# Guide to Suicide Assessment

Developed by David J. Knesper MD, Department of Psychiatry
University of Michigan; last revised 3/03

## 1. Facts That Pertain to Risk and/or Trigger Suspicions:

**Self-assessments (e.g., Beck Suicide Scale):** Like risk factors, self-rating scale information is used to alert you to intent, deceit and estimates of probability.

**SAD PERSONS (risk factors):** **S**ex, **A**ge, **D**epression (*especially with global insomnia, severe anhedonia, severe anxiety, agitation, and panic attacks*), **P**revious attempt, recent **E**thanol abuse, **R**ational thought loss, **S**ocial supports lacking, **O**rganized plan, **N**o spouse, **S**ickness.

**Other Facts:** Diagnoses (especially major depression, bipolar illness and/or psychosis), available means/weapons, recent life-altering events (death, divorce, etc.), command hallucinations, religious preoccupation, persistent hostile environment, frightened friends and relatives.

## 2. The Examination: *A detailed interview determines immediate dangerousness.* Absent suicidal ideation is misleading!

**Initial Approach:** Never accept the first "No." *The first attempt is the last for the bulk of all inpatient suicides.* Be non-judgmental, calm and matter-of-fact. Validate the patient's right to view suicide as a rational solution. Understand the detailed, step-by-step evolution of thought and behavior.

**Empathize:** Explicit questions about suicide intent are best explored *after* the person's situation is understood and validated (e.g., "When people are very upset…."). Suicidal behavior may be understood as a communication or solution. Over the course of understanding, cognitive-behavioral techniques may transform the suicide crisis and develop problem-solving skills and alternative solutions. Look for self-denigration, overgeneralization, catastrophic and/or black-or-white thinking, and other cognitive distortions.

**(*Strategies*) & Questions:**

a. (*Normalize*): When someone feels very upset, they may have thoughts that life just isn't worth living. Have you had such…?

b. (*Challenge*): Your "No" does not convince me. Why wouldn't you want to kill yourself with all that's happened?

c. (*Chronologize*): Walk me through every step of the last two days. A "verbal videotape"….

d. (*Overestimate*): In the last two weeks, how many times did you think of killing yourself? Twenty or thirty times?

e. (*Prohibit*): What's going to prevent you from killing yourself? Persuade me that….

f. (*Homicide/Suicide*): The medical textbooks tell us that someone in your situation may have strong or just fleeting thoughts about killing _____ and then killing themselves. When have you had such thoughts?

g. (*Delve*): You didn't die. Was death your intention? Share what you have been thinking. What more…?

h. (*Eulogize*): If you were to die, what would your funeral be like? What meaning does your death have?

i. (*Corroboration*): The *standard of care requires* contact with corroborative source(s)—if necessary, without permission.

### 3. (*Issues*) & Disposition:

a. (*Inconsistency*): Do the risk factors and the reported ideation match? Is this person hiding information?
b. (*Impulsiveness*): Was there rehearsal and planning or sudden action? A note?
c. (*Severity*): What was the most serious past suicide attempt? What is the lethality of the actual or proposed method?
d. (*Archives*): What experience does this institution have with this person?
e. (*Precipitants*): Are the suicide motivators understood and what is their strength? Public humiliation (especially adolescents)? Insight? Is there a habit of manipulation?
f. (*Change*): As a result of this suicide attempt, what, if any, major changes have occurred in the environment from whence this person came?
g. (*Intoxication*): Was this person intoxicated at the time of the attempt?
h. (*Weapons*): Are weapons available? If so, have they been removed?
i. (*Compassion Fatigue*): Are clinicians too complacent, exhausted or angry to be effective?

### 4. (*Questions*) & Discharge Planning:

a. (*Alliance*): What is the strength of the therapeutic alliance? Is this person a partner in care planning?
b. (*Consultation*): Is there sufficient uncertainty to seek consultation about the standard of care?
c. (*Denial*): What other ways have you thought of killing yourself? Why not try...?
d. (*Persuasiveness*): How persuasive and believable is this person?
e. (*Safety*): What will this person do when suicidal thoughts return? Is there a *hand-written* safety plan? What are this person's future plans?
f. (*Skills*): What is this person's reaction to counseling? Has this person learned and practiced new skills and strategies for resolving intense affect, rage,…? How motivated for change is this person? Insight?
g. (*Companion*): Will someone leave with and stay with and *be involved with* this person? Support system?
h. (*Guilt*): Does this person understand a suicide's consequences for his/her children, parents, friends,…?
i. (*Sobriety*): What are the predicted consequences of further alcohol and/or drug use?

### 5. The No-Suicide Contract:

The most effective contract is the one the person writes and signs. *The suicide contract is an assessment tool.* The process of negotiating the contract is a window on deceit and ambivalence. When the contract is completed, make eye contact and shake hands.

### 6. The Discharge:

This person must leave in the company of a spouse, relative, close friend…someone. Prior to discharge there is a meeting between the person and involved others. During the meeting there is an explicit discussion about the level of comfort in sharing and asking about suicidal issues. There is agreement on post-discharge plans and the availability of lethal weapons.

References: See "Suicide: Documentation and Risk Management Guidelines."