Suicide Assessment – Step-by-Step

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If you're working with humans–and that means anyone–in counseling or psychotherapy, sooner or later you'll have the need to conduct a more formal or less formal suicide assessment. Depending on your client's/patient's presenting symptoms, cooperation, and other factors, your assessment may range from simply asking directly, to a more comprehensive assessment approach. The following steps constitute a useful model that you can shrink or expand, along with some linked resources.

1. As you talk with your client/patient, **normalize the experience of suicidal ideation** as a natural response to difficult life situations and psychological or emotional pain. Listen closely to the client's story and show empathy and validate their experiences as challenging. You might use one or both normalizing strategies: (a) "I ask everyone about suicide" and/or (b) "It's not unusual for people to think about suicide, especially if they're in a difficult life situation or are feeling emotional pain." See Dr. Shawn Shea's website for more excellent examples for different interviewing situations: https://suicideassessment.com/resources/interviewing-tips/the-validity-technique-of-normalization/

2. **Explain** your "policy" on suicidal ideation. Many clients/patients deny having suicidal thoughts, often because of fears about immediate hospitalization. Saying something like the following can help clients be more honest with you about their private thoughts. "One thing I want you to know is that if something shares thoughts about suicide, I do not immediately think about hospitalization. My approach is to work on identifying and understanding the difficult emotions or situations that are driving the suicidal thoughts. Then, we can discuss and plan together how to address the difficult emotions or situations. In most cases, the goal is to find the best strategy for dealing with your emotions and situation and keeping you safe. Sometimes, the best plan involves hospitalization. But usually hospitalization is not the best plan."

3. You can use shorter or longer **suicide assessment protocols**. The longer protocol is described below, but you might just follow a shorter protocol that includes use of a standardized instrument. For example, you may use the Columbia (okay), the PHQ-9 (not so good), or something more interactive, like JSF's "Mood scaling with a suicide

floor." See: https://johnsommersflanagan.com/2018/05/25/suicide-assessment-mood-scaling-with-a-suicide-floor/

4. As needed, do a **formal and comprehensive assessment** that includes the RIPSCIP components described below. At the very least, you will want to address the RIPSCIP items in your suicide assessment note. They include: (a) Risk and protective factors (in particular, individualized risk and protective factors); (b) Suicidal Ideation; (c) Suicide Plan; (d) Self-Control (including impulsivity, agitation, akasthisia, etc.); (e) Suicide Intent; and (f) Safety Planning.
    - R – [Risk Factors]
        - individualized risk factors: Instead of just going down a general risk factor checklist, use David Jobes's "The one thing" question. Here it is: "If we could somehow magically change just one thing in your life that would eliminate your suicidal risk all together, what would that be?"
        - Warning signs: There are a variety of "warning sign" lists, none of which are very empirically useful. But, if you notice warning signs, they're worth exploring. Here's some info on ISPATHWARM: https://stepupprogram.org/docs/handouts/suicide_warning_signs.pdf and from JSF: https://johnsommersflanagan.com/2013/07/12/is-path-warm-an-acronymn-to-guide-suicide-risk-assessment/
        - Protective factors (including reasons to live): Be sure to ask about reasons for living. These may be especially important to your treatment planning. Cureton and Fink developed an acronym for asking about protective factors: https://onlinelibrary.wiley.com/doi/10.1002/jcad.12272
    - I – [Ideation] Evaluate suicidal (I)deation.
        - What activates SI?:
        - What's the client's experience of the frequency, duration, and intensity of the SI?:
        - Be sure to ask: "What's happening when you're NOT thinking about suicide?:
    - P – [Plan] Ask about the presence and details of a suicide (P)lan. As needed, S-L-A-P the plan by gathering info on the specificity, lethality, availability, of the plan, as well as the proximity of social support. As you talk about suicide plans, it may feel natural to also ask directly about and explore previous attempts. If possible, connect the IDEA of the suicide plan and previous attempts with the IDEA of a safety plan and note: "In a few minutes we'll be talking through a plan for your safety."
        - Specificity:

        - Lethality:
        - Availability:
        - Plan:
    - SC – [Self-control] Evaluate for self-control. This is tougher and it involves observations.
        - Agitation:
        - Impulsivity:
        - Self-report:
            - "What helps you calm down?"
            - "What do you find soothing or comforting in your life?"
            - "What do you do when you want to or need to wait and not act on an impulse or your first thought?"
    - I – [Intent] Evaluate for suicide intent. One of the big distinctions here is whether the client really wants to end his/her/their life, or just reduce their pain and/or escape from a disturbing situation. Clients may say they're sure they've tried everything and that nothing works. If so, try building hope from the bottom up.
        - Hope from the bottom up… "Of the things you have tried, what was the worst? [After they respond, move up from the bottom by asking something like: "Okay, the meds were the worst. I won't suggest that. What was another bad idea, but not as bad as the meds?" Then, keep working up to neutral ideas or positive ideas.]
        - Overall, consider (but don't necessarily ask): Do they want to stop the hurting, or do they actually want to end their life?:
    - P – [Safety plan] Collaboratively construct a safety plan with the client. The Stanley and Brown model is great and available online *(Also on the NEXT PAGE)* . Constructing a safety plan, like the whole process of a collaborative suicide assessment, is also an assessment of the client's willingness and ability to engage with you on a therapeutic task. When JSF uses the Stanley and Brown safety plan, he likes to ask the last question first, and then ask it again at the end. Click below for JSF's youtube video demo on safety planning: https://www.youtube.com/watch?v=jd7PM9HFDO4

5. If you're uncertain about any of this, **you should consult** with a colleague or your supervisor. You may want to have a professional colleague (or two or three) with whom you routinely consult on all suicide assessments.

6. **Document your decision-making process** (i.e., include the preceding content in your note or in your treatment plan) and the **rationale** supporting your treatment plan.

STANLEY - BROWN SAFETY PLAN

STEP 1: WARNING SIGNS:

1. _____
2. _____
3. _____

STEP 2: INTERNAL COPING STRATEGIES – THINGS I CAN DO TO TAKE MY MIND OFF MY PROBLEMS WITHOUT CONTACTING ANOTHER PERSON:

1. _____
2. _____
3. _____

STEP 3: PEOPLE AND SOCIAL SETTINGS THAT PROVIDE DISTRACTION:

1. **Name:** _____ **Contact:** _____
2. **Name:** _____ **Contact:** _____
3. **Place:** _____ **4. Place:** _____

STEP 4: PEOPLE WHOM I CAN ASK FOR HELP DURING A CRISIS:

1. **Name:** _____ **Contact:** _____
2. **Name:** _____ **Contact:** _____
3. **Name:** _____ **Contact:** _____

STEP 5: PROFESSIONALS OR AGENCIES I CAN CONTACT DURING A CRISIS:

1. **Clinician/Agency Name:** _____ **Phone:** _____

Emergency Contact : _____

2. **Clinician/Agency Name:** _____ **Phone:** _____

Emergency Contact : _____

3. **Local Emergency Department:** _____

Emergency Department Address: _____

Emergency Department Phone : _____

4. **Suicide Prevention Lifeline Phone:** 1-800-273-TALK (8255)

STEP 6: MAKING THE ENVIRONMENT SAFER (PLAN FOR LETHAL MEANS SAFETY):

1. _____
2. _____

Stanley-Brown
Safety Planning Intervention