694A Suicide Assessment Framework

1. Start the conversation
   a. Normalize the conversation. For example, “I want to follow up on some of your responses to get a little more information.”
   b. Restate the endorsed item to anchor the conversation. For example, “Specifically, you agreed with the following statement [read the endorsed MMPI-2-RF item(s)]. Is that correct?”
   c. Allow the participant to respond. Either way the participant answers, you will follow up, but this will start to give you an idea of what’s going on.

2. Assess suicidal thoughts
   a. Example: “have you been having thoughts about death or suicide lately?”
   b. Assess whether suicidal thoughts, if present, are passive or active
      i. Passive example: I think about suicide but don’t wish I were dead OR wish I were dead
      ii. Active example: I want to kill myself
   c. Assess frequency and duration of thoughts
      i. Every day? Multiple times per day?
      ii. Do the thoughts pass easily, or do you keep thinking about suicide for minutes/hours?

3. Assess suicidal plan
   a. “Have you thought about how you would die/commit suicide?”
   b. “Do you have a suicide plan?”

4. Assess access to means
   a. Does the participant have access to the means of suicide in their stated plan?
      For example, “do you own or have access to a gun? Do you know where you would get one?”

5. Assess intent
   a. “Do you have a plan for when you would commit suicide?”

6. History of suicide attempt
   a. Have you ever attempted suicide in the past? What happened?
      i. Assess for severity of attempt, both objective and expected lethality and chance of being discovered
   b. What were the circumstances
      i. Are current circumstances better/same/worse?

7. Other risk factors to assess
   a. Age
   b. Race
   c. Sexual orientation
   d. Gender identity
   e. Religion, and beliefs of what happens after death or if you commit suicide (assess for non-religious people as well as religious)
   f. Marital/relationship status including any recent arguments or breakups
   g. Relationship with parents/family
   h. Impulsivity – “have you done anything risky or impulsive lately? Or have you done anything without thinking about it first?”
   i. Alcohol and substance use – types of substances, frequency of use, amount of use, behavior and emotional state while intoxicated
j. Recent changes in mood
   i. Anger, fear, depression, isolation, hopelessness

8. Recent events/triggers
   a. (If unknown) “Did something happen that made you feel that suicide is the only option?”
   b. Death of loved one, especially suicide
   c. Dream-killers – has anything happened that has made previous high priority goals impossible. Breaking up with your “one true love,” not getting a particularly important scholarship, losing a valued job, etc.

9. Suicide-related cognitions
   a. Helplessness/locus of control
      i. Do you think there’s anything you can do to improve [your situation]?
      ii. Any alternative ways to reduce distress other than suicide?
   b. Hope for the future or that problems will improve?
   c. Assess thoughts and plans for the future – plans for this and next semester (academic, social, vocational)? Plans post-graduation?
      i. You as the clinician should consider whether these plans realistic

10. Actions
   a. Have you given away your possessions?
   b. Have you written goodbye letters?
   c. Have you had a feeling or peace or resolution (this can follow the final decision to commit suicide – there’s no longer any ambivalence)

11. Instill hope
   a. “Why are you alive now? You’ve described so much pain, how have you managed to stay alive?” Focus on strengths and resiliency
      i. Will that reason still be around for the foreseeable future?
   b. You weren’t suicidal before – what’s changed? Is that change certain? Is it irreversible? Is the information about the change reliable?

12. If participant appears to be at imminent risk of suicide, refer directly to treatment
   a. Walk participant over to CAPS, if willing
   b. Call 911 or the MAC team