

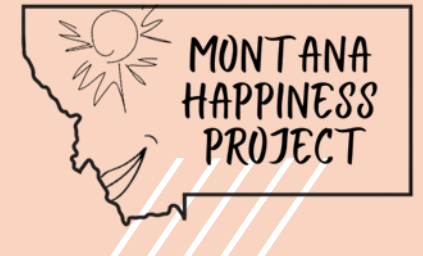
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Free Resources:
<https://johnsommersflanagan.com>



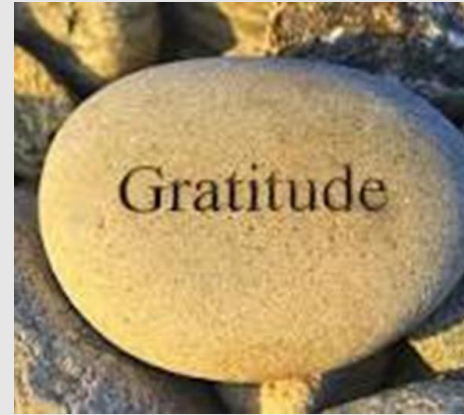
An Introduction to Strengths-Based Suicide Assessment

Enhancing Collaborative and Resilience-
Oriented Practices



Intro and Gratitude

- John Intro + Survey



- Welcome and thanks to Emily Dillow for the invitation and organization



- Thanks to the Center for the Advancement of Positive Education in the Phyllis J. Washington College of Education at the University of Montana:

- <https://www.umt.edu/education/cape/>



Preparation

- 30+ years ago – 2021 Networker article: <https://www.psychotherapynetworker.org/article/myth-infallibility>
- Trigger Warning and Why (2 things)
- But research indicates. . .
- Strength warning!!
- Please practice **proactive and positive coping**





REAL Learner Objectives



- You come with **YOUR** knowledge, experience, and expectations – You come with **YOUR WHY** and **PURPOSE**
- I offer **ideas** and exchange **experiences**
- You take **what fits for you** and apply it to your life and work
- **Caveats:** These are ideas. Nothing always works.
- Default = **relationship connection.**

Part 1

Busting Traditional Suicide Myths





SUICIDE, MENTAL HEALTH, AND HAPPINESS ARE WICKED PROBLEMS

Wicked problems are not linear

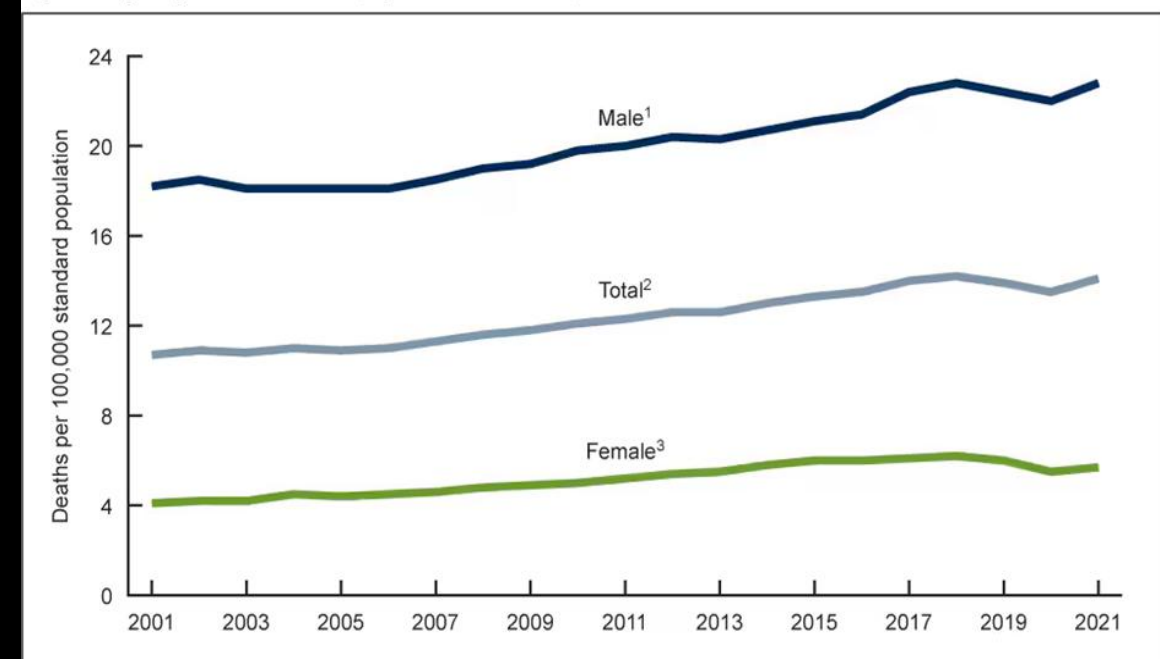
Multiple perspectives, formulations, and emotional reactions

Not testable; Efforts to solve can backfire [Happiness Party example]

WICKED PROBLEMS ARE WHY. . .

- ✓ **Everything** is worse
- ✓ GAD, Panic, MDD, PTSD, ADHD, SUDs, ODD, CD, etc.
- ✓ **Trigger warnings backfire**
- ✓ Suicide is up 40-80% over 25 years . . . Despite big efforts (**National, State, and Tribal** strategies; 2001/2012/2017, 2024)

Figure 1. Age-adjusted suicide rates, by sex: United States, 2001–2021



¹No statistically significant trend from 2001 through 2006; significant increasing trend from 2006 to 2018; no statistically significant trend from 2018 through 2021, $p < 0.05$. The rate in 2021 was significantly higher than the rate in 2020, $p < 0.05$.

²No statistically significant trend from 2001 through 2006; significant increasing trend from 2006 to 2018, with different rates of change over time; no statistically significant trend from 2018 through 2021, $p < 0.05$. The rate in 2021 was significantly higher than the rate in 2020, $p < 0.05$.

³Significant increasing trend from 2001 to 2017; significant decreasing trend from 2017 through 2021, $p < 0.05$. The rate in 2021 was significantly higher than the rate in 2020, $p < 0.05$.

NOTES: Suicide deaths are identified using *International Classification of Diseases, 10th Revision* underlying cause-of-death codes U03, X60–X84, and Y87.0. Age-adjusted death rates are calculated using the direct method and the 2000 U.S. standard population. Access data table for Figure 1 at: <https://www.cdc.gov/nchs/data/databriefs/db464-tables.pdf#1>.

SOURCE: National Center for Health Statistics, National Vital Statistics System, Mortality.



We're Not Good at Predicting Suicide

Imagine **Washington Grizzly Stadium** on **1/1/26** – Capacity 25K

It's filled with **Montanans**

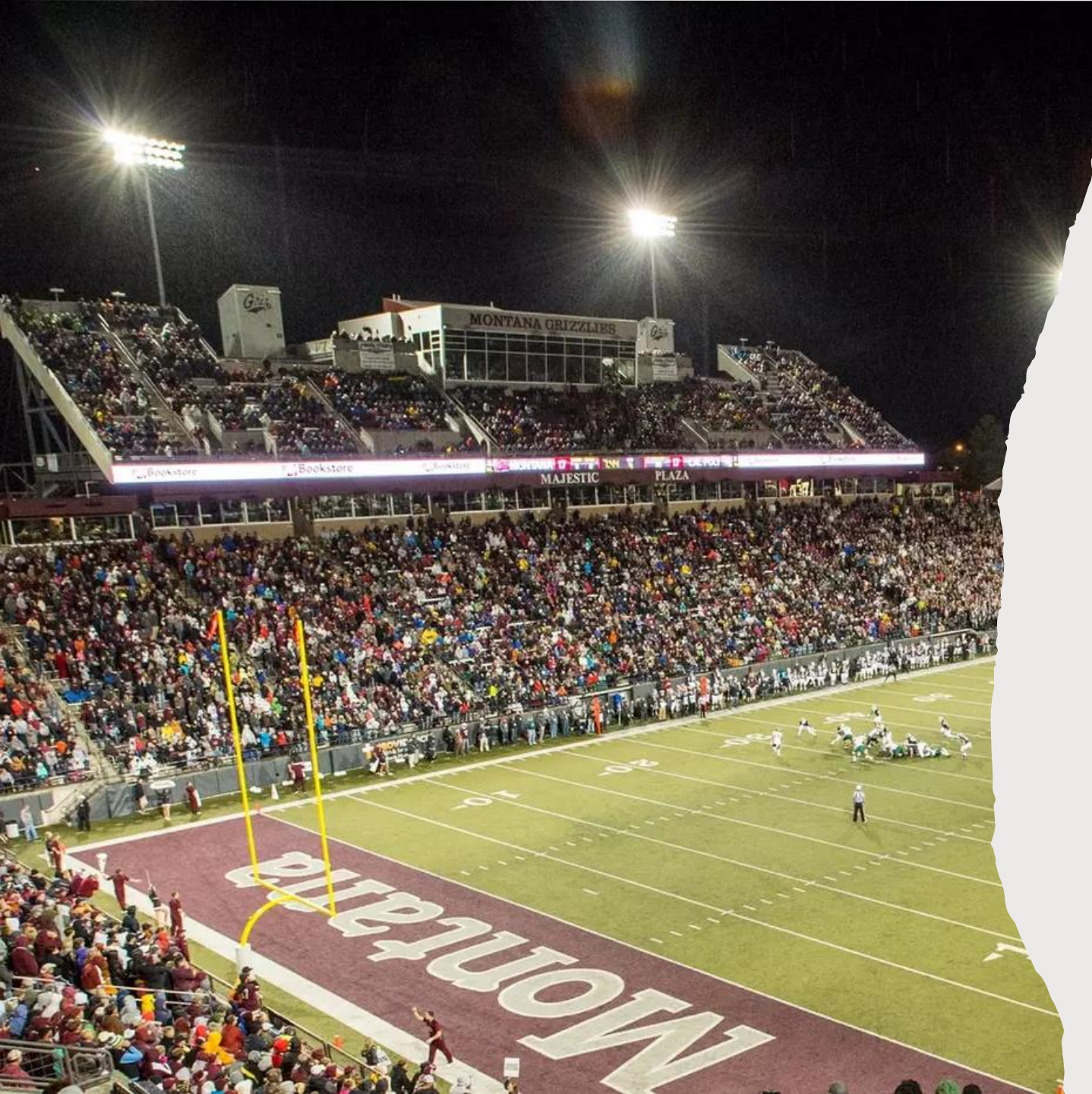
By Dec 31, about **6 of those 25K Montanans will die by suicide.**

Your job: Identify and intervene to prevent suicide?

Predicting Suicide II

- We could **screen for** depression and suicidal ideation
- With **depression**, we might cut our number from 25K to about 5K (but **which 6 of the 5K?**)
- If we screen for **suicidal ideation**, we might cut our numbers to about 4K (but **which 6 of the 4K?**)





Predicting Suicide III

- But, if we dismiss people who screen negative, we'll lose about $\frac{1}{2}$ of those who will die by suicide because they won't report SI or depression
- If we screen for so-called "Mental Illness" we'll do even worse

Predicting Suicide IV

rethinking suicide

WHY PREVENTION
FAILS, AND HOW
WE CAN DO BETTER

CRAIG J. BRYAN

- “The majority of patients who die by suicide screen negative for suicidal ideation. If you are a MH professional/agency who uses decision trees that designate negative screens as ‘low risk,’ you should consider discontinuing that practice. This is especially applicable to clinicians/agencies that use the C-SSRS’s red/orange/yellow scoring system. The C-SSRS will ‘miss’ most patients who kill themselves.” [False negatives]
 - **Craig Bryan, Ph.D., Feb 7, 2024** – LinkedIn post



We're ALSO Not Good at Preventing Suicide

- Here's a Typical* Suicide Prevention Message
- Suicide rates for at-risk youth can be substantially reduced by:
- Knowing the signs. Four of five suicide deaths are preceded by warning signs, like suicidal threats, previous attempts, preoccupation or obsession with death, depression, and final arrangements.
- https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/teen_suicide/state/MT

Time Out for Reflection

- Why am I saying these depressing things?
- We should **DO EVERYTHING WE CAN** to prevent suicide . . . AND
- We also should be **REALISTIC** . . .
- Because if we assume suicide is predictable and preventable . . . We will feel **EVEN MORE GUILTY** when people die by suicide (Ex: Educators and Signs of Suicide)

rethinking suicide

WHY PREVENTION
FAILS, AND HOW
WE CAN DO BETTER

CRAIG J. BRYAN

Part 2: Outside the Box

Strengths-Based Principles and Suicide



You're with a patient. You need to ask about suicide. Notice your reactions:

**Tommie, 18 y/o
Yup'ik tribe**

https://players.brightcove.net/624142947001/r1evdKsni_default/index.html

[?videoId=5095441194001](https://players.brightcove.net/624142947001/r1evdKsni_default/index.html?videoId=5095441194001)




Two SB “Prep” Concepts

Dealing with Our Issues

- **YOUR issues? [Anxiety thoughts? Physical sensations? Behavioral impulses? Cognition?]**
- **My friend Scott**
- **Life experiences, culture, family, religion, temperament, etc., will make this assessment and treatment process easier or more challenging**

Connect First

- **Explore distress.**
- **What hurts and how can I help?**
- **Come alongside the emotion and cognition, and ask: “What’s happening when you’re NOT thinking about suicide?”**
- **You might feel the impulse to control; connect first instead.**



SB – 1 – Suicidal Ideation is not an Illness, Mental Disorder, Sin (or even a good predictor of suicide)

- Suicidal ideation is a **natural human response** to painful emotions and stressful circumstances, over which we feel little control. Think of being bullied, of historical trauma, of systemic oppression, and sexual assault or abuse.
- SI means students are **living lives of despair and feeling hopeless.**
- The distress may not even be “IN” them. They might be in a traumatizing life situation.

Strengths-Based Principles – 2



Recognize the limits of risk/protective factor assessment (because **mostly it doesn't work**; 50-year meta-analysis; cutting; cultural variability).

We are **transparent** (e.g., hosp), **build trust** and **collaborate** to develop **individualized safety plans** and **decrease personal distress**. [This is our focus]

Strengths-Based Principles – 3

While focusing on suicide (which is essential), **resist the temptation to over-focus** on suicide.

The student is a whole person with **unique** strengths and resources: Show compassion for suicide pain. Also **pay attention to and draw out positives** (not naively; the best way is to **be with**). [7 dimensions]

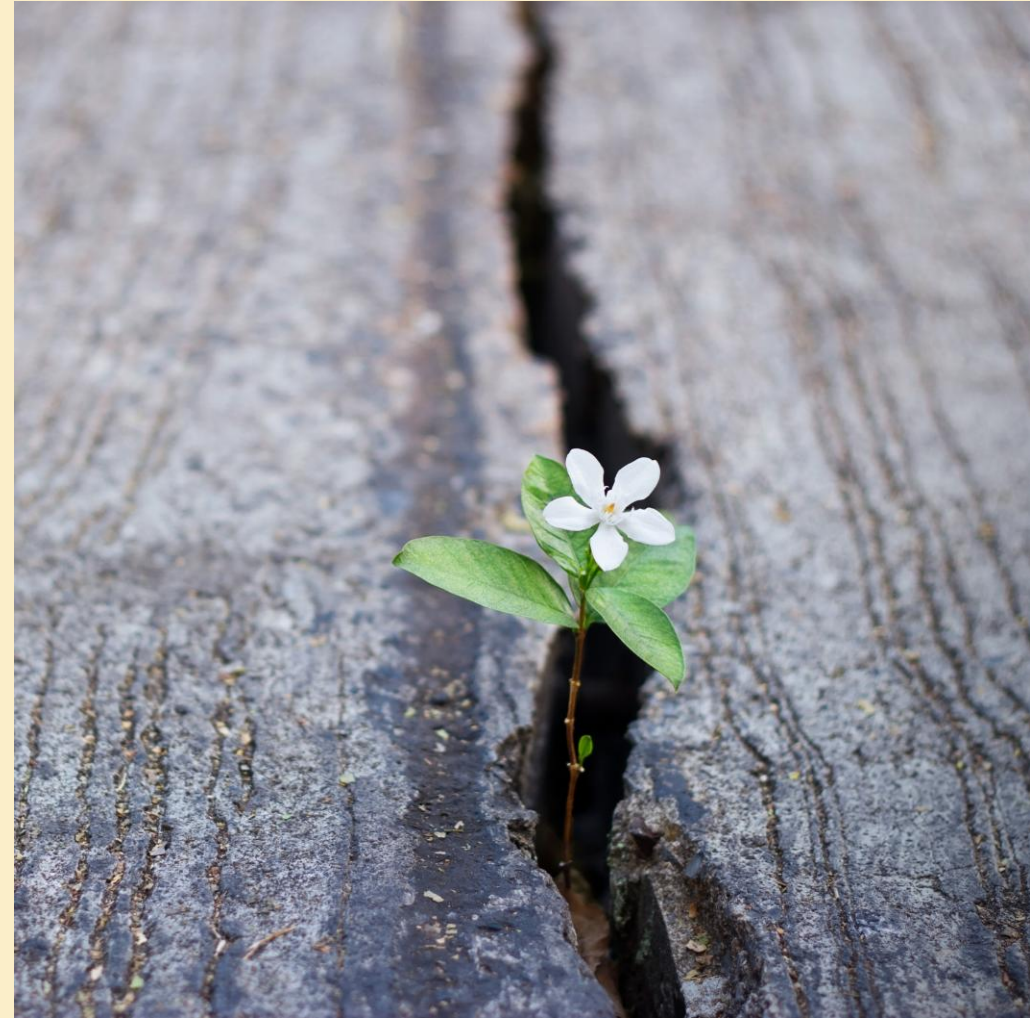


Strengths-Based Principles – 4

Use specific intervention strategies that **target distress and suicidality.**

Treatment by diagnosis – not as effective

Remember – **Interventions can stimulate HOPE**



Strengths-Based Principles – 5

Despite embracing a strengths-based model. . . you will sometimes need to **be directive**, to **initiate protective action**, and be the **voice of authority** and rational decision-making in the room.



Strengths-Based Principles – 6

Recognizing the immense stress we carry in this role, **we practice excellent self-care**, including evidence-based happiness activities (learn more at JSF)

- We **support each other**
- We acknowledge and talk about our own emotional challenges
- We use the skills we teach
[Positive affect now!]



Medical Model vs. Strengths-Based

[Let's embrace both]

A Positivistic Philosophy

- Suicidal thoughts and behaviors **represent illness**; we need to intervene
- We are **authority figures** who know more about patient health than they do
- The student is a **suicidal person**
- We can **predict* and prevent** suicide
- We use **risk assessment** procedures and questionnaires
- We treat **mental disorders**

A Social Constructivist Philosophy

- Suicidal thoughts and behaviors are a **natural communication of pain**
- We **collaborate** to develop **individualized safety plans**
- The student is a **whole person**
- Suicide is mostly **unpredictable***
- We **individualize risk factors** and use **collaborative and therapeutic** assessment
- We treat student **distress and suicidality**

Part 3: Strengths-Based Tools for Suicide Assessment



Everyone Agrees: Always Ask Directly

Have you had thoughts about suicide (or dying)?

Say those words now. . .

[This does not “plant” the thought.]

Ask Directly II

Even if you do that wrong. . .

**Your intent and authenticity is more important than
“doing it right”**

**We can and will do better . . . and we will continue to
do better**

| #1 Assessment Skill/Tool: Normalizing

Ask **directly but PREP FIRST**

- Prep – **Role Induction** – Use the word suicide with limits of confidentiality
- Prep – **I will ask you personal questions**. For example, I'll ask about suicidal thoughts. Something you should know: Suicidal thoughts are common and not usually an indicator that people want to die. Thoughts about suicide are a sign of difficult life situations and painful emotions.

#1 Assessment Skill/Tool: Normalizing

Ask **directly AND normalize** the asking

- I've read that up to **50% of teenagers** have thought about suicide. Is that true for you? [Construction workers]
- People who are **oppressed and negatively judged** may think about suicide from time to time. Have you had thoughts about suicide?
- Normalize the asking: **"I ask everyone I see."**
- Acknowledge **"Thank you for sharing with me."**

#1 Practice: Use Normalizing Language

It can be difficult to find the right words in the moment. Practice. You don't need to use our words; it's better to use your words, words authentic to you and that fit your setting and population. [LGBTQ+ youth]



Reflection: Think of a patient and, **for practice**, imagine what you would say to convey the normalizing message (Jillian story)

| #2 Assessment Skill: Evaluate Ideation

Ask directly and then **evaluate ideation**

Disclosure is good news (it's a sign of trust; say “thank you”)!

- Trigger – What triggers your SI? What’s happening when. . .SI
- Frequency – How often?
- Intensity – All you can think? Or background? Whole brain?
- Duration – How long usually?

Termination – What’s going on when no SI?



Exploring Ideation Therapeutically

Assessment should be therapeutic

Tommy: Singing and poetry [self-expression]

Other examples:

- Sean – “Biking and playing basketball”
- Haley - “Snuggling with my dog”
- Chase – “Being with someone (or somewhere) that validates who I am”
- Cory – “Doing something meaningful with my niece or for my tribe”
- Your students?

#3 Assessment Skill: That One Thing (1/3)



- “If we could somehow **magically change** just one thing in your life that would eliminate your suicidal risk all together, what would that be?” (Jobes, 2023, p. 63)
- This question **points you** and the patient toward a treatment focus
- It also may **reveal** irrational expectations

That One Thing (2/3)



Possible “irrational” responses:

- “My mother would be alive”
- “I wouldn’t have been sexually abused as a child”
- “There would be no more hate”

What treatment targets are linked to these responses?

Turn and practice now . . . 😊

That One Thing (3/3)

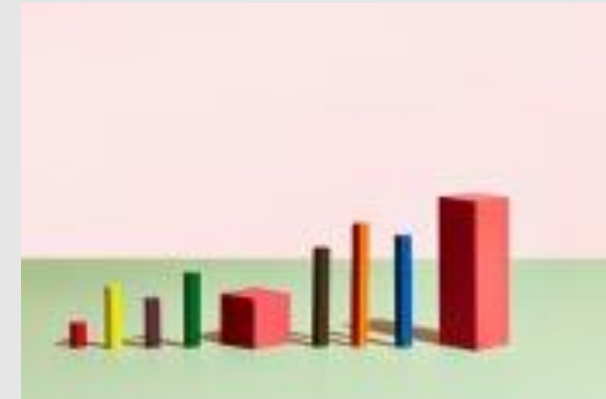


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- This question **points you** and the client toward a treatment focus
- It also may **reveal** irrational expectations

#4 Assessment Skill: Mood Scaling [11:25] with Suicide Floor

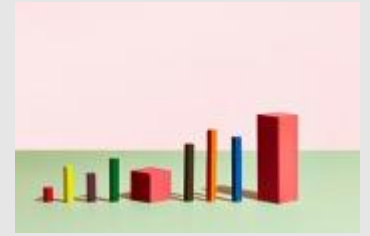
○ This is John's favorite **5-minute interview** strategy

○ Demo or **video**



○ May I ask some questions about **your mood?**

#4 “Script” for Mood Scaling



1. Rate your mood, using a zero to 10 scale. Zero is the worst mood possible. Zero means you're totally depressed and so you're just going to kill yourself. A 10 is your best possible mood. A 10 would mean you're as happy as you could be, maybe dancing or singing or doing whatever you do when you're extremely happy. Using zero to 10, what rating would you give your mood right now?
2. What's happening now that makes you give your mood that rating?
3. What's the worst or lowest mood rating you've ever had? What was happening to make you feel so down?
4. For you, what would be a normal mood rating on a normal day?
5. What's the best mood rating you've ever had? What was happening that helped you have such a high mood rating?

| Mood Scaling Reflections

- ✓ **Advantages:** More relational; we learn what improves mood and mood-lowering situations.
- ✓ **Disadvantages:** Time and lack of standardized norms.
- ✓ How might you use it (**variations**)?
- ✓ Other reactions?



Integrating Medical and Strengths-Based Models: The Minimal



Frame the Questionnaire Process

- I'm going to ask you nine questions from this questionnaire. These are important questions. I hope you'll answer them honestly.
- I want to know much more about you than what's on this questionnaire. When we're finished with the questionnaire, I want to learn more you.

More Integration

Sample with Columbia Questions

Have you been thinking about **how you** might do this?

Add: What thoughts do you have that make you feel like you don't want to die? (or how to prevent this suicide from happening)

Have you had these thoughts and had some **intention** of acting on them?

Add: Have you had thoughts and then decided not to act on them? What made you not act?

Have you started to work out or worked out the details of how to kill yourself? Did you **intend** to carry out this **plan**?

Add: Just to be balanced, we should work out a detailed and easy to enact plan to save yourself.

And More Integration |

Combine Two Approaches

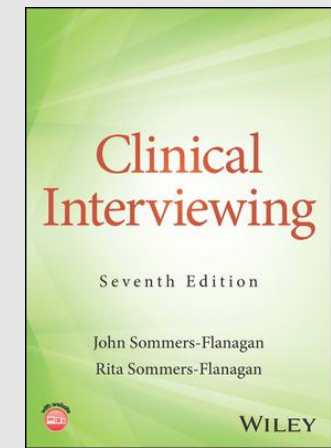
Example: Use a questionnaire and. . .



Add the Mood Scaling with a Suicide Floor to start generating ideas for treatment

Balance Questions: If you ask about RFD,
then ask about RFL

For Additional Assessment Info



The comprehensive suicide assessment interview (RIPSCIP) <https://johnsommersflanagan.com/2016/02/06/r-i-p-s-c-i-p-an-acronym-for-remembering-the-essential-components-of-a-suicide-assessment-interview/>

Need a PHQ-9 or C-SSRS alternative? David Jobes recommends the ASQ Toolkit.pdf: <https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials>

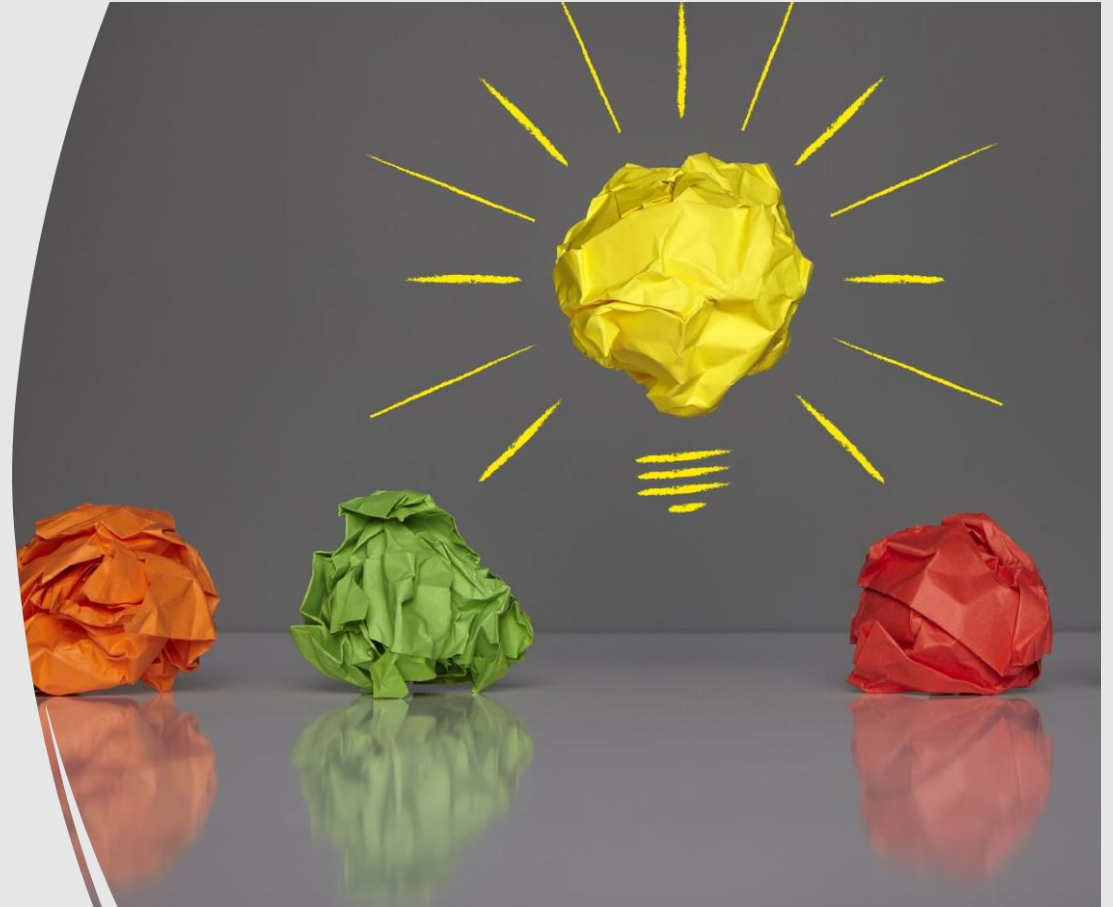


Assessment Reflections: Notice. . .



1. Q and R on Assessment
2. What feels challenging?
3. Where do you need or want practice?
4. Prizes??

Part 4: Strengths-Based Suicide Interventions



A Treatment Planning Model

Seven Organizing Life Dimensions

1. **Emotional** [Core: Excruciating distress]
2. **Cognitive** or Mental [Mental constriction, “nothing helps”]
3. **Interpersonal** [Social disconnection or perceived burden]
4. **Physical/Biomedical** [Agitated, impulsive, ill, and drugs]
5. **Spiritual/Cultural** [Meaninglessness or disconnection]
6. **Behavioral** [Suicide plan/intent, lethal means, desensitization]
7. **Contextual** [Sociological, political, oppression, poverty, and other environmental stressors]

| 1. Emotional Dimension

Main Treatment Planning Targets

1. Excruciating Distress [Psychache]
2. Affect dysregulation
3. Acute or chronic shame, guilt, sadness, or anger (***something wrong with the self***)



Case – Kennedy – Opening

Kennedy is a 15-year-old referred by her parents for depression/suicide ideation [Simulation]

Watch for:

- Opening statements and focus
- Collaboration?
- First mention of suicide
- The “gun” mention
- Individualized distress and risk
- What makes Kennedy suicidal?

00:01:38:15



Case – Kennedy – Opening

Kennedy is a 15-year-old referred by her parents for depression/suicide ideation [Simulation]

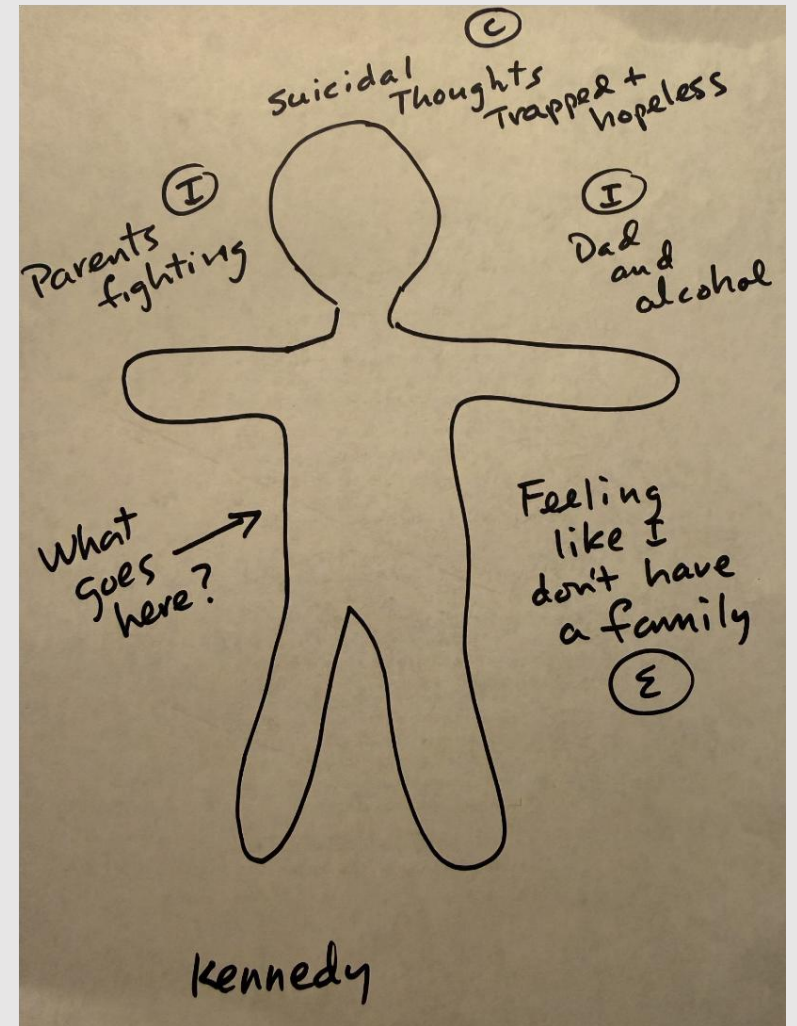
Watch for:

- Opening statements and focus
- Collaboration?
- First mention of suicide
- The “gun” mention
- Individualized distress and risk
- What makes Kennedy suicidal?

Emotional: Separate Pain from Self

Label problems (even emotions and diagnoses) and PAIN **outside the person**

Put strengths, strategies, and skills **inside the person**



| Emotional: Dysregulation and Regulation

We want Kennedy to learn emotional regulation tools

- DBT (Linehan): Mindfulness+
- Distress tolerance: Just breathe + Cold water splash
- Wise mind

Clients will have idiosyncratic regulation methods. . .
[Use: Yes. . . And]

2. Cognitive Dimension



Main Treatment Planning Targets

1. Problem-Solving Impairment
2. Hopelessness
3. Negative Core Beliefs

ALTERNATIVES TO SUICIDE

- Shneidman Story – An intervention for mental constriction
- Kay story
- Final story [Later]



NEGATIVE CORE BELIEFS

- Mark them using “**Active listening.**”
“Sometimes . . .” [Core beliefs are activated; when are they off; when are they on?]
- “**Sometimes** the way you talk makes me think you think there’s something wrong with you.”
- Explore, and **bookmark** for later [CBT].
- What’s Good About YOU? **What’s bad??**



3. Interpersonal [Social]



Main Treatment Planning Targets

1. **Unwanted Social Disconnection*** [aka thwarted belongingness; Joiner]
2. Social Skill Deficits
3. Feeling Like a Social Burden

THE CHASE VIDEO (7 MIN) – WATCH FOR

Cognitive Interventions

Interpersonal interpretation of a longstanding pattern

Building hope from the bottom up

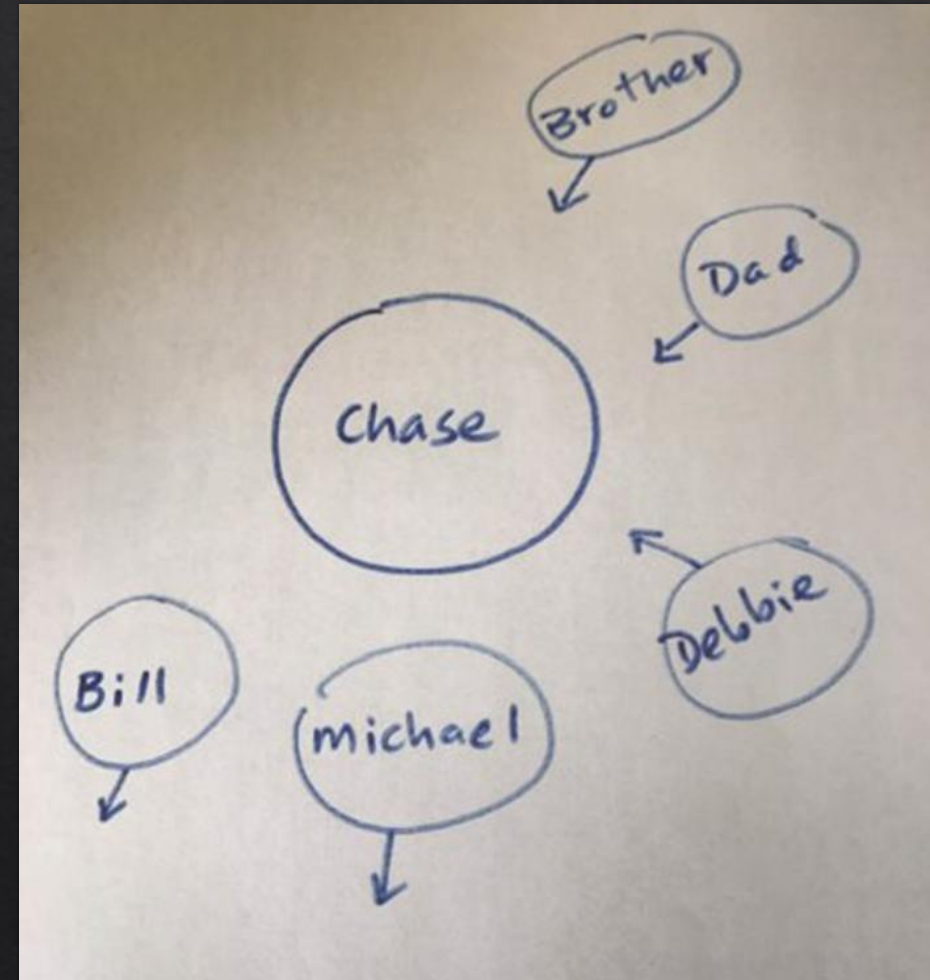
Social Intervention

Chase's social universe



Hope From the Bottom Up

- ◆ Who gives you validation?
- ◆ “No one gives me validation.”
- ◆ Who is the most toxic person in your life?
- ◆ “Bill”
- ◆ Who’s the next most toxic?
- ◆ Michael
- ◆ Who’s neutral?
- ◆ Debbie



SOCIAL UNIVERSE SKILL

How might you use
this **social universe
assessment**
therapeutically?

Building hope
(continuum) from
the bottom up

 **Victor Armstrong, MSW** ✓
@1of2vics

Severe depression and suicidal thoughts can make you feel weak, helpless, and hopeless but you are stronger than your thoughts. You have the courage and strength it takes to choose life even when your mind tells you life is too painful, and death is the only option. #StopSuicide



Relevant people

 **Victor Armstrong, I** ✓
@1of2vics Follows you Following
VP for Health Equity & Engagement at AFSP | Advocate for Social Justice |
Podcaster | Tedx Speaker | afsp.org |
[@strongtalkpod](https://twitter.com/strongtalkpod)

SOCIAL CONNECTION

Getting connected can be with you, in-person, or online.

Finding relatable people who generate hope is important.

This is **Victor Armstrong** who gives encouraging and insightful messages on Twitter (X).

4. Physical Dimension



Main Treatment Planning Targets:

1. Arousal-Agitation
2. Trauma, insomnia, nightmares
3. Physical symptoms of depression

Cory and Trauma and Culture

➡ 1:48:01 – 1:54:48

➡ Cory is a 28-year-old member of the Lakota-Sioux tribe and Iraqi war veteran

Cory Debrief – Chat Time

- What do we know about Cory in the emotional, cognitive, interpersonal, and other dimensions?
- What barriers are there to working with Cory on emotions? [Your patients?]
- What will goal-setting look like with Cory?
- What are your thoughts on his risk level?

Case Formulation and Planning - Cory

Problems or Chief Distress

- **PTSD and Alcohol Abuse:** War trauma; intergenerational trauma; alcohol use for numbing
- **Emotional:** Shame, anger, nightmares
- **Cognitive:** Mental constriction
- **Interpersonal:** Social disengagement
- **Cultural/Spiritual:** Tribal disconnection
- **Behavioral:** Destructive impulses [no intent + reasons for living]

Interventions [to Move Toward Goals]

- **Cognitive:** Collectivist goal-setting [in-session]
- **Emotional:** Reframe talking about emotions as a strength he can share [this will take time]; use IRT
- **Interpersonal:** Weekly contact with niece via telephone. Build community at UM
- **Cultural/Spiritual:** Brainstorm and enact tribal connections
- **Behavioral:** Addictions counseling; collaborative safety plan

Collaborative Goals

- **Cognitive:** Stay focused on collectivist goals
- **Emotional:** Increase positive affect; engage in trauma work*; practice culturally accepted shame/anger expression
- **Interpersonal:** Increase meaningful local and tribal community interactions
- **Cultural/Spiritual :** Re-establish sense of social/community identity
- **Behavioral:** Enact safety plan as needed

TRAUMA, INSOMNIA, NIGHTMARES

TF-CBT, EMDR, CPT . . .

CBT-I

Imagery Rehearsal Therapy (IRT)

WHAT IS IRT?



Imagery rehearsal therapy (IRT) is a cognitive-behavioral treatment for reducing number and intensity of nightmares

Empirically supported treatment

Commonly used in persons with PTSD who experience chronic nightmares

Relatively simple and short-term

Does not require clients to relive trauma event.

FOUR STEP APPROACH

DEMO?

1. **RECALL** NARRATIVE OR CENTRAL ELEMENTS OF THE NIGHTMARE.
2. **REWRITE** THE NIGHTMARE. “CHANGE IT ANYWAY YOU WISH.”
3. **REHEARSE** THE NEW DREAM FOR AT LEAST 5-20 MINUTES EACH DAY AT TIME OF CLIENT CHOOSING AND BEFORE FALLING ASLEEP INVOKE INTENTION.
4. **REPEAT** AND CONTINUE TO PRACTICE WITH 1 TO 2 NEW DREAMS A WEEK.

| 6. Behavioral [12:10]

Main Treatment Planning Targets

1. Suicide (Rehearsal) Desensitization

2. Lethal Means

3. Suicide Intent and Planning*

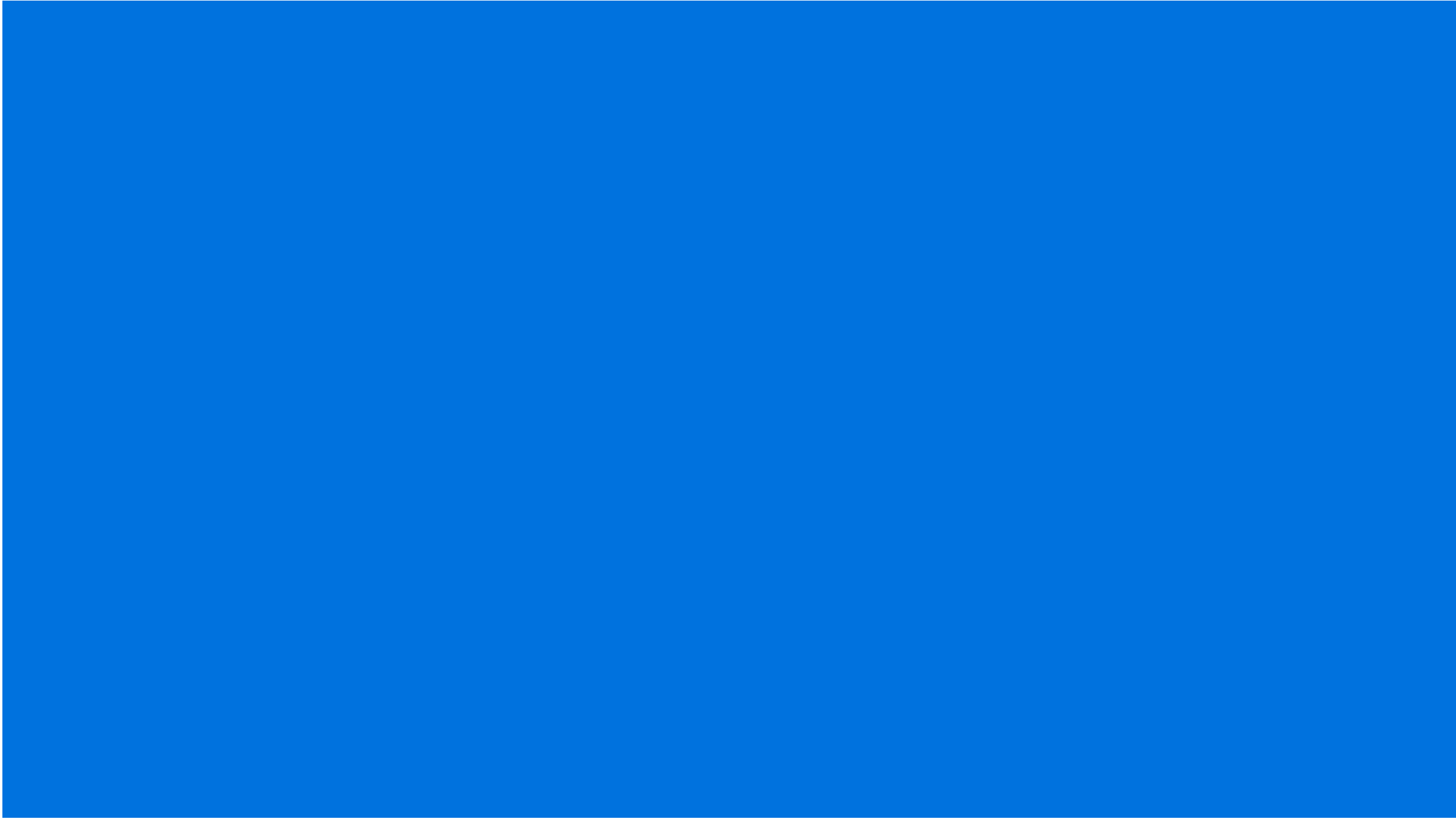
| **COLLABORATIVE Safety Planning**

- How Can I Make My Environment Safe?*
- My Unique Warning Signs
- My internal Coping Strategies
- People and Settings that Provide Support and Distraction
- Who Can I Ask for Help?
- Professionals or Agencies I Can Contact for Support
- How I Can Make My Environment Even Safer?

COLLABORATIVE Safety Planning II

- Follow the Stanley and Brown SPI protocol – or whatever your agency is using
- Be explicitly collaborative and compassionate
- To watch an 8-minute safety planning example of JSF with Kennedy: <https://johnsommersflanagan.com/2021/03/30/how-to-do-suicide-safety-planning-a-case-example/>

Optional: Safety Planning with Kennedy: <https://www.youtube.com/watch?v=jd7PM9HFDO4>





Closing Story

The Bridge

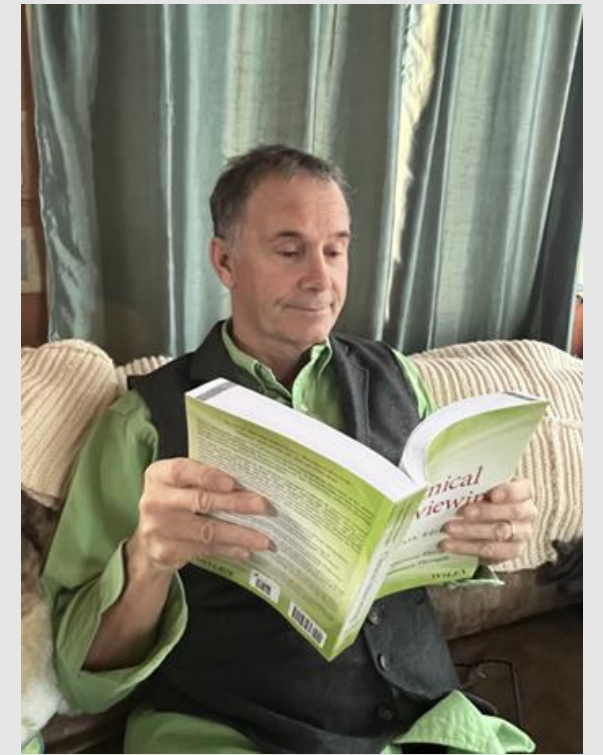
| How About You?



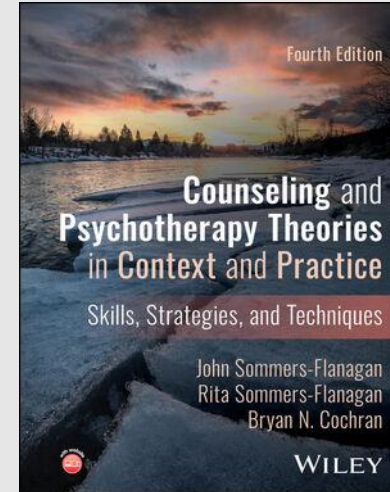
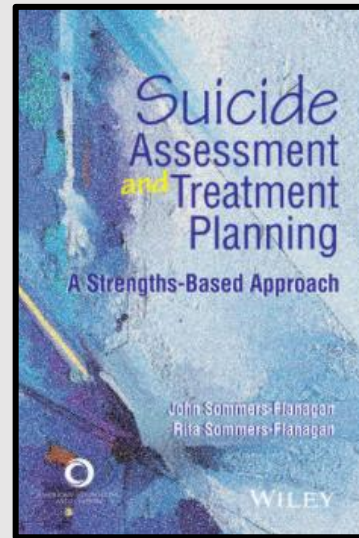
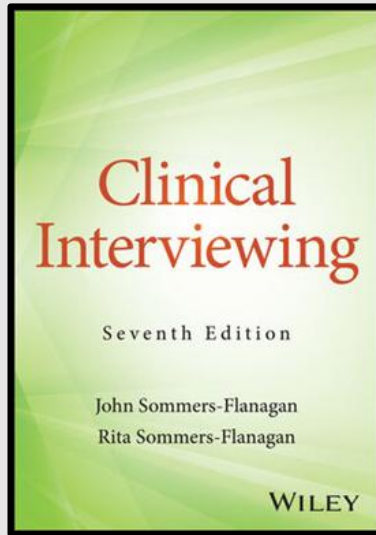
- What do you want to remember?
- What can you implement soon?
- **Thanks for being you . . .**
- Monitor and take care of yourself and your colleagues

| Resources

- <https://montanahappinessproject.com/>
- <https://johnsommersflanagan.com/>
- <https://www.umt.edu/education/cape/>
- Janssen et al., 2025: Cognitive Behavior Therapy With and Without Narrative Assessment and Suicide Attempts: A Systematic Review and Meta-Analysis
<https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2841680>
- Rudd, M. D., & Kratholm, O. (2026). Brief Cognitive–Behavioral Therapy+ as a suicide-specific treatment add-on. *Practice Innovations*. Advance online publication. <https://doi.org/10.1037/pri0000327>



Books by... JSF





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Zone

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Bonus Information: On Predicting Suicide

- “The U.S. Preventative Services Task Force concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for suicide risk in children and adolescents” (2022, October)
- Suicide screening (in low base rate settings) is not without risk
- About 15-20% of those screened may feel emotionally WORSE; early childhood/adolescent labelling can be problematic
 - “. . . there is currently little to no data to show that screening decreases suicide attempt or deaths rates” [Cwik, M. F., O'Keefe, V. M., & Haroz, E. E. (2020)].
- That doesn't mean we should not ask – Asking directly is a different issue

The Columbia (C-SSRS)

Two Opening Questions

1. Have you wished you were dead or wished you could go to sleep and not wake up? **[Passive suicidality]**
2. Have you ~~actually~~ had any thoughts about killing yourself? **[Suicidal ideation]**

Actually

- You shouldn't use the word "Actually"

The Columbia – Next Three Questions

3. Have you been thinking about **how you** might do this?
4. Have you had these thoughts and had some **intention** of acting on them?
5. Have you started to work out or worked out the details of how to kill yourself? Did you **intend** to carry out this **plan**?

The Columbia – Always Ask

6. Have you done anything, started to do anything, or prepared to do anything to end your life?

Examples: Took pills, tried to shoot yourself, cut yourself, tried to hang yourself, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump, collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, etc.

If yes, was this within the past 3 months?

The Columbia – Limits and Problems

The question on the Columbia that has limited predictive value is #6 (the previous attempt/prep question). . .

Problems

False positives – Passive SI, SI, intent, and suicide planning have low predictive value. Previous attempt* is likely better, but not good.

False negatives – Suicide is frequently impulsive, often coupled (coal gas in UK), and not pre-meditated.

Machine Learning option – But we still have to interview