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# Therapeutic Risk Management of the Suicidal Patient

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Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury Webinar  
September 24, 2015



## Poll 01 – Familiarity w/Suicide Risk Management?

- No to little experience
- A few cases a year (monthly)
- Regularly perform suicide risk management (weekly)
- Almost all of my job is dedicated to suicide risk management (almost daily)



## Poll 02 – Comfort w/Suicide Risk Management?

- Not at all comfortable/very anxious
- Some comfort but feel anxious throughout
- Decent level of comfort but occasional cases cause stress
- Quite comfortable – no to little anxiety

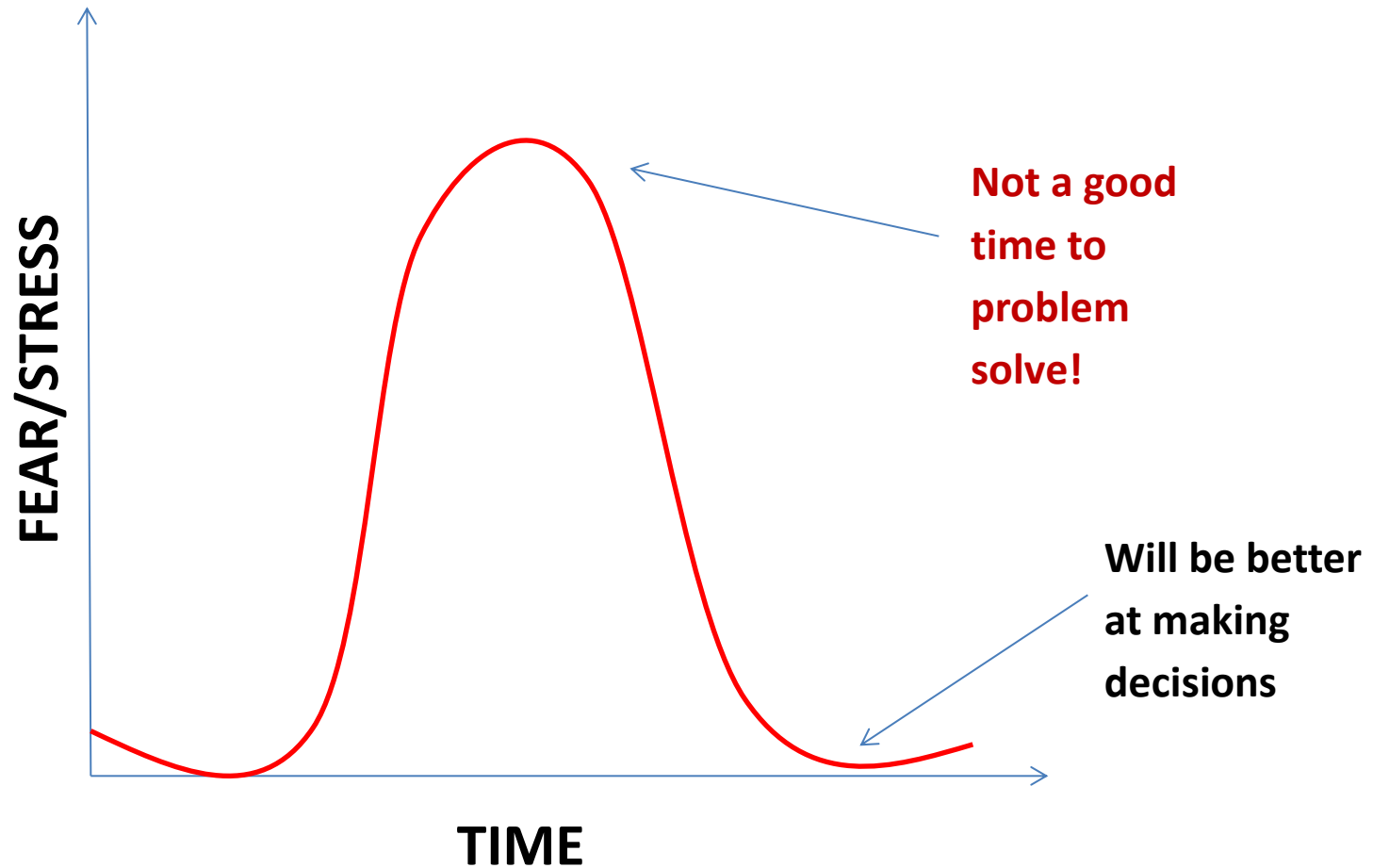


## Why Assess Risk?

- Take good care of our patients and to guide our interventions
- Take good care of ourselves
  - Risk management is a reality of psychiatric practice
    - 15-68% of psychiatrists have experienced a patient suicide
    - Suicide/attempted suicide is one of the most common malpractice claim

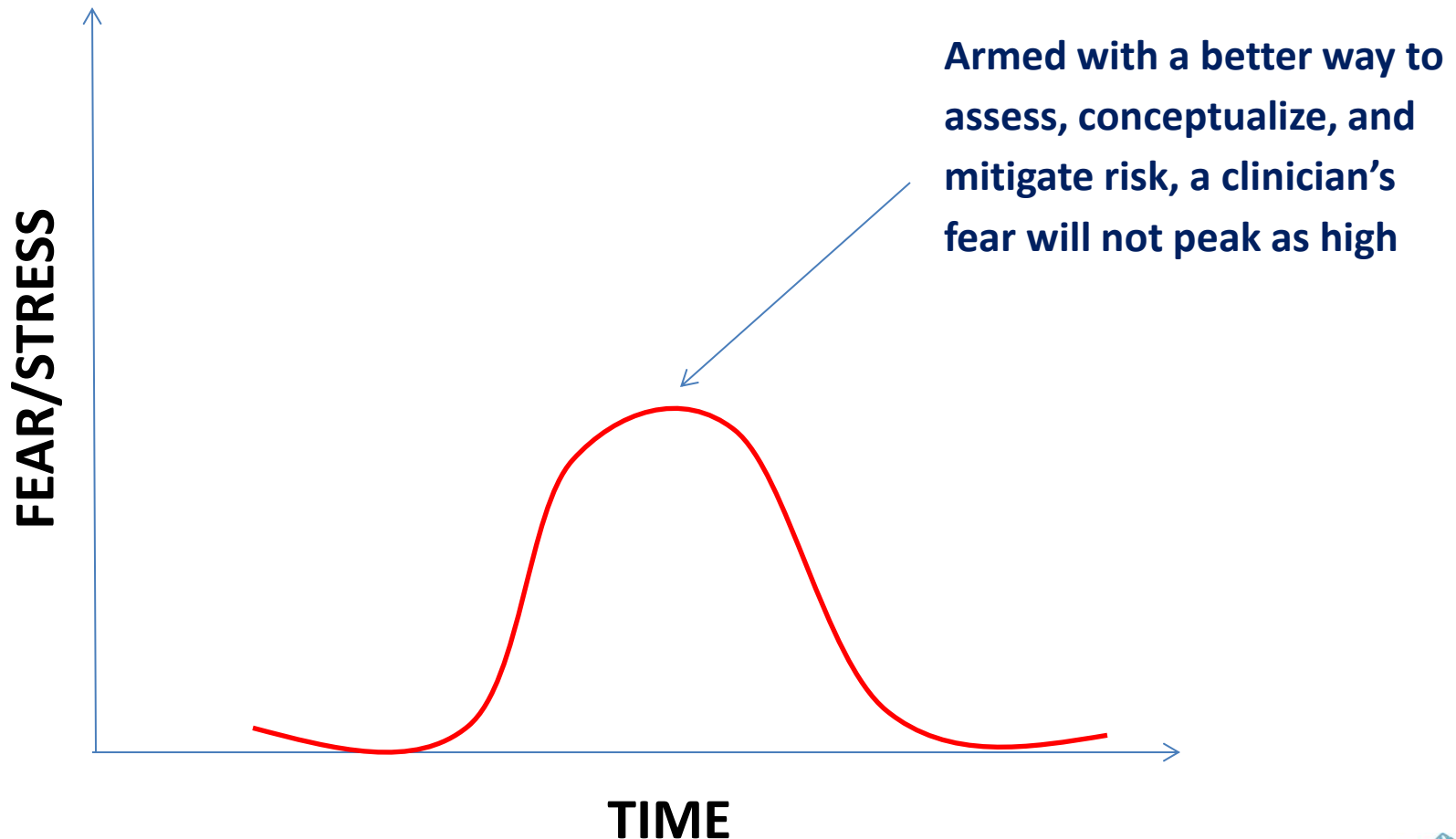


# Fear/Stress and Clinical Decision Making





# Fear/Stress and Clinical Decision Making





## Mitigating Fear...

- **Via medicolegally informed practice that exceeds the standard of care**
- **Fortunately, the best way to care for our potentially suicidal patients and ourselves are one in the same**
- **Clinically based risk management is patient centered**
  - Supports treatment process and therapeutic alliance
- **Good clinical care = best risk management**



# Therapeutic Risk Management (TRM) of the Suicidal Patient

1. Conduct and document clinical risk assessment
2. Augment clinical risk assessment with structured instruments
3. Stratify risk in terms of both severity and temporality
4. Develop and document a Safety Plan

The series can be found in *The Journal of Psychiatric Practice*

Acknowledgements:

Hal Wortzel, PhD

Beeta Homaifar, PhD

Bridget Matarazzo, PsyD

Lisa Brenner, PhD, ABPP (Rp)





## Therapeutic Risk Management

- Supports the patient's treatment and the therapeutic alliance
- Seeks to balance the sometimes competing ethical principles of autonomy, non-maleficence, and beneficence
- Avoids defensive practices of dubious benefit that, paradoxically, can invite a malpractice suit
- Unduly defensive mindset can distract the clinician from providing good patient care



# **1. Conduct and document clinical risk assessment**



## Concepts to be on the same page about

- Suicide is a rare event
- No standard of care for the prediction of suicide
- Efforts at prediction yield lots of false-positives as well as some false-negatives
- Structured scales may augment, but do not replace systematic risk assessment
- Actuarial analysis does not reveal specific treatable risk factors or modifiable protective factors for individual patients



## Overarching Goal

- Gather information related to the patient's intent to engage in suicide-related behavior
- Evaluate factors that elevate or reduce the risk of acting on that intent
- Integrate all available information to determine the level of risk and appropriate care



# **VA/DoD Clinical Practice Guideline for the Assessment and Management of Suicide Risk**



## Intent of the guideline

- Reduce current unwarranted practice variation and provide facilities with a structured framework to help prevent suicide and other forms of suicidal self directed violent behavior
- Provide evidence-based recommendations to assist providers and their patients in the decision making process



**Annotations are presented in four modules addressing the following components of care**

**Module A: Assessment and Determination of the Risk for Suicide**

**Module B: Initial Management of Patient at Risk for Suicide**

**Module C: Treatment of the Patient at Risk for Suicide**

**Module D: Follow-up & Monitoring of Patient at Risk for Suicide**



## Decision point:

- For whom should suicide risk assessment processes be completed?
- Any person who is identified as being at possible suicide risk should be formally assessed for suicide risk

### A. Person Suspected to Have Suicidal Thoughts, a recent Suicide Attempt, or Self-directed Violence Behavior

#### A1. Any patient with the following conditions should be assessed for suicide risk:

Person reports suicidal thoughts on depression screening tool

Person scores very high on depression screening tool and is identified as having concerns of suicide

Person is seeking help (self-referral) and reporting suicidal thoughts

Person for whom the provider has concerns about suicide- based on the provider's clinical judgment

Person with history of suicide attempt or recent history of self directed violence.



## What About Screening?

- **Universal Screening:** routine depression screening as part of regular health maintenance.
- Instruments like the PHQ-9 (which includes a question regarding presence of suicidal ideation) are widely accepted and administered to patients in primary care settings.

### DEPRESSION SCREENING

Over the <u>past 2 weeks</u> , how often have you been bothered by...	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF THE DAYS	NEARLY EVERY DAY
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

Adapted from the PHQ-9 developed by Spitzer, Williams, and Gendlin.

ADD COLUMNS

\_\_\_\_\_ + \_\_\_\_\_ + \_\_\_\_\_ + \_\_\_\_\_

#### What does my score mean?

If your response was 1 or higher, you might be at risk for depression.

#### What should I do?

Please feel free to contact the Late-Life Depression Prevention and Treatment Center for further information.

( 4 1 2 ) 246-6006



## Suicide Risk Assessment

A **process** in which the healthcare provider gathers clinical information in order to determine the patient's risk for suicide.



## Assessment and Determination of Risk

- **Gather** information related to the patient's intent to engage in suicide-related behavior.

- **Evaluate** factors that elevate or reduce the risk of acting on that intent.

- **Integrate** all available information to determine the level of risk and appropriate care.

**C. Assessment of Suicidal Ideation, Intent, and Behavior**

**D. Assessment of Factors that Contribute to the Risk for Suicide**

**E. Determine the Level of Risk**



# Suicide Risk



**Not just suicidal ideation**



**Risk Factors**

**Warning Signs**

**Protective Factors**



## Indicators of Risk

**Ideation → Intent → Plan → Access to Means**



## Ideation → Intent → Plan → Access to Means

### •Specific & Direct

- “Tell me about what you think/what goes through your head”

### •Assess

- Onset, frequency, duration, severity

**C1. Ask the patient if he/she has thoughts about wishing to die by suicide, or thoughts of engaging in suicide-related behavior.**

C2. Should be directly asked if they have thoughts of suicide and to describe them. The evaluation of suicidal thoughts should include the following: a. Onset, b. Duration, Intensity, and c. Frequency.



Ideation → **Intent** → Plan → Access to Means

## •Intent

- Willingness to act/Reasons for dying
- How do these size up to barriers to act/reasons for living?

**C2. Assess for past or present evidence (implicit or explicit) that the individual wishes to die, means to kill him/herself, and understands the probable consequences of his/her actions or potential actions.**



## Suicide Intent

Subjective  
Suicide Intent



Objective Suicide  
Intent





Ideation → Intent → **Plan** → Access to Means

## •Plan

- Preparatory Behaviors?
  - Access to means, letters, rehearsal, research

**C3. Assess if the patient has begun to show actual behavior of preparation for engaging in Self-Directed Violence (e.g., assembling a method, preparing for one's death).**



## Recognize Warning Signs

**Precipitating emotions, thoughts, or behaviors that are most proximally associated with a suicidal act and reflect high risk**

### Direct Warning Signs

1. Suicidal communication
2. Preparation for suicide
3. Seeking access or recent use of lethal means



## Other Potential Warning Signs

**Substance abuse** – increasing or excessive substance use

**Hopelessness** – feels that nothing can be done to improve the situation

**Purposelessness** –no sense of purpose, no reason for living

**Anger** – rage, seeking revenge

**Recklessness** –engaging impulsively in risky behavior

**Feeling Trapped** –feelings of being trapped with no way out

**Social Withdrawal** – withdrawing from family, friends, society

**Anxiety** – agitation, irritability, feeling like wants to “jump out of my skin”

**Mood changes** – dramatic changes in mood, lack of interest in usual activities

**Sleep Disturbances** – insomnia, unable to sleep or sleeping all the time

**Guilt or Shame** – Expressing overwhelming self-blame or remorse



•**Decision point:** How do additional factors contribute to risk?

•**Evaluate** factors that elevate or reduce the risk of acting on that intent.

**D1.** Assess factors that are known to be associated with suicide (i.e., risk factors, precipitants) and those that may decrease the risk (i.e., protective factors).

**D2.** Risk factors distinguish a higher risk group from a lower risk group. Risk factors may be modifiable or non-modifiable and both inform the formulation of risk for suicide. Modifiable risk factors may also be targets of intervention.

**D3.** Protective factors are capacities, qualities, environmental and personal resources that drive individuals towards growth, stability, and health and may reduce the risk for suicide.

**D5.** Assess the availability or intent to acquire lethal means including firearms and ammunition, drugs, poisons and other means in the patient's home.



# Risk vs Protective Factors

- **Risk Factors**

- Increase the likelihood of suicidal behavior and include modifiable and non-modifiable indicators

- **Protective Factors**

- Capacities, qualities, environmental and personal resources that increase resilience
- Drive individuals towards growth, stability, and health
- Increase coping with different life events
- Decrease the likelihood of suicidal behavior



## **2. Augment clinical risk assessment with structured instruments**



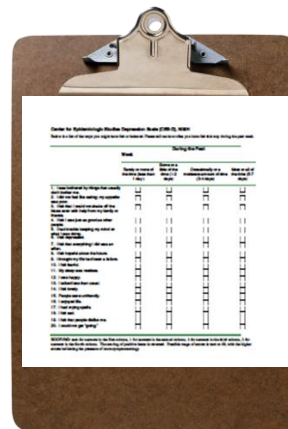
## Poll 03 – Do you regularly use standardized assessments during suicide risk assessment?

- Yes
- No



## Formal Assessment Approaches

- Providers across disciplines generally avoid using formal assessment approaches (e.g., validated tools) in favor of using their own clinical interviews (Jobes, 1995)
- Unstructured clinical interviews have the potential to miss important aspects of risk assessment
- Using both will facilitate a more nuanced, multifaceted approach to suicide risk assessment







## The addition of reliable/valid self-report measures can...

- Augment clinical care
- Serve an important medicolegal function
- Help to realize therapeutic risk management of the suicidal patient

A Review of Suicide Assessment Measures for Intervention Research with Adults and Older Adults

Gregory K. Brown, Ph.D.

University of Pennsylvania

<http://www.sprc.org/sites/sprc.org/files/library/BrownReviewAssessmentMeasuresAdultsOlderAdults.pdf>



## Things to Consider

- Time
- Accessibility
- Credentials/Training of administrator
- How it will inform risk assessment
- Measuring baseline and movement over time



## Some Measures Used by Rocky Mountain MIRECC Suicide Prevention Consultation Service

- Beck Hopelessness Scale (BHS)
  - Assesses hopelessness within the past week
  - ~5 minutes
  - One of the few measures that has demonstrated an association with death by suicide
- Reasons for Living Inventory (RFL)
  - Assesses reasons for living that may serve a protective function for someone considering suicide
  - ~10 minutes
- Beck Scale for Suicidal Ideation (BSS)
  - ~5 minutes
  - One of the few measures that has shown an association with death by suicide



## What if I am unfamiliar with how to incorporate these tools into practice?

### BSS

- During the first appointment, the BSS is used to establish a baseline regarding an individual's level of suicidal ideation
- Due to the transient nature of suicidal ideation, the BSS is also administered at the beginning of subsequent appointments
- Any changes in the score and/or composition of responses are then discussed with the patient, and this information is used to augment the assessment of the patient's acute risk for suicide

If a patient endorses the BSS item indicating uncertainty about whether he or she will make a suicide attempt, and this is a different response than that given in the previous appointment, the provider will then follow-up with questions aimed at further understanding this change in response.



## Rationale for use

The inclusion of instruments such as the BSS in the patient's medical record helps to establish a baseline regarding suicidal ideation

- Facilitates subsequent risk assessments, including those performed by providers with less familiarity with the patient
- May reduce unnecessary hospitalizations (as may occur when baseline levels of suicidal ideation are misidentified as suicidal crisis)
- May facilitate life-saving interventions (when spikes in suicide risk are more readily apparent because of a well documented baseline)



## Advantages:

- Require little time to administer
- Relatively easy to administer and therefore conducive to settings where time constraints are heavy
- Provide a modality in which patients may feel more comfortable disclosing sensitive information, such as suicidal ideation and behaviors
- Provide a quantitative measure of suicide risk

## Potential Challenges:

- Time needed to familiarize themselves with the administration/scoring/interpretation of such measures
- Potential for over-reliance on a quantitative score of suicide risk which, if used in the absence of clinical judgment, is not capable of capturing the gestalt of the drivers of suicide risk
- Tendency to focus on suicide risk assessment as an event, rather than a process



## Caveat

While suicide-specific assessment instruments can assist providers in the clinical assessment of suicidal ideation and behavior, such instruments are not a substitute for clinical judgment

No single assessment or series of assessments is able to accurately predict the emergence of a suicidal crisis



## **3. Stratification of Risk**





## 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 history of suicide**
- **Owns a gun**
- **Intermittent homelessness**
  - Currently reports having stable housing
- **Alcohol dependence**
  - Has sustained sobriety for 6 months
- **Borderline Personality Disorder**



## Poll 04 – What's your risk estimation?

- Low
- Intermediate
- High



## Severity

**Low**

**Intermediate**

**High**



## 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, rltp), 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



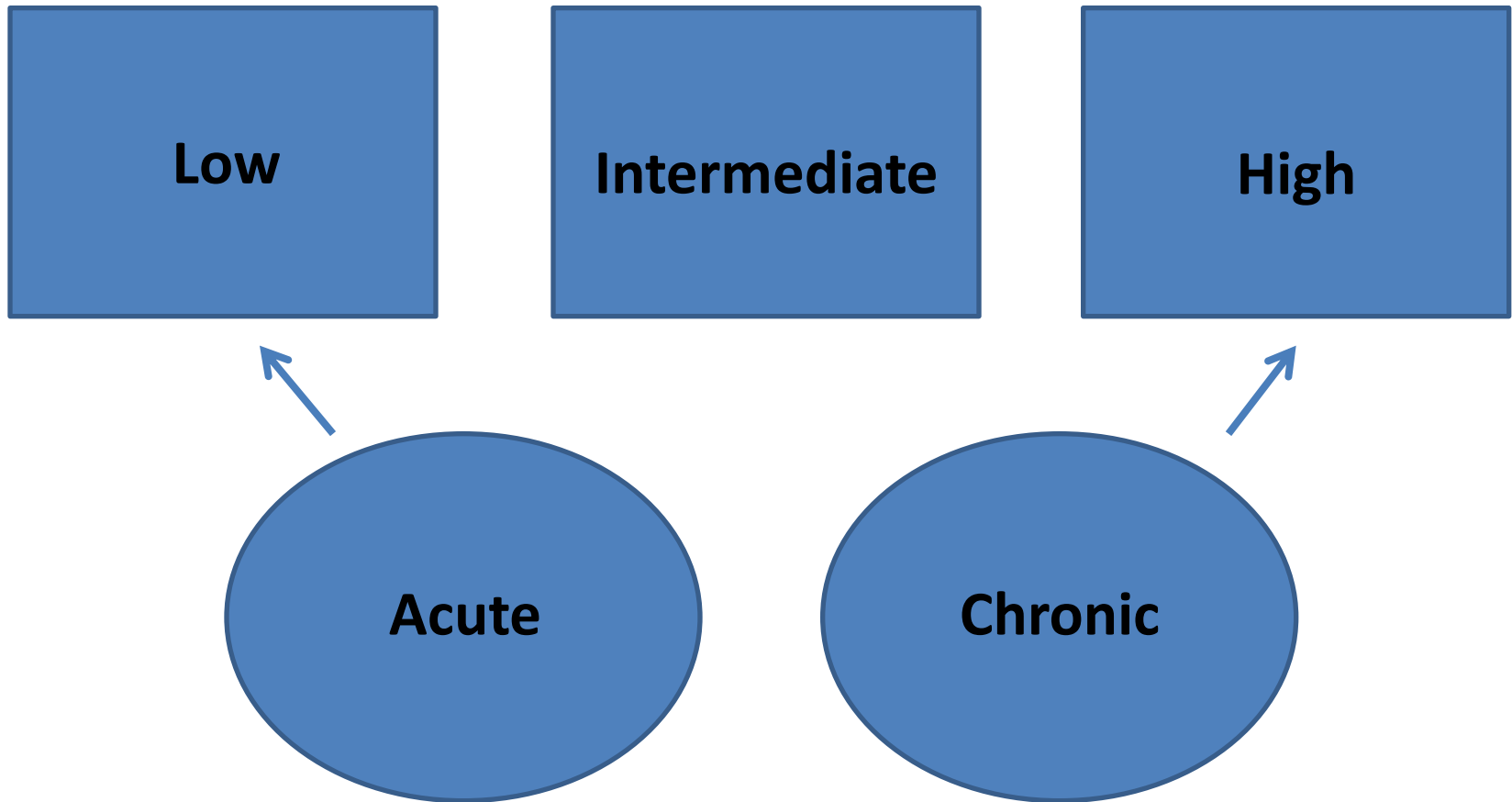


## What's the Risk?

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## Stratify Risk – Severity & Temporality





## Risk Assessment and Formulation: Documentation

Ideation → Intent → Plan → Access to Means

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 and no current intent suggest ***low acute/imminent risk*** for suicidal behavior



## **4. Develop and Document a Safety Plan**



## “No-Suicide Contracts”

- Typically entails a patient agreeing to not harm themselves
- Despite a lack of empirical support, commonly used (up to 79%) by mental health professionals
- Not recommended for multiple reasons
  - No medicolegal protection
  - Negatively influences provider behavior
  - Not patient-centered

Drew, 1999; Range et al., 2002; Rudd et al., 2006; Simon, 1999

## Safety Planning

- Brief clinical intervention
- Follows risk assessment
- Hierarchical and prioritized list of strategies
- Used preceding or during a suicidal crisis
- Involves collaboration between the client and clinician

SAFETY PLAN	
<b>Step 1: Warning signs:</b>	
1.	<u>Suicidal thoughts and feeling worthless and hopeless</u>
2.	<u>Urges to drink</u>
3.	<u>Intense arguing with girlfriend</u>
<b>Step 2: Internal coping strategies - Things I can do to distract myself without contacting anyone:</b>	
1.	<u>Play the guitar</u>
2.	<u>Watch sports on television</u>
3.	<u>Work out</u>
<b>Step 3: Social situations and people that can help to distract me:</b>	
1.	<u>AA Meeting</u>
2.	<u>Joe Smith (cousin)</u>
3.	<u>Local Coffee Shop</u>
<b>Step 4: People who I can ask for help:</b>	
1.	Name <u>Mother</u> Phone <u>333-8666</u>
2.	Name <u>AA Sponsor (Frank)</u> Phone <u>333-7215</u>
<b>Step 5: Professionals or agencies I can contact during a crisis:</b>	
1.	Clinician Name <u>Dr John Jones</u> Phone <u>333-7000</u> Clinician/Pager or Emergency Contact # <u>555 822-9999</u>
2.	Clinician Name _____ Phone _____ Clinician Pager or Emergency Contact # _____
3.	Local Hospital ED <u>City Hospital Center</u> Local Hospital ED Address <u>222 Main St</u> Local Hospital ED Phone <u>333-9000</u>
4.	Suicide Prevention Lifeline Phone: <u>1-800-273-TALK</u>
<b>Making the environment safe:</b>	
1.	<u>Keep only a small amount of pills in home</u>
2.	<u>Don't keep alcohol in home</u>
3.	_____

Stanley, B., & Brown, G.K. (with Karlin, B., Kemp, J.E., & VonBergen. H.A.). (2008). *Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version*.



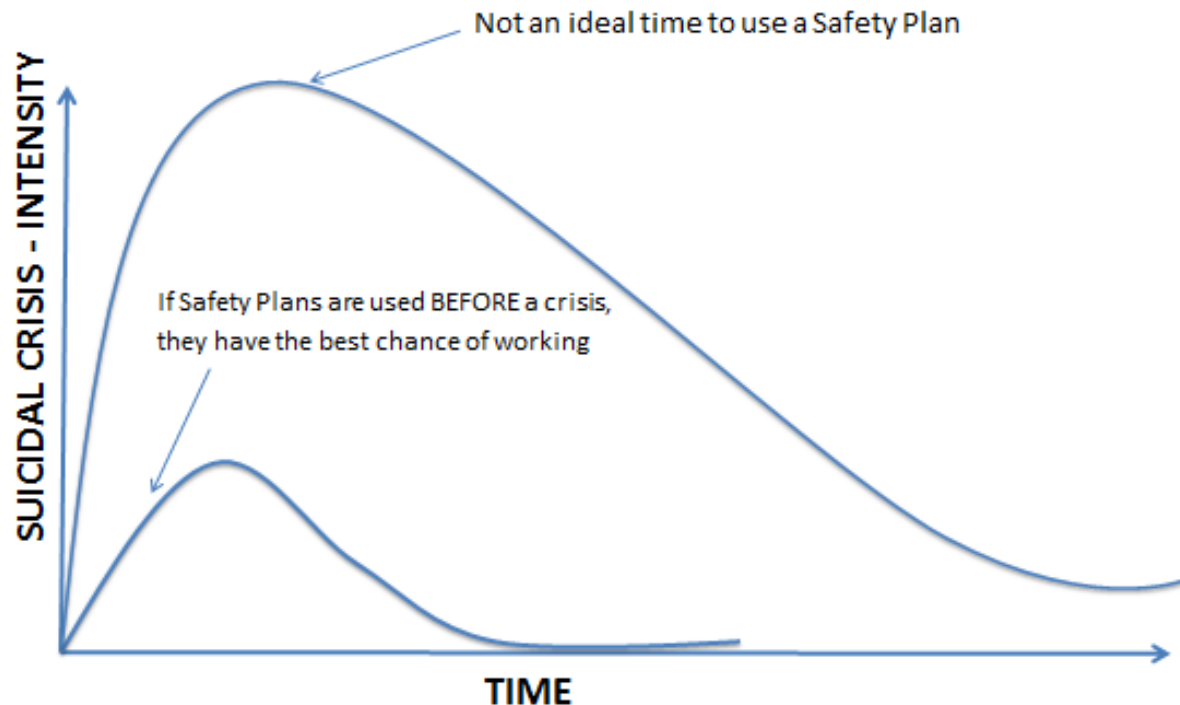
## Tips for Developing a Safety Plan Collaboratively

- Collaboration essential when working with individuals who are suicidal
- Ways to increase collaboration
  - Sit side-by-side
  - Use a paper form
  - Have the individual write
  - Provide brief instructions using client's words
  - Conversational approach
  - Jointly address barriers and use problem-solving



## Provide Rationale

- **Ask: What's your thinking like in a crisis?**
- **Stop, Drop, & Roll analogy**
- **Catch it early!**







## Step 1: Warning Signs

- Purpose: Identify and attend to warning signs for suicidal ideation/behavior
- List specific and personalized examples in patient's own words
  - Thoughts
  - Emotions
  - Behaviors
  - Physical sensations

*Ask:*

*“How will you know when to use your safety plan?”*

*“What are your personal red flags?”*



## Step 2: Internal Coping Strategies

- Purpose: Take the individual's mind off of problems to prevent escalation of suicidal thoughts
- List activities client can do without contacting another person
  - Take a hot shower
  - Listen to my "chill out" play list
  - Pet my dog
- Encourage patient to build "coping memory"

Ask:

*"What can you do on your own to prevent yourself from acting on suicidal thoughts or urges?"*

*"How likely would you be able to do this during a time of crisis?"*



## Step 3: Social Contacts and Settings for Distraction

- Purpose: Engage with people and social settings that provide distraction
- List people or safe places that offer distraction
  - Important to include phone numbers and multiple options
  - Avoid listing any contentious relationships
  - Examples of places: park, coffee shops, places of worship

*Ask:*

*“Who helps you feel better when you socialize with them?”*

*“What social settings help you take your mind off your problems at least for a little while?”*



## Step 4: People Who I can Ask for Help

- Purpose: Tell a family member or friend that he/she is in crisis and needs support
- List names and phone numbers of supportive others
  - Can be same people as Step 3, but different purpose
  - Include multiple options and prioritize list
  - If possible, share safety plan with the family member or friend

*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?”*



## Step 5: Professionals and Agencies to Contact for Help

- Purpose: List professionals/services to reach out to if previous steps did not resolve the crisis
- List name, phone number and location of
  - Primary mental health provider and other providers
  - Emergency psychiatric services
- National Suicide Prevention Line: 1-800-273-TALK (8255)
- Veterans Crisis Line: 1-800-273-TALK (8255), press 1
- 911

### **Ask:**

*Who are the mental health professionals that we should identify to be on your safety plan?"*



## Step 6: Making the Environment Safe

- Purpose: Eliminate or limit access to lethal means
- Bonus purpose: Increase reminders of reasons for living
- Means-restriction counseling
  - Always ask about access to a firearm
  - Assess access to other means
    - Example: Discuss medications and how they are stored/managed
  - Consider alcohol and drugs as a conduit to lethal means
- Reminders of reasons for living may include photos of loved ones, inspirational quotes, etc.

Ask:

*“What means do you have access to and are likely to use to make a suicide attempt?”*

*“How can we develop a plan to limit your access to these means?”*



## Enhancing Patient Use of the Safety Plan

- Increase access
- Personalize
- Encourage regular practice
- Share with others
- Update regularly
- Use technology

**Thank you!**

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