Risk Assessment and Safety Planning Guide

Strategies for Risk Assessment

Normalize the conversation.

Let the patient know that thoughts of suicide are a common symptom of mental health disorders and that this is something that you talk about with all of your patients. Talking about suicide won't make it more likely to happen, and sharing details with their providers will actually help to keep them safe.

Be direct.

You won't increase the risk of suicide by asking directly about it. Use specific language, such as:

> *"Are you feeling hopeless about the present or future?"*
>
> *"Thoughts of suicide, even very fleeting thoughts such as not wanting to wake up in the morning, are common in people with depression and anxiety. Is this something that you've experienced?"*
>
> *"Have you had thoughts of taking your life?"*
>
> *"Do you have a plan to take your life?"*

Clarify any misconceptions about involuntary hospitalization, if needed.

Many people are nervous that they'll be sent to the hospital if they mention any thoughts of suicide. Clarify that, in reality, many who have these thoughts are successfully treated in primary care and outpatient settings. Let patients know that it's better and safer to talk about it, and that if they do need to be kept safe by increasing the level of care, that's something you'll share with them.

Risk Factors

Risk Factor Identification

To remember your risk factors, you could use the mnemonic, 'IS PATH WARM.'

Ideation (threatened or communicated)
Substance use (increased or excessive)
Purposelessness (no reason for living, feeling like a burden)
Anxiety (agitation, insomnia, panic attacks)
Trapped (finding no one out, no one cares)
Hopelessness (no improvement possible)
Withdrawal (from friends, family, society)
Anger (uncontrolled rage, seeking revenge)
Recklessness (uncontrolled acts and being in harm's way)
Mood (intolerable changes and/or dramatic differences)

Key Acute Risk Factors and Behaviors Include:

- Current ideation, intent, plan, and access to means
- Rehearsing a plan (e.g., holding a gun, loading a gun, counting pills)
- Previous suicide attempt/s
- Alcohol/substance use
- Recent discharge from an inpatient psychiatric unit

Conducting a Systematic Suicide Inquiry

This information is based on the SAFE-T, via SAMHSA.

Beliefs: Reasons to stay alive vs. reasons to die

"What brings these thoughts up for you?"
"What keeps you here?"

Ideation: Frequency, ideation, intensity

"How often do you feel this way? Can you tell me what your thoughts look like? What do you do when they come up?"

Plan: Preparatory acts, availability, lethality, timing

"Have you thought about how you might end your life?"
"Do you have (pills/gun/weapons/etc) in your home?"

Behaviors: Past attempts, aborted attempts, rehearsals, risk-taking

"Have you ever tried hurting yourself in the past? What did you do? What happened?"
"Have you started acting on this plan at all, practicing or preparing in any way? How?"
"Have you been taking any risks lately or putting yourself in danger?"

Intent: Extent to which the patient expects to carry out the plan and also believes it to be lethal vs. self-injurious behavior

"What's the likelihood that you'll follow through on this?"
"How do you want this to end? Are you trying to simply cope with pain or are you hoping to end your life?"

Homicide inquiry, when indicated: Paranoid males, loss or humiliation, revenge

"Are you having thoughts of hurting anyone in your life? What have you thought about doing?" (Remind them that you are a mandated reporter, as appropriate.)

Strategies for Safety Planning

Do not "contract for safety."

"Contracting for safety" is not considered to be effective and is no longer the standard of care. This asks the patient to promise to stay alive without collaborating to discuss the "how" to stay alive.

Keep it brief, personal, discrete, and dynamic.

Safety plans should be in the patient's own words, so they understand this is a personal tool to be used for their own safety. It should be brief, portable, and discrete, so the patient can keep it with them as desired. Safety plans are also dynamic, and should be able to be revised regularly.

Key elements of a safety plan

- Means- Ask about firearms or any lethal means within the environment. If present, work with the patient around removing or securing the means, possibly involving a trusted support person.
- Warning signs
- Coping skills
- Support people – Both for distraction and for specific help and support within a crisis
- Emergency contact information/crisis line(s)
- Reason(s) for living

Always have a conversation about follow-up.

Part of safety planning is discussing next steps for care and follow-up, whether that include a phone call later that week, a follow-up visit with the PCP, helping the patient contact their therapist, or an ED visit.

Hope Boxes and Survivor Kits: An optional part of a safety plan

These kits include tangible objects that remind the patient of their reasons for living. These can be created out of anything that is easily accessible, whether a box, wallet, phone, etc. It might include:

- Written safety plan
- Coping cards
- Pictures
- Letters
- Prayer cards
- Poetry
- Music
- Emails
- Text messages
- Comforting objects, such as a blanket or a soothing scented oil

For further resources, visit http://mccist.org/training/behavioral-health-care-manager/.