Overview

Although the guidelines below are general guidelines for the assessment of suicidality, they were written specifically for cases where students or research participants have endorsed some significant suicidality on a questionnaire or in the context of an interview. Before detailing what to ask and how to ask it, you should know that your duty is to assess imminent risk. If there is no imminent risk, you have met the letter of the law, but it still can be useful to assist the person in finding some assistance, by providing referrals for example. Imminent risk means that there is a reasonable chance the person may cause harm to him or herself in the near future (today, tomorrow, this week, or a specified time thereafter [e.g. on an anniversary]). In cases of imminent risk, confidentiality can be broken, by calling a crisis agency to assess the person. In the introductory psychology screening pool, there is rarely imminent risk, and even in cases where there might be imminent risk, breaking confidentiality is rarely required, as the person will often agree to be seen by a crisis agency.

If phoning in response to a survey, the clinician should clearly state up front why the call is being made; e.g., “Hello, this is __________. I am a graduate student in the Department of Psychology. Last week you participated in the large-scale survey, and I am making a routine follow-up call to everyone who answered one particular question in a particular way – that was the question concerning thoughts of death or suicide. I am calling now ask you to tell me a bit more about those thoughts, and to see if there is any assistance we might provide. Do you have a couple of minutes?”
It is obviously best to speak to the person upon first contact. If they are busy, make a tangible plan for when you can talk to them. Ask them to suggest a time, and then make a firm commitment to that time. If upon first call you receive a message machine, you cannot disclose the reason for your call since this may constitute a breach of confidentiality if the student or research participant has a roommate or partner living in the same house. In such cases, it is best to request a return call in a specific window of time at a number where you know you can be reached; e.g., “This is ______ from the department of psychology, and I need to clarify something from the large survey you completed last week. It is important, and I hope you can call me at ______ between ___ and ___ on __________.” If they do not call, call back later in the day or the next day. Do not “pester” the person, but do be persistent shy of being a pest.

Once you have the person on the line, and have disclosed the reason for your call, it is best to begin with some open-ended questions such as “Tell me what kinds of thoughts you have been having.” Other useful prompts would include “How often do you have such thoughts?”, “How strong are these thoughts?”, “Have these thoughts been so strong that you have thought of doing something about them?”, “When you have these thoughts, tell me what you say to yourself.”, and “When you have these thoughts, what happens next?” It is also often helpful for the person to know that he or she is not the only person with such thoughts, and that in fact such thoughts are rather common among students at the University of Arizona.

Assessing Risk

One may conceptualize risk for suicide in terms of the increasingly serious levels of thoughts, plan, means, and intent:
Framework for Screening

- **Thoughts:** Suicidal thoughts can range from passive thoughts such as "I wish I wouldn't wake up" to more active thoughts such as "I wish I were dead" or "The world would be better off if I just killed myself" to even more seriously active thoughts such as "I want to kill myself." Active thoughts typically pose greater risk than passive thoughts.

- **Plan:** Without a plan on how suicide will be carried out, thoughts alone do not pose an imminent risk (although they may still pose a longer-term risk). The seriousness of the plan can range from a vague plan (e.g. "Maybe I'd jump off something") to something more concrete (e.g. "I'd probably jump from a cliff") to very specific ("I'd asphyxiate myself in the car in the garage"). Greater risk is associated with a more specific plan.

- **Means:** Even if a client has some level of a plan, the risk is realized only if they have (or can obtain) the means to carry out the plan. If a client indicates a plan (e.g., using a gun), it is important to assess whether the client possesses or could easily obtain the means to carry out the plan (e.g., the practitioner should ask "Do you have access to, or plan to get, a gun?"). Having the means to carry out a plan increases risk.

- **Intent:** Even given a plan and means, some individuals will have no intent to commit suicide, citing reasons such as "I haven't given up all hope yet" or "My children need me" or "My family would be devastated" or "It's against my religious beliefs." Intent can be conceptualized in three increasingly risky
categories: "Intent not to commit suicide," "Lack of intent not to commit suicide" (i.e., some uncertainty) and "Intent to commit suicide."

- **Behaviors:** Some suicidal behaviors can be preparatory, such as making sure that one’s affairs are all in order (e.g., writing a will) or distributing precious belongings to others. These activities may indicate increased risk.

The assessment of suicide risk progresses along the distinctions made above. Keep in mind that although the person may be at significant risk at the time you call, the thoughts or impulses may come and go. For that reason, it is important to get a sense of what goes through the person’s mind when they are in the midst of such thinking. You might say, for example, “So it sounds like you are not feeling that way right now, but you have at other times this week. At the time you had these thoughts, tell me what went through your head. … What happened next? … Were the thoughts so strong that they led to something more?”

If the student or participant’s response is quick or defensive, the clinician can attempt to put the person at ease by explaining that this thoughts may come and go. If the client had thoughts of death, the provider’s next task is to establish if these were passive or active thoughts and determine whether instruments of suicide are readily available. The third step is to consider whether the person has ever considered a specific method of suicide and whether or not the person intends to follow through with the suicidal ideas -- and why or why not. If the person had considered a specific plan in the past, it is important to follow up to determine what happened then, and to determine whether the person has ever translated these thoughts into actions, however tentative. When there are past incidents where a plan was considered, there are often factors that were important in stopping the plan from being implemented. Find out
what these are (e.g. “What stopped you from [shooting yourself/taking pills, etc]?”) The clinician should then determine whether similar factors are operative that might stop a plan if one exists at present. It can also be useful to compare the present episode to such a time, to get a sense of whether there is comparable risk at present; e.g., “Things must have been pretty bad that time; have they been that bad this time?”

It is also important to keep in mind that some people’s suicidal thoughts and intentions can change rather rapidly. For this reason, all people with suicidal ideation should have a list of crisis numbers that they may call. People are especially likely to increase their suicidal thoughts and risk if they are under the influence of alcohol. Alcohol, in addition to being a central nervous system depressant, impairs judgment and can increase impulsivity thereby increasing the risk for suicide. Intoxication by drugs -- prescription or illegal -- can also increase risk by impairing judgment, by depressing central nervous system function, or (depending on the drug) by serving as a lethal means for attempting suicide. Other important factors that increase the risk are a previous suicide attempt and living alone (or no one home when the suicidal impulses occur). It is important, however, to realize that even in absence of these risk factors, suicide risk should be taken very seriously. Moreover, even when person’s depressive episode is “situational”, appearing to be an understandable reaction to a serious life condition, the person is no less likely to die by suicide than a patient in an episode of “endogenous” etiology (Fawcett et al., 1990).
The student clinician is advised to consult with a senior clinician whenever any doubt about the safety of the person arises. Even if a person fails to demonstrate the risk factors listed above, but the student clinician has an intuitive feeling that risk may be present, a consultation is in order. If a person has passive suicidal thoughts and a clear plan not to commit suicide, no consultation is necessary, although it is still encouraged if the student clinician feels that any risk may exist. If more serious thoughts or intent are mentioned, a mental health professional should be contacted immediately -- while the client is still in the on the phone.
There are numerous resources available to you both on and off campus:

### Counseling & Psych Services (CAPS) at UA Student Health

Call 24 hours a day, 7 days a week: (520) 621-3334

*They have therapy and medications options. Walk-in or Triage available M-F from 9am to 4pm.*

Getting started:
https://caps.arizona.edu/appointments

### Behavioral Health Clinic (BHC) in UA Psychology Department

Graduate student therapists in training, supervised by licensed psychologists.

~$20 per session

Getting started:
https://psychology.arizona.edu/bhc
(520) 621-1579

In the event of an emergency and you are off-campus or otherwise unable to access the resources available on The University of Arizona main campus, then other locations are available to you. These include, but are not limited to:

- **Emergency:** 911
- **Southern Arizona Mental Health Corporation (SAMHC) Mobile Team:**
  - They will come to you
  - (520) 622-6000 (Mobile team)
  - samhc.com
- **Palo Verde Hospital:**
  - 2695 N. Craycroft Tucson, AZ 85712
  - (520) 322 - 2888
- **St. Mary's Hospital:**
  - 1601 W St. Mary's Road Tucson, AZ 85745
  - (520) 872-3000
- **National Suicide Prevention Lifeline:** 988
- **Banner - University Medicine Crisis Response Center:**
  - 2802 E District St, Tucson, AZ 85714
  - (On South U of A Medical Center on Ajo Way)
  - (520) 301 - 2400
- **St. Joseph's Hospital:**
  - 350 N. Wilmot Road Tucson, AZ 85711
  - (520) 873 - 3000
- **Tucson Medical Center:**
  - 5301 E. Grant Rd. Tucson, AZ 85712
  - (520) 327 - 5461

**What are risk factors for suicide?**

Suicide risk is commonly assessed along a gradation of cues that include thoughts, plans, means, and intent. Generally, increasingly serious undertones in any of these categories indicate an increased risk for suicidal behaviors, but often times there is a progression through these categories. Thoughts indicating suicide risk generally include beliefs that passively or actively lower the self-worth of the individual. Such thoughts include “I wish I wouldn't wake up” or “I wish I were dead.” Plans that heighten an individual's risk for suicide include those that detail some form of committing suicide. More vivid depictions often confer a heightened risk because the amount of detail suggests more though spent on the subject. Means provide an avenue to fulfill the individual’s plan, and the individual’s level of access to instruments for their plan increases his or her risk. Finally, intent reflects how uncertain or committed the individual is to fulfilling their plan, and is assessed according to 1) an intent not to commit suicide 2) lack of intent not to commit suicide, and 3) intent to commit suicide.