Process Consultation



- Example Questions
  - "How do I best document suicide risk?"
  - "Need assistance with recommendations to mitigate suicide risk given patient's lack of engagement with mental health providers"
  - "Please help us better understand how impulsivity is contributing to suicide risk"

## Apps



## Table Resources

- SDV Nomenclature Tools
- Safety Plan Quick Guide
- Suicide Risk Assessment Guide
- Crisis Line Cards
- ACE Brochure/Cards



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