ASSESSMENT OF RISK OF SUICIDE

There is no evidence to suggest that asking a person directly about suicidality increases their likelihood of making a suicidal attempt. Having said that, it is reasonable to proceed in a cautious manner when a person has sought assistance, rather than just abruptly asking, 'Have you thought about killing yourself?' or 'Is this injury self-inflicted?' especially if they are unknown to the clinician. This has two important advantages.

1. It does not alarm a person who has no suicidal ideation.
2. It 'warms up' a person who might be having such thoughts and potentially facilitates disclosure.

Questions that a clinician might consider include:

- How has your mood been lately?
- Has anything been troubling or worrying you?
- Have you had times when you have been feeling sad or 'down'?
- Have you ever felt like life is just getting on top of you?
- Do you sometimes wish you could just make it all stop, or that you could just end it?
- Have you thought about how you might do this?
- Have you ever wished you were dead?
- Have you ever thought about taking your own life?

If a person endorses any of these questions careful probing is warranted (the what, where and how of the situation). The clinician needs to go on to determine the level of intent, the presence of a plan, access to means, any underlying mental health problems and the availability of supports and protective factors. The severity and pervasiveness of current suicidal ideation also gives important information about severity and immediacy of risk (eg, are the thoughts mild and fleeting or is the person preoccupied with thoughts of suicide?).

SUICIDE INTENT

This refers to the extent that the person actually anticipated and wished to die as a result of their action. This is an important point because intent does not always correlate with bodily harm; some people may deliberately self-harm with no intent to die (eg, using their self-harm as a tension reduction strategy) but employ potentially lethal means. Others will take a relatively 'safe' overdose in the belief that it will kill them.

About a third of people who engage in deliberate self-harm will say that they actively meant to die. Another third will say that they did not care whether they lived or died. Even if the person says that they did not wish to die, the clinician still needs to check that their method of deliberate self-harm is not potentially lethal (ie, the risk of them dying by 'accident').

However, whether the person meant to die or engaged in self-harming behaviour for other reasons, both are dangerous scenarios and are associated with a high risk of death by suicide.

In assessment, the following features will help the clinician gauge the degree of intent.

- Preparation - had the person planned the act in advance? Had they written a suicide note? Had they been arranging their affairs?
- Circumstances - had they taken measures to prevent discovery or had they purposely engaged in deliberate self-harm where they were highly likely to be found and 'rescued'?

- How serious or potentially serious was the action that they took? Ask about how many pills they took, where they cut themselves etc.
- How well planned was their attempt, as opposed to being an impulsive act?
- Did alcohol or drugs play a role in the attempt?
- Why did the attempt fail? Did they seek help? Were they discovered?
- Afterwards - did they seek help? Did they express regret that they had not died? Did they believe that their act would have killed them? People who are disappointed that they did not die (rather than feeling relieved) remain at high risk of future attempts.

It is important to ask about the chronology of events leading up to the suicide attempt and then the events afterwards (questions focusing on what, where, how, who, thoughts, feelings and actions will help elicit this material). The clinician should ask the person to start at the point 'where you first began to think about suicide'.

SUICIDE PLANNING

The degree of planning gives crucial information about the person's level of intent and also the degree to which their suicidality is part of a thought-out process rather than an impulsive act. On a practical level, killing oneself is not that easy to do. People will often spend time weighing up different methods, considering the degree of pain that is tolerable, the finality of the plan, where to do it, the prevention of premature discovery, who they wanted (or did not want) to find their body, the decision about suicide notes, or the possible use of alcohol to firm their resolve etc. The more information the clinician is able to elicit about the level of forethought and planning that has gone into suicide, the better they will be able to assess the person's risk of suicide.

The following questions need to be addressed (the more questions they endorse the greater the risk of future suicide attempts).

- Have they planned how they will commit suicide?
- How plausible a plan is it ('I'm just going to lie down and not get up' vs 'I'm going to use a gun')?
- Have they been making efforts to organise their life around their plan (eg, such as making wills, saying good-bye to people)?
- Was there a note?
- Did they go to efforts to ensure that they would not be discovered?
- What do they anticipate will happen to them after they die (such as being reunited with a loved one, which might make suicide appear very compelling to the person)?

AVAILABILITY OF MEANS

Anyone who has indicated that they are considering suicide should be asked directly about the method they planned to use and the likelihood of them being able to carry this out. It should be noted that despite guns being less accessible in New Zealand than some other countries, 10% of people die by suicide using firearms.[12] Specific questions could include:

- Have you thought about how you would end your life?
- (Depending on method) how available is that to you? For example, how many pills have you stockpiled?

BARRIERS TO COMMITTING SUICIDE

Understanding what has prevented a person from acting on their suicidal impulses thus far gives the clinician insight into the immediacy of risk. A clinician also needs to assess whether the barriers that have existed still remain (eg, in the past a person has felt suicidal but would never act on it because of the distress it would cause to his wife. However, if his wife has recently died, he is at a greatly increased risk of committing suicide).

A clinician has to be careful that their own values and beliefs don't cloud their assessment, for example, a person who has two young children may not in fact see them as a reason for not committing suicide. Instead, they may endorse beliefs such as, 'They would be better off without me,' or less commonly, 'I'll kill them and then myself'.

Specific questions could include:

- You have said that in the past you have had thoughts of suicide, what has stopped you from acting on them until now?
- You have said that you have been having thoughts of harming yourself. Is there anything you can do, or people that you can be with, that makes you want to hurt yourself less? Makes you feel safer?
- You have said that in the past you didn't act on these thoughts because of X. How much does that factor into your decision-making now?

PREVIOUS SUICIDE ATTEMPTS

The major predictor of future suicidality is previous suicidality. However, the absence of previous suicide attempts cannot be taken as an indicator of diminished risk. While many people who seek help at an emergency department or mental health service following a suicide attempt will have made a previous attempt, 60–70% of people who die by suicide do so after their first attempt.[85]

Given the time constraints of a session or the pressure on staff in emergency departments, clinicians should focus their initial assessment on the following key aspects of previous suicidality.

- What was the most serious past attempt (previous attempts that were potentially lethal raise greater concern than multiple non-serious attempts)?
- Are attempts escalating in potential lethality? Escalating seriousness of attempts suggests that the person is increasingly nearing the end of their resources to cope and is at greater risk of dying by suicide.
- How long ago was this previous attempt?
- In what way is the current situation similar?