Notes on using the IMV Suicide Risk Formulation Form (ISRFF)
[27-05-24] [beta version]

This form should be used as part of a risk formulation when conducting a psychosocial assessment. It is designed for use for those with suicidal ideation, who have attempted suicide or who may be suicidal. The form is usually completed by a mental health professional in collaboration with a person who is/may be suicidal. Although the form is organised into 5 sequential sections, the formulation is a conversation, so it does not need to be completed strictly in that order, however, all sections should be completed.

Section A. Demographics.
This first section asks about demographic characteristics. Gender, age, ethnicity, sexual identity, marital status and living arrangements are recorded as they are associated with increased suicide risk. Men are at increased risk of suicide, women are at increased risk of attempted suicide, trans men and women are at increased risk of suicidal thoughts and behaviour. Suicidal thoughts or behaviours are rare before puberty but can increase markedly during adolescence and suicide is the second leading cause of death among 15-29 year olds. Suicide is also leading cause of death for men aged 35-49 years and leading cause of death among men and women aged 20-34 years. Although the relationship between ethnicity and suicide risk is complicated, it is important to be aware of cultural influences such as stigma which may contribute to suicide risk. LGBTQ+ people are also at increased suicide risk as are those who are single, separated/divorced or widowed or living alone.

Section B. Pre-motivational phase: Background Factors & Triggering Events
As part of the risk formulation, the person is asked to tell their story, what led to the current crisis, what factors were central to their suicidal thoughts and/or behaviour and what triggered their suicidal thoughts and/or behaviour. In short, guided by the 'Five Ps' approach to formulation, vulnerability factors, environmental influences, and triggering events are explored.

Section C. Motivational Phase: Emergence of Suicidal Ideation or Suicidal Intent
In this section, individuals are asked to rate how they feel now, including in the past 24 hours. They are asked to make 7 Likert-type ratings in total. The first six items relate to feelings, derived from the IMV model, which are common factors associated with suicide risk, starting with 'I feel defeated'. It might be helpful to introduce the ratings to the person saying that some people who are suicidal find that these feelings are associated with their suicidal thoughts. The final rating asks the person to rate how suicidal they feel now. Each item is rated on a 1 to 5 scale. In addition, for the first six ratings, the person is asked to say what led them to feel that way and to write it down briefly. Some people may be able to pinpoint the cause(s) of their feelings easily, whereas others may find this difficult or simply don't know why they are feeling the way they are. Reassure the person that many people find it difficult to know precisely why they are feeling a particular way and it is okay if they don't know what led them to feel the way they do. The ratings should help to identify what feelings, thoughts and circumstances may be contributing to their suicidal thoughts and/or behaviours and, therefore, help to identify potential targets for treatment. If someone rates their suicidal feelings as extreme, explore whether they are at imminent risk of suicide and/or are able to keep themselves safe. If seeing the person more than once, they should complete the ratings

at each session to see how things are progressing. The ratings are not designed to yield a risk score, rather they are a guide to inform treatment planning. Consider using the answers to these questions as anchors to explore these feelings in more detail.

Section D. Volitional Phase: The Transition from Suicidal Thoughts to Suicidal Acts

The 8 questions within Section D are taken directly from the IMV model. According to the model, these questions distinguish between those who think about suicide and those who are more likely to act on their thoughts. There are three response options: [Yes, No, Don't Know]. Don't know is appropriate where the answer is not known, unsure, or not disclosed. When asking about impulsivity, consider that alcohol and drugs can make someone act more impulsively. Although it is difficult to assess someone's pain sensitivity, the question is trying to ascertain whether people are aware of the extent to which they can withstand physical pain. It might be helpful to frame this question in terms of how the person experiences pain. If being asked over time, perhaps ask about any changes in how they experience pain. Together with the fearlessness about death question, these two questions are tapping the capability for suicide; this is important as an individual has to overcome the life instinct and oftentimes withstand physical pain to carry out a suicidal act. Similar to Section C, the answers to the questions within this section should not be used as a checklist, but rather should be incorporated into the clinical dialogue and formulation.

Section E. Treatment Plan including Safety Planning

Whereas the previous sections have focused on risk and vulnerability factors, Section E explores an individual's strengths and protective or positive factors. It may be helpful to sensitively explore the nature of social support that a person may have available and explore different ways of coping, including challenges, barriers or difficulties. Thinking about reasons for living can be helpful, helping the person to identify specific reasons to stay alive. Using the information (and ratings) in Sections B and Section C (in particular), try to identify the main factor(s) that is (are) driving the suicidal thoughts. This should help to prioritise treatment planning. The treatment plan should include co-developed actions to manage these factors that are potentially contributing to their suicidal thoughts. This should normally also include the co-creation of a safety plan or reviewing and updating (if necessary) an existing safety plan. Ultimately, Section E is endeavouring to foster hope.

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