

# BEHAVIORAL RESEARCH AND THERAPY CLINICS

## UNIVERSITY OF WASHINGTON RISK ASSESSMENT PROTOCOL (UWRAP)

### Suicide Risk/Distress Assessment Protocol for BRTC Assessments



30801a

*Marsha M. Linehan, Ph.D., Director*

---

1. The first step in management of risk during and following assessments with suicidal and other highly distressed or volatile patients is to assess subject's mood before the assessment starts. To this end, the assessor administers the *Face Sheet* at the beginning of each assessment session. Substance use questions and additional [Six items](#) on the *Face Sheet* assess the subject's stress and urges at the beginning of the assessment. The assessors use this information in structuring and pacing the assessment to the subject's tolerance.
2. At the first assessment meeting (and reviewed thereafter as needed) the assessor should also begin the *Mood Improvement Protocol*. [Two items](#) review strategies the subject can use to manage any distress caused by the assessments. (At the end of a stressful interview, subjects are often resistant to developing strategies.).
3. At the end of each session, the assessor administers the *Debriefing Form*, which asks about the subject's mood and stress at that point and reassesses the initial *Face Sheet* items. Thus, the assessor can tell how the subject's mood has changed during the session. The *Debriefing Form* also includes items eliciting strategies for managing any distress caused by the session and a plan for handling a crisis (should one occur).
4. An *Imminent Suicide Risk and Serious Self-Injury Form* must be completed if the subject rates suicidality higher than 4 on a 7-point scale or states that she is uncertain about being able to control suicidal impulses.
5. If suicide risk is moderate to high, the assessor implements the necessary [Suicide/Distress Intervention Protocol for Assessors](#).
6. The *Debriefing Form* lists the strategies for responding to suicidal risk and those used should be checked off and described, if necessary.
7. Trainees and assessors without professional degrees must call the on-call clinical supervisor at the end of the session to review the suicide risk assessment and intervention.
8. At the end of the assessments, assessors offer and engage subjects in [mood improvement activities](#) according to the *Mood Improvement Protocol*. Because going back to rating risk factors and risk protocols would reintroduce the old mood, the debrief is conducted first and any suicide crisis management strategies next. If there is not high risk, the assessor then closes the assessment, works with the subject to improve her mood, and sends the subject home. The assessor then makes a mood improvement rating for the subject.
9. At the end of each assessment, assessors give subjects a BRTC crisis card with emergency phone numbers.

## FACE SHEET

### Pre-Assessment Risk Assessment Questions

1. \_\_\_ Has client taken any alcohol, drugs, or medications today? (0 = No; 1=Yes)

If YES to question 1, list any drugs or medications taken on testing day:

<u>DRUG TAKEN</u>	<u>AMOUNT TAKEN</u>	<u>TIME TAKEN</u>
2. _____	3. _____	4. _____
5. _____	6. _____	7. _____
8. _____	9. _____	10. _____
11. _____	12. _____	13. _____

14. \_\_\_ Does client feel the drugs or medications taken might affect her performance today? (0 No; 1=Yes)

15. \_\_\_ On a scale of 1 to 7, what is your level of stress right now?

Low 1    2    3    4    5    6    7    High

16. \_\_\_ On a scale of 1 to 7, what is your urge to harm yourself now?

Low 1    2    3    4    5    6    7    High

17. \_\_\_ On a scale of 1 to 7, what is your intent to kill yourself right now?

Low 1    2    3    4    5    6    7    High

18. \_\_\_ On a scale of 1 to 7, what is your urge to use drugs or alcohol right now?

Low 1    2    3    4    5    6    7    High

19. \_\_\_ On a scale of 1 to 7, how angry are you. (i.e., what is your level of anger right now)

Low 1    2    3    4    5    6    7    High

20. \_\_\_ On a scale of 1 to 7, what is your intent to physically hurt another person right now?

Low 1    2    3    4    5    6    7    High

UNIVERSITY OF WASHINGTON  
BEHAVIORAL RESEARCH & THERAPY CLINICS

MOOD IMPROVEMENT PROTOCOL

1. If not first session, check here and skip to 4: \_\_\_\_\_

At the beginning of the first session:

(As you know,) these assessment interviews can be very stressful. We ask a lot of personal questions, and often these questions remind you of things you would just as well forget. Hopefully, we are reminding you of positive things too, but we want to be sure the interviews go as easily as possible. What I'd like to do before we start the interview is to act as if the interview will be stressful, and figure out how to handle the stress before it happens.

2. Let's talk first about what might help during the interview. [pause] Is there anything you could do or I could do that might make it easier if you got upset?

3. What about after the interview is over? [pause] Is there anything you or I could do to make managing negative emotions later more tolerable?

4. At the end of each session, *after the debrief*, offer mood induction activity (check all used and specify exactly what you did)

- |          |                                      |          |  |
|----------|--------------------------------------|----------|--|
| a: _____ | TV comedy<br>specify: _____          | b: _____ | Music<br>specify: _____                  |
| c: _____ | Chit chat<br>specify: _____          | d: _____ | Out for walk with them<br>specify: _____ |
| e: _____ | Scents<br>specify: _____             | f: _____ | Food<br>specify: _____                   |
| g: _____ | Client not stressed, needed to leave | h: _____ | Client refused, insisted on leaving      |

5. Rate effect of mood induction activities on client's mood (please circle):

	Much Worse			No change			Much better	
a. Overall stress level:	---	--	-	o	+	++	+++	
b. Urge to self-harm:	---	--	-	o	+	++	+++	
c. Intent to die/SI:	---	--	-	o	+	++	+++	
d. Urge to use drugs:	---	--	-	o	+	++	+++	
e. Anger Level:	---	--	-	o	+	++	+++	
F Urge to injure someone	---	--	-	o	+	++	+++	

UNIVERSITY OF WASHINGTON  
BEHAVIORAL RESEARCH & THERAPY CLINICS

DEBRIEFING CHECKLIST & PROTOCOL

REVIEW THE FOLLOWING WITH S:

1. \_\_\_\_ Feedback on her experience during this assessment and other experiences she has had with the BRTC (i.e., other assessments -- how did this one compare? How was it different? What made the difference?) (DESCRIBE)

---

---

---

2. \_\_\_\_ On a scale of 1 to 7, what is your level of stress right now?  
Low    1    2    3    4    5    6    7    High

- 3a. \_\_\_\_ On a scale of 1 to 7, what is your urge to harm yourself now?  
Low    1    2    3    4    5    6    7    High

- 3b. \_\_\_\_ On a scale of 1 to 7, what is your intent to kill yourself right now?  
Low    1    2    3    4    5    6    7    High

4. \_\_\_\_ On a scale of 1 to 7, what is your urge to use drugs or alcohol right now?  
Low    1    2    3    4    5    6    7    High

- 4a. \_\_\_\_ On a scale of 1 to 7, how angry are you (i.e., what is your level of anger right now)?  
Low    1    2    3    4    5    6    7    High

- 4b. \_\_\_\_ On a scale of 1 to 7, what is your intent to physically hurt another person right now?  
Low 1    2    3    4    5    6    7    High

5. \_\_\_\_ How will you cope with any negative feelings or suicidal impulses generated by the assessment? (DESCRIBE BELOW)

---

---

---

6. \_\_\_\_ Do you have any fun activities planned for the rest of the day? (DESCRIBE BELOW)

---

---

---

7. \_\_\_\_ Is S either suicidal (higher than a 4 on Question 3b) or stating that she is uncertain about being able to control suicidal impulses? (1=Yes, 2=No)

7a. \_\_\_\_ Suicide Risk Assessment Worksheet completed? (Required if 7=Yes)  
(1=Yes, 2=No. If no, explain: \_\_\_\_\_)

7b. \_\_\_\_ Suicide Risk Assessment Worksheet completed? (Required if 7=Yes)  
(1=Yes, 2=No. If no, explain: \_\_\_\_\_)

If risk is high, implement suicidal behavior strategies:

8. \_\_\_\_ Refer clients to their primary individual therapist. Assist S in making contact, if necessary.

9. \_\_\_\_ Remain with S until risk is lowered, using emergency means as may seem necessary (please check which actions taken):

- \_\_\_\_ a. Referred to positive thing(s) in subject's life;
- \_\_\_\_ b. Suggested going for a walk together/getting food or coffee;
- \_\_\_\_ c. Validated subject's feelings, i.e. "That was really long. I'm tired too." "You must be exhausted." "What have you done with feelings like this in the past?"
- \_\_\_\_ d. Focused on what she can do about her feelings;
- \_\_\_\_ e. Made sure she had BRTC card with emergency numbers;
- \_\_\_\_ f. Contracted with S to not engage in suicidal acts
- \_\_\_\_ i. Called people in S support network
- \_\_\_\_ j. Asked people in S support network to come & pick her up, waited with S until they came
- \_\_\_\_ g. Asked non-blind assessment back-up staff to call S's therapist and inform of risk assessment.
- \_\_\_\_ h. Took lethal methods from S and locked in designated "lethal means" safe.
- \_\_\_\_ i. Accompanied S to Emergency Room;
- \_\_\_\_ j. Contacted CDMHP if danger to life is imminent and S refuses help.

Other Interventions and Notes:

ASSESSOR

If any client seems actively suicidal during assessments, or you either suspect or know she is engaging in any parasuicide act, or S displays considerable/significant distress, stop the assessment.

(INDICATE BELOW IF YOU NEEDED TO STOP THE ASSESSMENT FOR PARASUICIDAL BEHAVIOR OF SUICIDAL IDEATION AND WHICH OPTION(S) WERE TAKEN).

Stopped for:

10. \_\_\_\_ Parasuicidal behavior/impulses
11. \_\_\_\_ Suicidal ideation/behavior
12. \_\_\_\_ Significant distress (DESCRIBE: \_\_\_\_\_)
13. \_\_\_\_ Other reasons (DESCRIBE: \_\_\_\_\_)

Action(s) taken were:

14. \_\_\_\_ Stopped the assessment without scheduling future session, as S was too distressed.
15. \_\_\_\_ Stopped the assessment and rescheduled with plan for frequent breaks now that difficulties have been detected.
16. \_\_\_\_ Took a break and continued when client improved, taking frequent breaks now that difficulties have been detected.

TIME END: \_\_\_\_\_

**BEHAVIORAL RESEARCH AND THERAPY CLINICS**  
**UNIVERSITY OF WASHINGTON**



SRA

Suicide/Distress Intervention Protocol  
for BRTC Assessments



3091a

***Marsha M. Linehan, Ph.D., Director***

---

The following steps should be taken when a subject is either very distressed or is at high risk for imminent suicide or intentional self-injury according to the *Suicide Risk Assessment Worksheet*. The various strategies should be employed in order (generally) while continuously evaluating the subject's distress and suicidality. Remain with a suicidal or distressed subject until risk is lowered, using emergency means as may seem necessary, or if not suicidal, distress is at tolerable levels. At the end of the assessment the assessor (or Participant Coordinator if assessor is blind) should call the subject's therapist to inform him/her that the subject was at an assessment and appears more suicidal/distressed than usual.

1. Refer to positive thing(s) in subject's life. Spend a few minutes discussing with the subject non-stressful aspects of her life.
2. Suggest going for a walk together/getting food or coffee.
3. Validate subject's feelings, i.e. "That was really long. I'm tired too." "You must be exhausted." "What have you done with feelings like this in the past?"
4. Focus on what she can do about her feelings.
5. Made sure she had BRTC card with emergency numbers.
6. Contract with subject to not engage in suicidal acts.
7. Call people in subject's support network.
8. Ask people in subject's support network to come and pick her up; waited with subject until they come. If the subject seems unwilling to make the call, the assessor should offer to call for her.
9. Refer the subject to his or her primary individual therapist. The assessor should assist the subject in making contact if necessary and should not leave the subject until an intervention plan is worked out with the subject's primary therapist.  
  
If the assessor is blind to who the psychotherapist is, then the subject should be allowed to sit in a private room and call her therapist. If the subject does not know her therapist's phone number, the Participant Coordinator or other staff should be asked to get it for her.
10. Phone on-call non-blind assessor and ask him/her to call the subject's therapist and advise therapist of risk assessment and difficulties and stress subject is experiencing.
11. Accompany the subject to Emergency Room if suicidality cannot be reduced, risk is high and no other support can be found.
12. Contact County Designated Mental Health Professional (CDMHP) for out-reach assessment if danger to life is imminent and subject refuses help.