

University of Washington Risk Assessment and Action Protocol: UWRAAP

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:

3. IMMINENT suicide risk factors

(Comment required if "somewhat" is selected.)

Not reported /observed	No	Somewhat	Yes	Suicide Risk Factor	Comment
				HISTORY of suicide attempts/self-injury	
				CURRENT suicide intent, including client belief that he/she is going to commit suicide or hurt self	
				Preferred METHOD CURRENTLY or easily AVAILABLE	
				LETHAL MEANS (of any sort) CURRENTLY or easily available	
				CURRENT PLAN and/or preparation (including specific method and time)	
				CURRENT PRECAUTIONS against discovery; deception about timing, place, etc.	
				CURRENT SUBSTANCE USE, including ETOH and Rx meds (last 3 hours)	
				Currently or will be ISOLATED or ALONE	
				PROMPTING EVENTS for previous self-injury/suicide attempt	
				RECENT LOSS, other negative event.	
				ABRUPT CLINICAL CHANGE, either negative or positive	
				INDIFFERENCE/DISSATISFACTION with therapy	
				1st night of INCARCERATION; 1st week psychiatric INPATIENT, 1st four weeks after psychiatric INPATIENT DISCHARGE	
				Current Severe HOPELESSNESS.	
				Current MAJOR DEPRESSION PLUS:	
				Current Severe TURMOIL, ANXIETY, PANIC attacks, mood CYCLING	
				Current Severe, GLOBAL INSOMNIA	
				Current Severe ANHEDONIA	
				Current Inability to CONCENTRATE, INDECISION	
				Current PSYCHOSIS, voices telling client to commit suicide	
				CHRONIC PHYSICAL pain	
				USUALLY OR CURRENTLY HIGHLY IMPULSIVE	
				Client MOTIVATED TO UNDER-REPORT/LIE about risk Comment REQUIRED if NO.	
				OTHER:	

4. IMMINENT suicide protective factors

Not reported /observed	No	Yes	Protective Factor	Comment
			HOPE for the future	
			SELF-EFFICACY in problem area	
			ATTACHMENT to life	
			RESPONSIBILITY to children, family or others, including pets, who client would not abandon.	
			ATTACHED to therapy and at least one provider	
			PROVIDER attached, will stay in contact	
			Embedded in PROTECTIVE SOCIAL NETWORK or family	
			FEAR of act of suicide, death and dying or no acceptable method available	
			Fear of SOCIAL DISAPPROVAL for suicide	
			Belief that suicide is IMMORAL or that it will be punished; HIGH spirituality	
			COMMITMENT to live and history of taking commitments seriously or reason to trust this commitment	
			Client WILLING TO FOLLOW CRISIS PLAN	
			Client MOTIVATED TO OVER-REPORT risk Comment REQUIRED if YES	
			Other:	

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

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

6. I believe, based on information currently available to me (Check all that apply)

A. Client is **NOT IMMEDIATELY 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: