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BOOK REVIEW

Managing suicidal risk: a collaborative approach, by D.A. Jobes, New York, Guildford Publications, 2006, £21.00, ISBN 9781593853273

Reviewed by Dr Judi Miller, Senior Lecturer and Co-ordinator of Counsellor Education, University of Canterbury, New Zealand

Whilst the main title of this book *Managing Suicidal Risk* might suggest another 'how-to' book describing a suicide-risk assessment tool with limited clinical applicability, the minor title, *a collaborative approach* provides the clue that this is not the case. The author, David A. Jobes, has dedicated many years of his academic life to developing and researching the outcomes of a 'tool' that will help both clients and clinicians manage suicidal risk. The result is a comprehensive, easily read, logically presented, clinically relevant 'manual' designed to support clinicians, of any theoretical orientation, as they work collaboratively *with* their clients.

Jobes begins the book by outlining his rationale for developing the Suicide Status Form (SSF) and its administration using a process he calls the Collaborative Assessment and Management of Suicidality (CAMS). His motive was partly promoted by anecdotes and experiences of clinicians (including himself) who have felt helpless and incompetent when using established risk-assessment tools, hospitalisation and/or medication with seriously suicidal patients. He presents the Collaborative Assessment and Management of Suicidality as a clinical approach, and a therapeutic framework, that guides both clinicians and their clients through assessment and treatment planning where the fundamental orientation is towards keeping suicidal patients out of hospital.

In Chapter 2, Jobes discusses the clinical process and empirical research that underpins each aspect of the Suicide Status Form. Chapters 3–7 comprise a detailed description of the procedural steps involved in administering the SSF in a collaborative manner. Chapter 8 deals with the difficult, but essential, topic of decreasing malpractice liability and in Chapter 9, Jobes describes his ongoing research. The appendices include Suicide Status Form forms for reproduction by readers. In short, the book is an excellent clinical manual well suited for specialised courses in suicide prevention, intervention and management, for general graduate level counselling courses and for therapists of any orientation wanting to base their practice with suicidal clients on sound, evidence-based principles.

My one caution is that Jobes's clearly written description of procedural steps may give the impression that using the Suicide Status Form with clients is simple and straightforward. This is not the case. To use the Suicide Status Form effectively, a therapist will need to consider seriously what it means to work collaboratively, how best to ask the questions on the form and how best to help the client develop his or

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her own therapeutic treatment plan. The guide offers the essential tools, and Jobes offers clear guidance, but therapists will need to accept the philosophy underpinning the approach and gain experience in using the tools to work effectively with their clients.

The Suicide Status Form has a number of unique features that render it clinically accessible, the most important of which is the emphasis on clinicians working collaboratively with their clients. Because I work using a solution-focused modality, I particularly like Jobes's definition of collaboration as being 'where the patient – who is the expert of his or her own experience – is engaged as an active collaborator in clinical care' (p. 41). Regardless of a therapist's orientation, however, the effective use of the Suicide Status Form requires therapists to align themselves with their clients. As Jobes notes: 'By maximising clinical alliance and patient motivation, CAMS helps the patient find alternative ways of coping' (p. 6). In the initial assessment, therefore, the client is invited to write his or her own responses to a number of questions presented in three sections. Section A and B cover assessment risk and Section C provides prompts for the collaborative development of a treatment plan.

In Section A the client is invited to use Likert scales to rate his or her own level of such constructs as psychological pain, stress, agitation, hopelessness and self-hate. Further, the client is invited to respond in his or her own written words to sentence stems for each construct. This section encourages client participation and therapeutic alliance. Another feature of the Suicide Status Form is that it provides an opportunity for clients to have their pain and suffering recognised and their internal debate acknowledged. Jobes provides case study reports and empirical research to support his view that there is tremendous value in having a client consider both sides of the life-versus-death coin simultaneously. The assessment form therefore includes a section where clients are invited to list and rank their reasons for living and their reasons for dying. Finally, in Section A there is a 'one-thing' response that allows clients to consider the one thing that would make them no longer suicidal. Again, these questions resonate with my solution-focused preference where counsellors encourage clients to consider future-oriented, self-motivating, hopeful alternatives. The philosophy underpinning Jobes's work is encapsulated in his statement: 'It is my sense that anyone can get through a rough patch if they have hope and a belief that things will one day change and improve' (p. 24).

Section B of the inventory resembles most suicidal risk assessment inventories in that it gathers information on empirically-based psychosocial risk variables. The difference with the Suicide Status Form is that, these risks are discussed collaboratively. Section C allows the client and clinician to consider seriously a time-specific plan to best ensure the client's stability and safety. Jobes rejects the use of a safety or no-suicide contract, and describes the usefulness of a Crisis Response Plan – what will the client do? Again, this sits well with therapists who use positive-oriented language; when a client states what they will not be doing, they're prompted to consider what they *will* be doing instead.

The Suicide Status Form is comprehensive and flexible. Slight variations of Sections A–C can be used for each client visit to enable both clinician and client to track the ongoing risk, change the treatment plan, and note clinical outcomes. An additional section provides an efficient way of maintaining a medical record that complies with Health Insurance requirements.

On page 34, Jobes asserts that: 'The book represents a fundamental effort to make this new approach available and to help empower clinicians to give their suicidal patients the live-saving [sic] help they so desperately need'. It succeeds in part because of the accessible manner in which it is written but essentially because the Collaborative Assessment and Management of Suicidality approach is fundamentally an example of best-practice whose adoption will strengthen the effectiveness of clinical care by all therapists. It resembles a win-win situation where what is best for the needs of the client is also best for the needs of the clinician.