The Florida State University PSYCHOLOGY
THE LAB OF THOMAS JOINER, PH.D.

Joiner Lab—How to Assess Participants Identified as At-risk:

1) ***Boilerplate IRB Protocol***
2) ***Actual Assessment for At-risk Participants***
3) ***Suicide Assessment Decision Tree***
4) ***Risk Category Designations***

1. BOILERPLATE IRB PROTOCOL

Appendix from:

Michaels, M. S., Chu, C., Silva, C., Schulman, B., & Joiner, T. E. (in press).

Considerations regarding online methods for suicide-related research and suicide risk assessment.

Sample Risk Assessment Protocol

All web-based participants will be required to provide a phone number where they can be contacted in the event that their scores on the {INSERT MEASURE NAME, e.g., BSS} indicate at least clinically significant current risk for suicidal behavior. {INSERT SURVEY SOFTWARE NAME}, an online questionnaire administration software package, will immediately total each participant's scores on the {INSERT MEASURE NAME, e.g., BSS} and send an email/text message notification to the investigators {INSERT INVESTIGATORS' NAMES AND EMAIL ADDRESSES}. The cutoff for clinically significant risk will be considered {INSERT CUTOFF RULE (SEE TABLE 1)}, e.g., a total score of at least 6 and also a score of "2" on items 12, 13, 14, or 15, or 16}. {INSERT INVESTIGATORS' NAMES} will contact at-risk participants at the phone number they provide within 15 minutes of receiving the notification email/text message to conduct an emergency screening/suicide risk assessment. To facilitate this process, the online questionnaire will only be available between the hours of 9:00 a.m. to 10:00 p.m. All phone numbers provided by participants will not be kept as part of their data files to ensure confidentiality. {INSERT INVESTIGATORS' NAMES AND DESCRIBE ASSESSMENT TRAINING EXPERIENCE IF APPLICABLE}.

For the emergency screening/suicide risk assessment above, level of risk will be assessed using Joiner et al. (1999)'s recommendations, which are as follows: Nonexistent risk is

designated if an individual has no current suicidal symptoms, no history of suicide attempts, and no or few other risk factors; Mild risk is designated if the individual is a multiple attempter with no other risk factors or is a non-multiple attempter experiencing suicidal ideation of limited intensity and duration, no or mild resolved plans or preparation, and no or few other risk factors; Moderate risk is designated if he or she is a multiple attempter with any other significant risk factor, a non-multiple attempter with moderate-to-severe resolved plans and preparations or moderate-to-severe suicidal desire and ideation accompanied by at least 2 other risk factors; Severe risk is designated if an individual is a multiple attempter with 2 or more risk factors or a non-multiple attempter with moderate to severe symptoms of resolved plans and preparations accompanied by 1 other risk factor; Extreme risk is designated if an individual is a both multiple attempter with severe resolved plans and preparations with severe resolved plans and preparations or a non-multiple attempter with resolved plans and preparations and two or more other risk factors.

Second, once an individual has been assessed for suicide risk, we will take the following actions, as recommended by Joiner et al. (1999): If an individual is at nonexistent or mild risk, he or she will be instructed to use self-control strategies and to seek out social support in the event that he or she becomes suicidal. If these strategies fail, he or she will be instructed to contact an emergency mental health resource or go to the emergency room, the phone numbers for which will be provided. If an individual is deemed to be at moderate risk for suicide, he or she will be given a list of steps to follow in case of an emergency, which will contain phone numbers for [INSERT LOCAL RESOURCE] as well as the [INSERT ADDITIONAL LOCAL RESOURCES], which are both appropriate mental health acute care providers; 911; 1-800-273-TALK (the National Suicide Prevention Lifeline); and the [INSERT OTHER APPROPRIATE

RESOURCE]. If the risk is imminent and immediate, then the [INSERT LOCAL CRISIS TEAM] will be contacted for further evaluation. If the participant refuses such further care, the investigator will call 911 so that the police can escort the participant to [INSERT CRISIS STABLIZATION UNIT(S)] for further care. Importantly, although one might be concerned that assessing suicide via questionnaires or direct questioning might have iatrogenic effects on participants, the evidence suggests that this is not the case—there is no evidence that assessment of suicide risk primes vulnerable populations to think about suicide (Reynolds et al., 2006) and, in fact, there is evidence to suggest suicide risk assessment may have positive effects with respect to reducing distress in at-risk individuals (Gould et al., 2005).

References

Gould, M. S., Marrocco, F. A., Kleinman, M., Thomas, J. G., Mostkoff, K., Cote, J., & Davies, M. (2005). Evaluating iatrogenic risk of youth suicide screening programs: a randomized controlled trial. *The Journal of the American Medical Association*, *293*(13), 1635-1643.

Joiner, T. E., Walker, R. L., Rudd, M. D., & Jobes, D. A. (1999). Scientizing and routinizing the assessment of suicidality in outpatient practice. *Professional Psychology, Research and Practice*, *30*(5), 447–453. doi: 10.1037/0735-7028.30.5.447

Reynolds, S. K., Lindenboim, N., Comtois, K. A., Murray, A., & Linehan, M. M. (2006). Risky assessments: participant suicidality and distress associated with research assessments in a treatment study of suicidal behavior. Suicide & life-threatening behavior, 36(1), 19–34.Reips, U.-D. (2000). The Web experiment method: Advantages, disadvantages, and solutions. In Michael H. Birnbaum (Ed.), *Psychological Experiments on the Internet* (89-114). San Diego: Academic Press.

2. Actual Assessment for Participants at Clinically Significant Risk or Higher

Suicide Risk Assessment

Danger Signs!!!	Talking about suicide → Agitation Insomnia Nightmares Social Withdrawal

Assess suicidal desire and ideation:

1. Have you been having thoughts of suicide? (thoughts of killing yourself?) Tell me about that.
2. Do you think about wanting to be dead?
3. Thwarted belongingness: Do you feel connected to other people? Do you live alone? Do you have someone you can call when you're feeling badly? [completely absent?]
4. Perceived burdensomeness: Sometimes people think: "the people in my life would be better off I were gone." Do you think that?

Assess Resolved plans and preparations:

5. Duration [look for pre-occupation]: When you have these thoughts, how long do they last?
6. Intent: How strong is your intent to kill yourself? 0 no intent at all, 10 definite intent
7. Past suicidal behavior: Have you attempted suicide in the past? How many times? Methods used? What happened (e.g., hospital?). Family hx?
8. Non-suicidal self-injury: Have you ever intentionally caused yourself physical harm by cutting, burning, or other means?
9. Specified plan [look for vividness, detail]: Do you have a plan for how you would kill yourself?
10. Means and opportunity: Do you have [the pills, a gun, etc.]? Do you think you'll have an opportunity to do this?
11. Have you made preparations for a suicide attempt? [e.g., buying pills]
12. Do you know when do you expect to use your plan?
13. Fearlessness: Do you feel confident you could attempt suicide? Do you feel afraid? 0 very afraid, 10 not at all afraid.

Assess "other significant findings":

14. Precipitant stressors: Has anything especially stressful happened to you recently? [death of loved one; divorce; major break-up; job loss]
15. Hopelessness: Do you feel hopeless?
16. Impulsivity: When you're feeling badly, how do you cope? Sometimes when people feel badly, they do impulsive things to feel better. Has this ever happened to you? [e.g., cutting your skin, drinking alcohol, running away, binge eating, promiscuous sex, physical aggression, shoplifting].
17. [Presence of psychopathology: rated by interviewer]

BSS ideation score = _____ (0-38)
[rule of thumb: ≥ 11 = clinically significant]

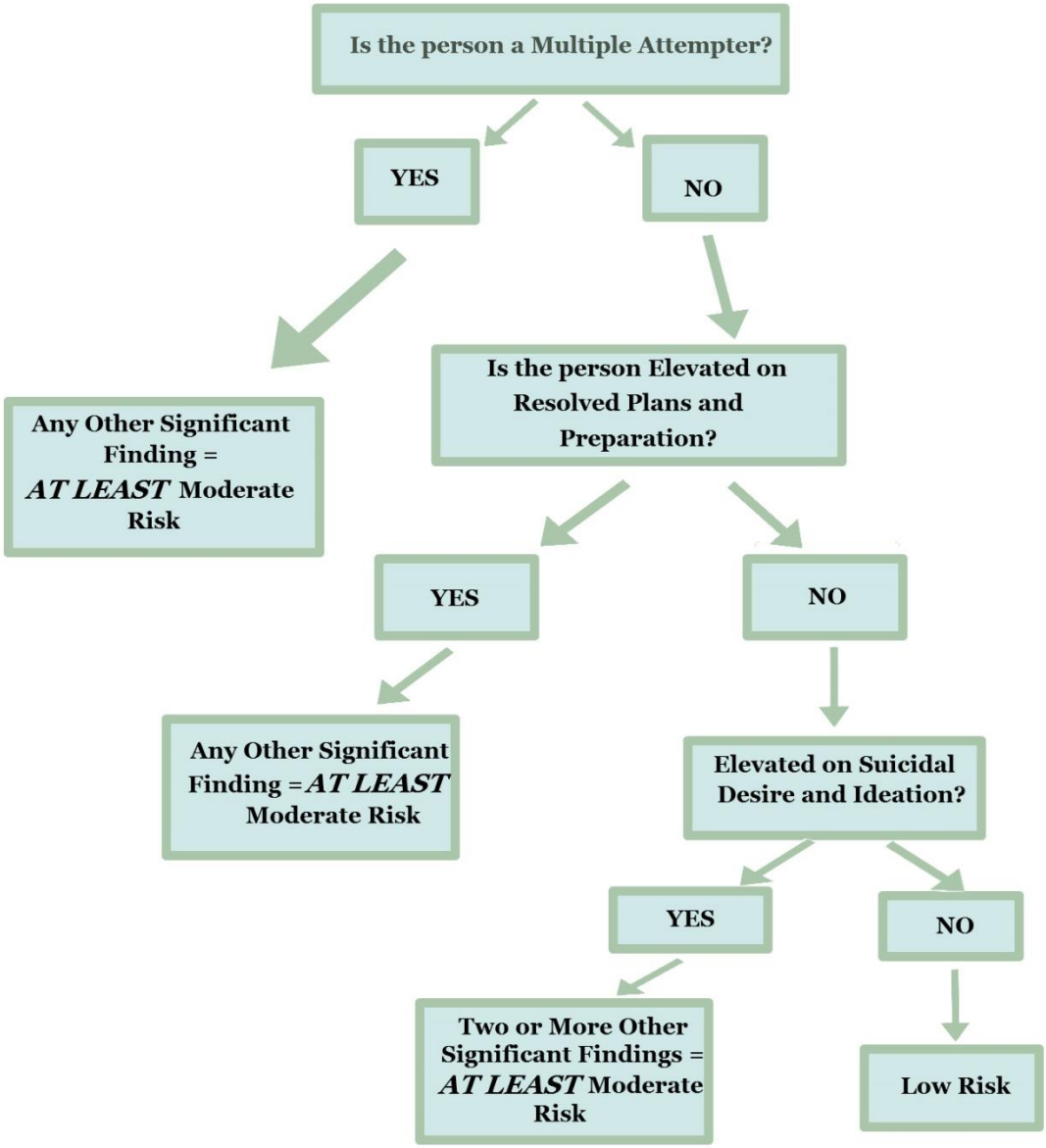
Actions taken:
- ❑ Will continue to monitor regularly;
- ❑ Given emergency numbers (incl. 1-800-273-TALK)
- ❑ Scheduled mid-week phone check-in;

Risk category (circle):
low moderate severe extreme

- ❑ Provided info about adjunctive treatment;
- ❑ Coping card
- ❑ Consulted Supervisor
- ❑ Other: _____

3. SUICIDE ASSESSMENT DECISION TREE

Joiner, T. E., Walker, R. L. Rudd, M. D., & Jobes, D. A. (1999). Scientizing and routinizing the assessment of suicidality in outpatient practice. *Professional Psychology*: *Research and Practice*, *30*, 1-7.



4. SUICIDE RISK CATEGORY DESIGNATIONS

RISK CATEGORIES

LOW:

- A person with no identifiable suicidal symptoms
- A multiple attempter with NO other risk factors OR
- A non-multiple attempter with suicide ideation of limited intensity and duration, no or mild symptoms of the Resolved Plans and Preparation factor AND no or few other risk factors

What to do if no current suicidal ideation:

- *Tell the client a variant on the following: "In the event that you begin to develop suicidal feelings, here's what I want you to do: First, use the strategies for self-control that we will discuss, including seeking social support. Then, if suicidal feelings remain, call [the emergency call person]. If, for whatever reason, you are unable to access help, or, if you feel that things just won't wait, call 9-1-1 or go to the ER."*
- *Give emergency numbers: including 1-800-273-TALK*
- *Continue to monitor risk in subsequent sessions (in case severity changes).*
- *Document activities in progress notes*

What to do if current suicidal ideation:

- *Give emergency numbers*
- *Create a coping card (a crisis response plan)*
- *Symptom-matching hierarchy*
- *Document activities in progress notes*

MODERATE:

- A multiple attempter with any other notable finding OR
- A non-multiple attempter with moderate to severe symptoms of the Resolved Plans and Preparation factor OR
- A non-multiple attempter with moderate to severe symptoms of the Suicidal Desire and Ideation factor (but mild or no Resolved Plans and Preparation) AND at least two other notable risk factors

What to do:

- *Give emergency numbers*
- *Create a coping card (a crisis response plan)*
- *Symptom-matching hierarchy*
- *Consider mid-week phone check-in's*
- *Inform about existence of adjunctive treatments (e.g., medication)*
- *Increase social support:*
  - *Encourage client to seek support from friends/family;*
  - *Plan with client for someone to check-in on him/her regularly;*
  - *Get client's permission for you to contact the person who will be checking-in.*
- *Document activities in progress notes*

[Severe] HIGH [Extreme]

- A multiple attempter with any two or more other notable findings, OR
- A non-multiple attempter with moderate to severe symptoms of the Resolved Plans and Preparation factor and at least one other risk factor

- A multiple attempter with severe symptoms of the Resolved Plans and Preparation factor, OR
- A non-multiple attempter with severe symptoms of the Resolved Plans and Preparation factor and two or more other risk factors

What to do:

- ***CONSULT a supervisor before the client leaves the clinic***
- *Consider emergency mental health options with supervisor*
- *Client should be accompanied and monitored at all times*
- *If hospitalization is not warranted, use steps from "moderate" category*
- *Document activities in progress notes*