

RISK ASSESSMENT PAPER

RISK ASSESSMENT FOR SUICIDE

A paper commissioned for square in 2005 by Dr Randall Long.



About the Author

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For a demonstration of the principles of Risk Assessment in practice, go to the Risk Assessment online tutorial on the **square** website and watch videos of simulated Risk Assessment interviews by [Dr Randall Long](#) and by [Andy Kelly](#).

INTRODUCTION: WHY RISK ASSESSMENT?

Risk Assessment involves a determination of the degree of probability that a certain event may occur. This is of importance to professionals who are concerned with their client's mental health in respect to the issue of suicide. The reason we try and determine whether a client is at risk of suicide is because we have the intention of preventing their suicide. This seems to be a self evident moral and just thing to do. It is something we are able to do, and believe we should do, from a basic humanitarian concern for others. However, it is important to examine some of the philosophical and ethical ideas that underpin this viewpoint.

Concern for our clients, with the ultimate intent to prevent them suiciding, can involve a number of therapeutic interventions. These interventions can be caring and supportive, but if this fails, the task may ultimately require authoritarian and coercive steps to prevent a patient harming themselves. Given

that these ultimate steps can sometimes involve coercive physical interventions on the part of a mental health service toward the patient, it is important that both the individual professional and society at large believe that these are warranted.

There is a general view that preventing someone suiciding is a beneficent act. It is also generally held that the concept of paternalism justifies intervention. Paternalism recognises that we are actively going against the desire of a suicidal patient by preventing their suicide. This is justified because we believe that the patient would later agree with our intervention. This involves an important assumption that the patient is in fact not rational at the time they wish to suicide.

Two important themes emerge from the ethical exploration of intervening with a suicidal client. These are the concept of impaired rationality and the idea of interfering with actions of others. These ideas can be understood and justified based on the philosophical principle of respect for autonomy. This idea basically states that we should recognise a person's unconditional right to determine their own destiny if their actions are autonomous. Autonomous actions are said to be intentional, done with understanding and without controlling influences which determine them. We know that mental illness is very commonly associated with suicidal actions. We also know that mental illness has the capacity to impair a person's intentions and understanding and can be a powerful controlling influence over their actions. This can be summarised by the idea that mental illness impairs a client's capacity for rationality. With rationality, and more specifically the three required cornerstones for autonomous actions disturbed, we can more easily understand why suicidal actions are not autonomous. Hence, our intention to intervene when a client is suicidal is not in violation of the principle of respect for autonomy. Realising this, we can be in a much easier position to argue that preventing clients suiciding is indeed a good thing.

HOW WELL IS RISK ASSESSMENT DONE?

In recent years Risk Assessment has become somewhat of a buzz word in the Health Services. This is because it is a legitimate concern linked to the important areas of patient safety, organisational risk management and the management of an individual professional's medico-legal risk. Unfortunately, risk assessment is talked about more often than it is conducted in a way which is based on empirical evidence or theoretically sound principles.

...the most frequent medical error was a failure to perform a risk assessment

In 2002 I undertook a research project entitled 'Critical Incidents in Mental Health' with the South Australian Department of Health. This study used a systems theory approach to analyse medical errors and system problems related to cases where patients suicided under the care of the South Australian Mental Health Service. This study found that the most frequent medical error was a failure to perform a risk assessment. This may seem surprising, given that practically all the patients under the care of the

Mental Health Service had experienced suicidality at some time. Further analysis of this finding revealed this omission was the most frequent for psychiatrists, trainee psychiatrists, general medical officers and mental health nurses. This wide range of professionals with a large variation of skills and training, all making the same error, suggested that this was an organisation-wide problem. It seemed that the system was either discouraging risk assessment or not enabling its staff to perform this important clinical task. This was evidence that this was a systemic problem and cannot simply be attributed to individuals making understandable human errors.

...without regular risk assessments being performed on clients, the professionals were unable to track and monitor the evolving suicide risk.

The study further examined the possible links between this lack of risk assessment and the possible contribution to patient suicide. It found that this error created what is termed a 'loss of situation awareness'. This means that, without regular risk assessments being performed on clients, the professionals were unable to track and monitor the evolving suicide risk. This study recognised that, although these highly trained mental health professionals in fact knew how to do a risk assessment, their every day work environment was not allowing this to be done.

...constantly consider your own professional practice and how these skills can be effectively adapted so that you have the best realistic chance of using them within the pressures of everyday work life.

The study made specific recommendations about how professionals should be required to perform clinical risk assessments on a regular basis. This last point is perhaps the most important one. After reading this educational package, you may end up with a very good set of skills on how to do a risk assessment for suicide. However, when you return to your busy professional life it is unlikely that these new skills will be integrated, unless you change your system of practice to force yourself to regularly use them. As you read this paper further and use this package to gain skills and motivation, I suggest you constantly consider your own professional practice and how these skills can be effectively adapted so that you have the best realistic chance of using them within the pressures of everyday work life.

WHAT EXACTLY IS RISK ASSESSMENT?

Risk is the possibility of suffering harm or loss. It is important to remember that risk is dynamic and changes regularly. Risk assessment is the process which involves determination of the degree of probability of occurrence for a range of factors.

When we talk about probability we are, of course, dealing with predictions about the future. Questions about the future are some of the most difficult that humans ponder. One can be forgiven for thinking that answers to these questions may be an impossible task, akin to crystal ball gazing. However, scientific endeavour actively concerns itself with these predictions. If we take meteorology as an example, we can see that complex science and powerful computer resources go into weather predictions. However, everyone knows all too well when the meteorologists have got it wrong. When we consider the challenges involved in predicting the future in the areas of individual human behaviour, we face similar challenges. However, there are some broad scientific principles and sound clinical strategies that we can use in this area.

Before we focus on risk assessment for suicide we should consider a broad range of risks important to professionals dealing with their clients' mental health issues.

There are a range of risk issues to be considered when addressing a client's mental health. These can be broadly divided into risks to self and risks to others (see Figure 1).

TYPES OF RISK



FIGURE 1.

RISKS TO SELF

ACCIDENTAL PHYSICAL HARM

Our clients' actions may inadvertently harm them even if this is not the intention. Common examples of this include substance use with the intention of pleasure seeking, resulting in a dangerous overdose. Accidents such as those involving motor vehicles or burns are another example. A client may also neglect their own care in the area of hygiene, nutrition or medical care.

DELIBERATE PHYSICAL HARM

This category refers to deliberate and intentional actions which have the potential to cause physical injury. These include:

SUICIDE

This refers to a range of actions which are directly intended to end the person's own life. All methods of suicide tend to be highly dangerous. The degree of success of the various methods tends to be proportional to chance and technical factors involved in their execution. Common methods used to suicide include: self poisoning by overdosing on various medications; hanging; a deliberate motor vehicle accident; jumping from a height or putting oneself into the path of a vehicle such as a truck or train; cutting oneself in order to create an injury to the arteries which will lead to death through bleeding; stabbing oneself or trying to poison oneself with gas (most commonly carbon monoxide poisoning by exposing oneself to car exhaust fumes).

OTHER DELIBERATE PHYSICAL HARM

Clients may wish to cause themselves deliberate physical harm which does not involve the primary intent to end one's life. These methods, of course, are intrinsically dangerous and may have death or serious injury as a non intended consequence. Superficial skin lacerations or burns using items such as blades and smoking paraphernalia are relatively common, particularly in the adolescent population. These actions cause excruciating physical pain which may serve as a distraction to the thoughts and painful emotions that are tormenting the client. This type of harm is often used by people to block out depression or intrusive traumatic memories that may occur in the setting of Post Traumatic Stress Disorder or Borderline Personality Disorder. Occasionally people may amputate body parts or cause other horrific mutilation to their bodies. These dreadful injuries are usually seen in very unwell patients who may be suffering from psychosis or substance intoxication. Other forms of deliberate self harm such as stitching one's lips together, or setting fire to oneself, have a particular demonstrative quality that

may serve as a protest against a life predicament. These types of injuries are increasingly being seen in the mental health service associated with clients in immigration detention centres.

OTHER HARM

Various behaviours associated with mental illness, or less specifically poor judgement, can damage a client's personal reputation, financial situation, relationships or occupational standing. These factors are particularly sensitive to damage from unwise actions. Embarrassing behaviour in occupational settings tends to be remembered above even a lifetime of satisfactory performance.

HARM TO OTHERS

Mental health practitioners are increasingly being expected by the public to prevent their clients harming others.

HARM TO HUMANS

Violence is one of the most important risk considerations when considering harm to others. Violence may be impulsive or carefully planned. The result of violence can be personal injury or even death. Relationships with others can also be damaged and should be considered in the area of risk assessment.

HARM TO ANIMALS

It is important to remember that in times of mental illness or distress clients may cause harm to animals through an act of cruelty or acts of omission which lead to neglect.

HARM TO PROPERTY

A client's property may be damaged, destroyed or sold and this may cause harm for financial or sentimental reasons.

AN INTRODUCTION TO SUICIDE RESEARCH

Prediction of who will suicide, or attempt it, is well known to be a difficult academic task. There are no satisfactorily reliable predictors of an individual's suicidal behaviour.

A large body of literature has assembled a range of risk factors (Table 1). However, these risk factors are not particularly useful when it comes to considering an individual client's risk assessment. This is because these factors lack specificity for a given individual. Another way of looking at this problem is that these risk factors are really only useful on a population-wide basis. For example, if we were to study who suicided over 20 years in Australia, we would see a statistical pattern emerge supporting the risk factors identified in Table 1. However, these factors would still remain relatively useless in respect to an individual client. This is because suicide itself is a relatively rare event when the rate is examined across a whole population. It is also because statistics have poor power to predict actions on the part of a given individual. It is important to remember that these risk factors are all constructed post hoc after the suicide, and have never really been shown to have validity to predict a future suicide.

TABLE 1: RISK FACTORS

DEMOGRAPHIC FACTORS

Adolescent or over 45 years, male, single, divorced or widowed, unemployed.

PHYSICAL HEALTH

Chronic Illness

MENTAL HEALTH

Depression, psychosis, severe personality disorder, substance abuse, hopelessness.

SUICIDALITY

Frequent intense and prolonged suicidal thoughts with a past history of multiple attempts. Methods selected are lethal and readily available.

SOCIAL SITUATION

Social isolation, isolated from family with poor coping mechanisms. Poor willingness to accept help. Recent losses or separations.

Note: Risk factors are poor predictors for an individual suicide risk. A large body of literature has produced many post hoc risk factors after examining completed suicides. Although often quoted, these risk factors have never been really tested and shown to be reliable predictors of an individual's future suicide risk. These risk factors may be useful on a population-wide basis for research or broad mental health planning strategies.

Researchers such as Pokorny, Goldney and Spence have also argued that even expert psychiatrists do not possess the skill to reliably predict the suicide of a particular client. This is despite the public perception that various professionals should be able to perform this task.

Interpretation of this body of research produces important implications. Firstly, it is not possible to develop a profile based on risk factors to reliably predict which clients may attempt or complete suicide. Secondly, one does not need to be expert to attempt to assess suicide risk. This is because experts may not possess a better chance of making these predictions than non experts. Finally, we need to look beyond risk factors and statistics to some other way of performing a risk assessment for suicide. I suggest that one method is to go back to basics and develop a regular and constant approach to the issue by asking the patient about suicidality. This apparently simple method will be expanded upon in subsequent sections.

UNDERSTANDING SUICIDE

There has been a lot of theory assembled to attempt to understand the meaning of suicide and why people choose it as an option. When one examines suicide in the context of psychiatry and mental health it is important to realise that suicidality should be seen as a symptom that may exhibit in a range of mental illnesses. Most mental illnesses can be associated with suicidality. Strong associations have been described with mood disorders such as major depressive disorder and bipolar disorder, psychotic disorders such as chronic schizophrenia, eating disorders, personality disorders such as borderline personality disorder, substance use disorders and those disorders associated with life and social stresses.

It is not unreasonable to assert that most suicidality is associated with mental illness. This is not to say that some suicide can be independent of mental illness but related to other life predicaments such as grief, loss or other disappointment. There also exists the category of rational suicide, which is most often seen when an autonomously functioning individual may choose to take his/her own life rather than befall a more horrible consequence such as a terminal illness or other life predicament. Having noted this range of examples, it is still essential to look for, and perhaps even presume, that mental illness is a cause of suicidality until proven otherwise. This deductive position is recommended for the target audience of this paper who by the nature of their professions, will have clients with a mental illness seeking their assistance or be involved with a group at high risk for mental illness.

Having drawn an association between mental illness and suicide we still need to understand how mental illness causes clients' thought and behaviour to become suicidal. Clinical experience with patients who have failed a suicide attempt suggests that they attribute a meaning to their suicidal actions. In my clinical experience it has been found that individuals often plan and attempt suicide as a solution. A number of factors tend to be brought to bear on the individual's life, including various states of mind and predicaments, which are then attempted to be transformed by the act of suicide.

The following factors tend to be common themes in suicide planning. Firstly, there is the cognitive state of hopelessness which is a false belief that the future is negative and there is no possibility of improvement. This state of mind then tends to be combined with a problem which may be overwhelming and serious or just the last in a line of accumulated issues. This in turn, tends to be combined with the individual's lack of ability to solve the problem. This may be because the person just does not possess the intelligence, education, resources or coping mechanisms to constructively address the problem. This may also be because he or she is in crisis – that is a state where active and constructive solutions are no longer able to be generated. Another common scenario is that mental illness such as depression or psychosis has so severely impaired the mind's ability to cope, that no problem solving is possible. This combination means that a problem seems overwhelming and insoluble, which when combined with the state of mind of hopelessness predicting that nothing will ever change, this leads to the individual feeling trapped and helpless. This then can often lead to seeing suicide as a solution which seems like an attractive transforming force. The transformation that suicide promises to bring may be the apparent comfort of annihilation or perhaps a fantasy of how others will grieve or suffer after the individual's death. Afterlife beliefs may also influence ideas about what death may hold.

These morbid calculations may seem to make sense to the individual but are based on faulty premises of hopelessness and unsolvable problems.

It is important to attempt to understand how a client may be using a suicide plan as a solution. This understanding provides a ready means to identify pathological states of mind, target these factors in a psychotherapeutic manner and also provide a direct form of problem solving assistance to critical issues. This suicide 'solution' should readily appear erroneous and faulty to the professional who can then use chosen modes of psychotherapy to point this out to the patient.

THE PROFESSIONAL'S ANXIETIES ABOUT DISCUSSING SUICIDE

As this paper progresses towards discussion of a detailed method of talking to clients about suicide, for the purposes of conducting a risk assessment, it is crucial that we first address various professional worries around suicide.

...the mere enquiry about a client's suicidality is therapeutic in itself.

Professionals often worry about whether asking a patient if they are suicidal can make the patient more unsafe and precipitate an attempt. There is no clinical or theoretical evidence that this is true. In fact, it can be asserted that the mere enquiry about a client's suicidality is therapeutic in itself. This is because clients who are suicidal feel hopeless and helpless. The mere act of a professional enquiring about this form of suffering can be the first spark of hope.

...while suicidal behaviour is the ultimate responsibility of the client, risk assessment and an appropriate response are the responsibility of the professional.

Another anxiety that professionals may have is, that if a client discloses they are suicidal, it becomes the professional's responsibility and they may not know what to do. This can sometimes lead to the dangerous tendency not to enquire about suicidality. It can be argued that anyone reading this paper and using this Resource already has a duty of care to their clients. It is this duty of care that dictates the important need to address this area. It seems reasonable to assert that while suicidal behaviour is the ultimate responsibility of the client, risk assessment and an appropriate response are the responsibility of the professional.

It should be remembered that even experienced mental health professionals have various anxieties around discussing suicide with their clients. This is largely because it can be emotional and challenging, as well as intensely rewarding, to provide a life-saving intervention. It is essential that professionals develop their own style and confidence in discussing suicide as part of a risk assessment. This confidence will indicate to the client that their suicidal thoughts can be openly discussed, are not unusual or shameful, and are amenable to many forms of help.

PRACTICAL RISK ASSESSMENT FOR SUICIDE

Risk assessment can be broken down into three basic steps (Figure 2). These are collecting data, analysing information and producing a conclusion. Only when these steps are completed can the process of risk management, to reduce or modify the risk, start.

Risk Assessment

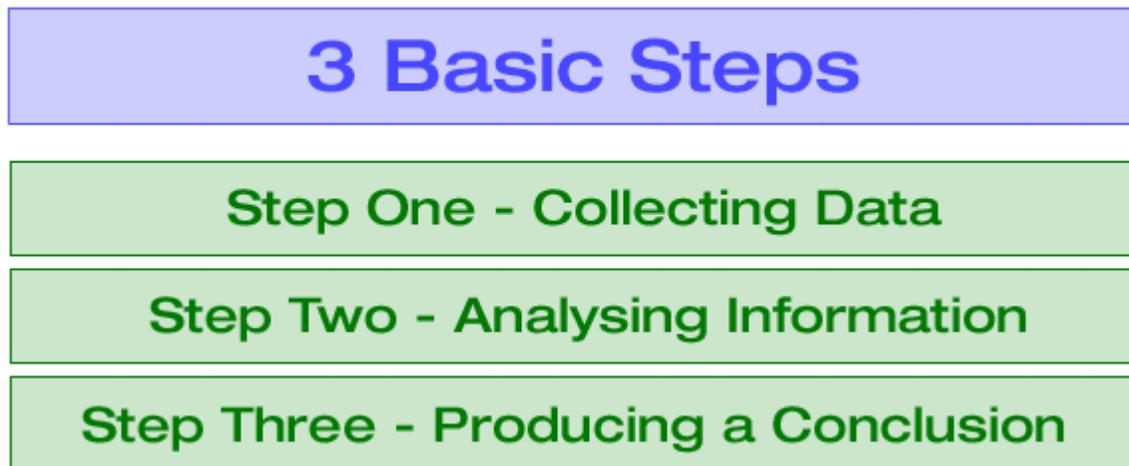


FIGURE 2.

THE RELIABILITY OF RISK ASSESSMENT TOOLS

This paper has discussed the problems with using general risk factors as predictors for an individual's suicidal behaviour. Even when we dismiss these risk factors as only useful on a population basis, we discover there is even less research in the area of methods to assess an individual's suicide risk. The difficulty here is that there are no empirical, valid and reliable methods proven for risk assessment for suicide. As such there are no gold standards and no tools that can assist this endeavour. Despite this, surveys of various mental health organisations reveal that many 'risk assessment tools' have been developed. The existence of such tools within organisations can have an unintended effect of becoming an end in themselves, especially if professionals spend more time and effort completing the risk assessment tool paperwork rather than actually assessing the client. Those who use them should see them as more of a record of the process of risk assessment rather than an end in themselves. These 'tools' are not a substitute for professional judgement.

With the above concerns noted it will now be suggested that a simple and informed method of questioning around suicidal thinking and behaviour can contribute to risk assessment. This method deliberately lacks a quantitative measure or scoring system but rather concentrates on a series of progressive questions that can identify increasingly concerning aspects of suicidality.

THE SPECTRUM OF SUICIDAL THINKING AND BEHAVIOUR

The spectrum of suicidal thinking and behaviour has been described widely in the literature. It can be seen as a progression that a suicidal client may take, with each step indicating increased risk for suicide (Figure 3).

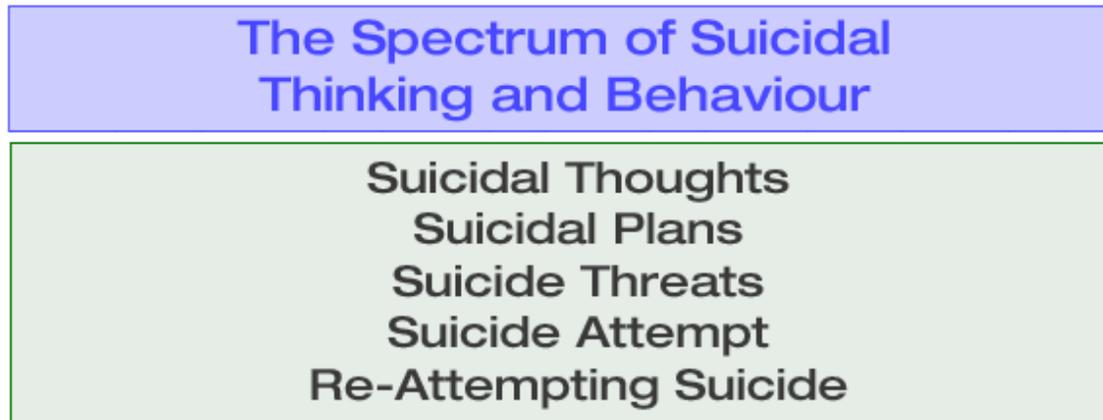


FIGURE 3.

The literature on suicide research consistently identifies the spectrum of suicidal thinking and behaviour that an individual may progress through towards suicide. This classification may be seen as indicating a progressively higher level of risk as the patient progresses.

A METHOD FOR SUICIDE RISK ASSESSMENT

WHEN TO ASSESS RISK

It is important to remember that a client's risk level for suicide may change. Risk in general is a dynamic and changing value. It is suggested that risk is assessed on first professional contact and regularly during the client's episode of care. This may vary from every couple of sessions to an ongoing and constant assessment by a person in close proximity to a high risk client. Risk assessment should be performed after an acute stressor such as job loss or relationship break-up. Risk assessment should be performed after psychiatric medication is initiated or ceased and after changes in the level of use of substances by a patient. In general, the more at risk for suicide a patient is deemed to be, the more often their risk level should be re-assessed.

WHY WILL CLIENTS ANSWER THESE QUESTIONS?

Clients often want help for their suicidal thinking and behaviour. They describe a great sense of relief when their suicidality is professionally enquired into.

In situations where a client denies suicidality, this should be compared to the broad clinical picture. For example, if a patient is suffering from a severe major depressive disorder with psychotic features, and has recently attempted suicide, they should be considered extremely high risk even if they are currently denying any form of suicidality.

There will always be a small proportion of clients who not only deny suicidality, but take extensive steps to disguise other signs that could possibly be interpreted as high risk. A proportion of these patients is extremely motivated to suicide and they often achieve this goal. This is a regular problem when trying to help people with a mental illness. However, it should not be an issue that overly concerns the professional to the extent that it distorts their judgement so that they believe that many of their clients are trying to fool them. It is a sad fact of providing professional help to clients that some will suicide despite efforts to help them.

The method of simple progressive questioning given below could be seen to have a weakness for the patient who wants to disguise their suicidality. However the strength of using these questions is that it addresses the even greater problem in professional mental health areas that risk assessment is not done at all or not done very well. If this method can be used to provide a model and motivation for risk assessment, it should be seen as a good thing in itself.

STEP 1: COLLECTION OF DATA

It is suggested that the professional use the following set of questions as a basis for developing their own style of enquiring about suicidality. Style variations may be made based on the professional's general manner with clients as well as characteristics of the client. The way the questions are phrased should always suggest an open, positive approach and indicate to the client that these issues can be discussed and something can be done to help. They may be modified for various age groups and characteristics of the therapeutic relationship. For example, elderly clients who may have spent much of their life living with society's stigma around mental illness and a general feeling that these things should not be discussed, may require a gradual and sensitive line of enquiry. A younger patient who enjoys a strong therapeutic relationship with his/her practitioner may best be served by a forthright, business-like, and perhaps even colloquial, style of questioning.

([A printable summary of the risk assessment questions](#) is available.)

SUICIDAL THOUGHTS

PASSIVE SUICIDAL THOUGHTS

Do you wish you didn't have to go on living?

Do you have thoughts of wanting to die?

Passive suicidal thinking refers to the wish for one's life to end without the thought of wanting to take one's own life. Sometimes this takes the form of a fantasy involving vanishing or dying from natural causes. Sometimes clients may be neglecting certain aspects of their health or behaving in a hazardous manner with the chance that this may speed up their own death.

ACTIVE SUICIDAL THOUGHTS

Do you have thoughts of wanting to take your own life?

Do you have suicidal thoughts?

Active suicidal thinking involves contemplation of killing oneself. Clients may have active suicidal thoughts for many months or years; these thoughts may only appear in times of stress or may be a daily occurrence which requires active resistance to combat. This type of suicidal thinking may be kept private and be associated with feelings of shame.

SUICIDAL THREATS

Did you talk with others about killing yourself?

Have you told anyone that you were going to kill yourself?

It is common for many individuals who go on to attempt and complete suicide to mention their intention to someone beforehand. The progression to this part of the spectrum has great significance because the suicidality no longer takes only the form of thought in the individual's mind but has now crossed the threshold into the outside world. This progression indicates a form of behaviour that is getting closer to practical action that is required to attempt suicide.

SUICIDE PLANS

Have you thought about methods to kill yourself?

When a client starts to consider practical means to end their own life their risk level is increasing. Planning a suicide attempt is not just a mental activity. It tends to involve research and active behaviour to procure paraphernalia for an attempt.

SUICIDAL PLANS – THE DETAILS

DECISION

Have you decided on a method to kill yourself?

DETAILS

Did you make a plan of exactly what you might do to kill yourself?

RESISTANCE

Have you been able to resist carrying this out?

What stopped you putting the plan into action?

PREPARATIONS

Have you started preparations to suicide?

TIME PROFILE

For how long have you had the plan?

Have you set a date to kill yourself?

AFFAIRS

Have you put your affairs in order?

Have you made arrangements for after you die?

Have you written a note?

The detailed enquiry about a client's suicidal plan can provide a clear level of risk. When a client answers all the above questions by describing their suicide preparations, the professional is likely to not only register concern but may also experience an intuitive and severe level of concern. If a client has actively gone through detailed research, reconnaissance, shopping trips for items and the like, in order to plan a detailed suicide attempt, it is usually indicative of a mental state impaired by serious mental illness such as depression or psychosis. Knowing about the details helps delineate this fact from an impulsive suicide attempt. Although an impulsive attempt may be deadly, it does not rely on the persistently morbid mental state required to plan one's own death without having a moment of utter dread which leads to the embracing of life again and the shaking off of this morbid preoccupation. In other words, the more detailed and affirmative responses you get in this line of questioning, the more likely that a mental illness is a large factor in the client's determination, and accordingly their risk for suicide is higher.

QUESTIONS AFTER A SUICIDE ATTEMPT

CIRCUMSTANCES

What were the circumstances of this attempt?

METHOD

What did you do?

INTENT

What did you want to achieve (to die/to sleep/euphoria)?

LETHALITY

Did you think it would kill you?

Professionals may find themselves seeing clients shortly after a suicide attempt. This may be because they are in a position to provide immediate medical and psychological care or it may be because the client is describing a recent failed suicide attempt. In all of these situations it is important to get a detailed account of the circumstances of the attempt. Try to delineate whether there were any acute stressors which may have been the final precipitant of the attempt. A detailed description of what the client did to attempt to suicide is important. If they have ingested medication in an attempt to overdose, they should be questioned about whether they took anything in addition. This is because research shows that individuals attempting suicide by overdose tend to take multiple substances, including alcohol. It is important to question the client's intent.

It is common for individuals after a suicide attempt to describe not necessarily wanting to die, but rather to “switch off” or find some nihilistic state to avoid problems or troublesome thoughts. It should also be clarified whether the primary intention was not indeed suicide but to achieve euphoria through recreational drug use.

If a client intended to die, a further line of questioning can assess whether they regret that they didn't die, or are pleased they are still alive. It is also important to ask questions about the client's perceived lethality of the attempt. Independent judgements should not be made from the professional's viewpoint about the objective lethality of the attempt as a risk indicator. This is because clients may not have a similar professional and scientific knowledge. Some individuals believe that four tablets of paracetamol can kill you, whereas others believe that ingesting a packet of antidepressants is a good way to get high. Toxicology tells us that both of these beliefs are indeed very wrong.

RE-ATTEMPTING SUICIDE

Have you ever tried to take your own life before?

Clients who have attempted suicide before are more likely to attempt suicide again in the future. Clients can be questioned about previous suicide attempts and asked to comment on the nature and subjective risk of their current predicament. In this way they may be able to indicate to the professional that they are at higher or lower risk than in their previous episode of suicidality.

Occasionally, a professional may come across clients who very regularly attempt, but do not complete suicide. The methods these patients use may be on a spectrum from high to low lethality. There seems to be a paradoxical and erroneous view, occasionally seen in the mental health field, that these clients are ‘attention seeking’, and hence are at low risk for actually suiciding. This assumption should be identified and dispelled. Firstly the concept of ‘attention seeking’ suggests that it describes some sort of empirically useful concept, yet it often does not. Secondly, it is generally evident that the more times a person attempts suicide, the more likely they are to complete it. This is analogous to playing Russian roulette. While each time the individual plays they have a theoretically similar risk of dying, it is also true that the more times an individual plays the more dangerous the whole endeavour becomes.

WILLINGNESS FOR HELP

DESIRE FOR HELP

Do you want help to avoid killing yourself?

ACCEPTANCE OF CARE

Will you accept my help to avoid suiciding?

Will you accept specialist mental health care?

This line of questioning can assess a client's insight and judgement about their suicidality. It is not unusual for a client to be battling with their own desires between living and dying. Often they are willing to accept help but just don't know how to access it.

CURRENT SAFETY

IMMEDIATE HARM

Do you have thoughts of wanting to suicide immediately?

HARM IN HOSPITAL OR CLINIC

Do you have thoughts of wanting to suicide here in this office/clinic?

Are you thinking of actively wanting to hurt yourself here?

HELP ELICITING

If you feel like hurting yourself here while you are waiting for me to make some arrangements, could you come back to me and indicate this before doing anything?

DANGEROUS ITEMS

Do you have anything you can use to harm yourself?

Are you thinking of using something in the immediate vicinity to harm yourself with?

These are some of the most important questions to ask a client. Just because an individual is within a health care facility does not mean that this in itself is therapeutic. Straightforward questions need to be asked to ensure that a client is not planning on immediately harming themselves or will not attempt to harm themselves while the professional is going about the arrangements for them to receive appropriate care. Before asking a client to wait in a waiting room or other location, it is very important to determine that this will be safe. If the client believes it is not safe, someone should be with the person at all times. Clients will often surrender dangerous items and be relieved to do so if they understand that they are receiving help.

HOMICIDAL THOUGHTS

HOMICIDAL IDEATION

Do you want to take anyone with you?

Do you have thoughts of harming or killing others?

HOMICIDAL PLAN

Do you have a plan to do this?

WEAPONS

Do you have access to guns or other weapons?

It must be realised that there is an important association between suicidality and homicide. This may occur in two particular situations. Firstly, the client may be particularly angry at another individual and wish to harm or kill them. Secondly, when suicide is used as an apparently logical solution by a person with a mental illness it seems a reasonable logical extension that they may wish to also kill others who are dependent on them or who they love. The morbid logic behind this is often tragically seen in cases of infanticide where a depressed mother cannot bear to leave her young baby in what she believes to be a horrible world, and believes she is doing a good thing by murdering her child and suiciding herself. It is important to always consider this murder-suicide risk when a client has children or other dependants.

Access to guns or weapons should always be enquired about. Many professionals will be mandated notifiers and may have a legal obligation to contact police authorities about people they believe to be unfit to hold a licence for a firearm or a weapon.

It is generally considered under ethical and legal precedents that a professional has a duty to protect others who are threatened by a client's homicide or violent ideas. To practically discharge this duty of care to protect others, the police should be notified.

STEP 2 – ANALYSING INFORMATION

A risk assessment may be initial or it may be an ongoing procedure as part of the professional relationship with the client. If other risk assessments have been performed by the professional or others the current risk assessment information should be compared with previous information. The professional should consider if there are new risk issues that have emerged and how the current issues are being managed.

This involves asking oneself if the client is the same risk, less risk or greater risk for suicide than a previous assessment. It then needs to be considered whether the level of professional care is appropriate for this risk. What is ultimately being determined here is whether the patient is safe. This calculation takes into account not only characteristics of the client, but also of the professional. There are multiple factors that determine the capacity of a professional to safely manage a client with ongoing suicidality. These factors may be related to professional training, resources, time, strength of the therapeutic relationship, cooperation with other professionals and personal preference.

The involvement of a professional mental health service should always be considered with a suicidal client.

STEP 3 – CONCLUSION

A conclusion involves expressing a clear opinion about the client's risk for suicide and the appropriateness of current management. This should be clearly documented in a manner dictated by the professional's organisation. It should be a medico-legal requirement that this documentation is clear, specific and precise in regard to the particular client. If the organisation requires a risk assessment form to be completed, this should be considered only the final step of the overall process, but not an end in itself.

It is important to note that the purpose of doing this documentation is not to conclude that the patient is perfectly safe. The temptation to skew the result towards a more optimistic risk assessment out of some sort of concern about the professional's accountability should be resisted. The reality is that this is a challenging area of professional involvement usually undertaken in poorly resourced organisations.

It is suggested that the details of the patient's symptoms and signs of suicidality should be clearly documented. The professional should note whether the patient seems more or less safe since the last assessment. Concerns for the patients and others should be documented. It should be clearly noted whether the current treatment provided by the professional and others is adequate to manage the risk. It should then be clearly documented what needs to be done to reduce the risk level, and who is able to do this.

RISK MANAGEMENT

The topic of managing identified risk for suicide will now be briefly addressed.

Strategies for reducing immediate suicide risk can include simple techniques such as listening and talking to the client with empathy and understanding. Reducing agitated arousal and anger through psychotherapeutic or medication techniques can be particularly useful. Environmental interventions, such as restricting access to weapons, increasing observation and restricting a client's movement by admitting them to an appropriate mental health facility, can also be useful. Facilitating access to community services that can assist with social or relationship issues, may also be useful.

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Those professionals who are registered medical practitioners and have access to the use of the Mental Health Act to detain a patient to mental health care should remember that the signing of these papers does nothing to reduce suicide risks. What it does do is enact a set of powerful laws which enable the legal actions to interfere with a client's suicidal behaviour. In other words, the use of a detention order should not give a false sense of security to the professional. It should signal the beginning of a detailed and comprehensive mental health management strategy.

Professionals should take care if they plan to use so called 'suicide prevention contracts'. It can be argued that suicide prevention contracts in themselves can be counter productive as they may give the professional a false sense of security. Suicide prevention contracts do not work in themselves, but rather it is the intuitive therapy that a professional may deliver around the contract that can actively reduce suicide risk. It should be remembered that a contract is a technical and legal agreement with benefit for both parties. In general, a client may not enter into a contract if they lack autonomy in that specific area. A suicidal client, by definition, probably lacks autonomy in this area, or the professional would not be trying to intervene. Therefore, based on this ethical argument clients cannot credibly enter into suicide prevention contracts. Other disadvantages with suicide prevention contracts are that patients may feel ashamed if they believe they are 'breaking the contract', and will not contact the professional for fear of letting them down.

REFERRING TO MENTAL HEALTH SERVICES

The risk assessment method that has been described can give the professional a set of readily understandable terms to communicate with a mental health service. The points and process of the risk assessment should be described to the mental health service and the professional's concern made clear. A referral accompanied by a copy of the documented risk assessment will be treated seriously by mental health services.

SUMMARY

Risk assessment for suicide is a challenging clinical area. There are no gold standard techniques or tools to make the job easier. There are a number of pitfalls and erroneous beliefs that the professional needs to avoid in order to prevent their assessment of a client's suicidality being skewed.

The implementation in one's own practice of a method using clear questions tailored to a style suiting the therapist is an excellent professional investment. The professional should have an internal audit process at their own worksite to ensure that risk assessments are regularly and efficiently performed.