Suicide Assessment & Response

In-Session Quick Reference

IDENTIFY → UNDERSTAND → RESPOND → DOCUMENT

Use this as an orientation aid alongside validated tools, clinical judgment, consultation, organizational procedures, and applicable law and ethics. It does not replace comprehensive assessment.

IDENTIFY

Follow the client's language first, then ask directly when clarity matters.

Ask:

"Have you been having thoughts of suicide?"
"Have you been having thoughts of harming yourself?"
"Are you thinking about suicide right now?"

When appropriate, use the **NIMH Ask Suicide-Screening Questions (ASQ)**. A positive screen means **assess further**, not that a particular disposition has already been determined.

UNDERSTAND

Clarify the clinical picture:

Current SI: Now? Most recent?
Passive vs. active: Wish to die/disappear or intentionally end life?
Pattern: Frequency, duration, intensity, controllability, change from baseline.
Method: Thought about how?
Plan: Specific plan, timing, or location?
Access: Access to lethal means?
Intent: Intend to act? How close to acting?
Behavior: Preparation, recent/past attempts, aborted or interrupted attempts.
Self-harm: Assess separately from suicidal intent.
Acute change: What changed? Consider losses, symptoms, substances, agitation, impulsivity, hopelessness, isolation, sleep disruption, and other destabilizing factors.
Meaning: What does suicide seem to offer? What feels unbearable?

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Tethers: What keeps them here? Who can help?
Safety: Can they maintain safety? What would they do if thoughts intensify?

Notice movement toward action:
Passive death wish → active SI → method → plan → access → intent → preparation/recent suicidal behavior → inability to maintain safety

This is not a scoring scale and is not necessarily linear. Increasing specificity, intent, behavioral movement, access, and decreasing ability to maintain safety generally warrant increasing concern and further assessment.

Use the **NIMH Adult BSSA** for broader assessment and the **C-SSRS** when more specific clarification of suicidal ideation or behavior is needed.

RESPOND

Safety planning can grow directly from the assessment.

Ask:

"What will tell you things are getting worse?"
"What can you try first?"
"Where can you go so you aren't alone?"
"Who can you tell directly that you are struggling?"
"What could become dangerous if the thoughts intensify?"
"How can we create more time and distance from that?"
"What would tell you that you need more help than you can manage at home?"

Use the **Stanley-Brown Safety Planning Intervention** when indicated. Address lethal-means safety, meaningful supports, barriers to using the plan, consultation, appropriate level of care, and follow-up/reassessment.

A completed safety plan does not, by itself, establish that outpatient care is appropriate.

If risk cannot safely be managed outpatient, follow emergency procedures, consult, and facilitate urgent evaluation or higher-level care as clinically indicated.

DOCUMENT

Capture the clinical story:

Why you assessed → what the client reported → SI characteristics → plan/access/intent/behavior → relevant risk and protective factors → current safety →

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interventions → safety/means planning → supports/consultation → disposition and rationale → follow-up/reassessment.

Avoid relying on *"denies SI/HI"* or *"continue to monitor"* alone.

Keep These Tools Close

ASQ → brief initial screening
Adult BSSA → broader suicide safety assessment
C-SSRS → additional specificity when needed
Stanley-Brown → collaborative safety planning

Remember

A positive screen is not a disposition. A client saying they can stay safe is not, by itself, proof of safety. Protective factors do not erase significant acute concern. When clinical concern and a tool do not align, continue assessing and consult.

Follow the client's story first. Ask directly when clarity matters. As concern increases, specificity increases.

Educational/informational resource only. Not a substitute for formal training, comprehensive clinical assessment, supervision or consultation, professional judgment, applicable law and ethics, organizational policies, emergency procedures, or the instructions for referenced clinical tools.

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