EDITORIAL

Can Suicide Be Assessed?

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ABSTRACT

Suicide is a major public health concern. **It is** death caused by self-directed injurious behavior with intent to die as a result of the behaviour. Suicide risk assessment is a structured approach and is the process of evaluating an individual's likelihood of dying by suicide. The approach used by healthcare professionals to identify individuals at risk of dying by suicide. There are so many instruments for the detection and assessment of suicide risk like- Suicidal Ideation Attributes Scale , Reasons for Living Inventory , The *Suicide Behaviors Questionnaire-Revised,* Suicidal Affect Behavior Cognition Scale , Modified Scale for Suicide Ideation , Suicide Intent Scale , Scale for Suicide Ideation , Columbia-Suicide Severity Rating Scale , Brief Suicide Safety Assessment for Patients Who Screen , Ask Suicide-Screening Questions ,The Nurses' Global Assessment of Suicide Risk, Sheehan Suicidality Tracking Scale, P4 screener. The BSI and the C-SSRS were the two most frequently mentioned as a standard tool for the clinical evaluation of individuals. Both were frequently used and equally important.

Key words: Suicide, Risks, Death, Assessments, Tools, Evaluation.

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INTRODUCTION

Suicide risk assessment is the process of evaluating an individual's likelihood of dying by suicide. During this process professional gathers information from various sources, including the patient/person himself, other contacts/informants of the patient/person (like-friends, family, primary care or other mental health clinicians), medical records, police records, screening tools regarding suicidal ideation, historical and current risk, and protective factors. Healthcare professional (HCP) have a key role in assessing the risk of suicide. More than half of the individuals who died by suicide have seen by HCP. Assessing and managing this risk remains challenging for HCPs, however, "The estimation of suicide risk as well as at the culmination of the suicide assessment is the essential clinical judgment, since no study has identified one specific risk factor or set of risk factors as specifically predictive of suicide or other suicidal behavior."(Ahmedani et al 2019, Ahmedani et al 2019 et al 2014).

There is also some limitation to assess suicidal ideation and suicidal thoughts. Suicidal ideation is often unrecognized in primary care or medical specialty settings due to an inability of patients to articulate their feelings to their health care providers and a discomfort among non–mental health clinicians to ask about such feelings. (Williams et al 1999, Feldman et al 2007). Another worry that asking about suicidal thoughts may actually trigger suicidal ideation and behavior is unfounded (Gould et al, 2005). Although asking about suicide when identifying and treating depressed patients is considered standard of care, competing demands in medical practice create particular barriers to interview

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techniques that require prolonged probing (Williams et al 1998). The sensitivity and discomfort surrounding suicide assessment and overestimates of how often urgent mental health referral may be required further emphasise these barriers. Surprisingly, there is even inconsistency in the degree to which mental health professional ask about and document suicidal ideation in routine clinical practice, an omission which can be improved by the use of brief assessment measures (Duffy et al 2008).

The purpose of suicide risk assessment is to identify warning signs, contributing factors- mental illness, prior attempts etc. and protective factors like family support as wells social supports. The task is very difficult about how to assess suicide risk, because suicide is a statistically rare event influenced by multiple interacting variables, which makes reliable prediction difficult. (Bongar,1991, Bryan 2022). Imminent suicide risk is often used to justify emergency interventions but lacks a solid empirical foundation some psychiatrists advocate abandoning risk suicide assessment as a clinical tool due to its inaccuracy and potential harm. (Simon,2006). Data suggest that most individuals who die by suicide are not identified as high-risk, and many classified as high-risk do not die by suicide.(Mulder et al 2016,Bryan,2022., *Large et al 2016.,*).Franklin et al (2017) findings have yielded only slight predictive power for suicidal ideation, attempts, and deaths; no risk factor category clearly outperforms, and accuracy has not improved over time. Similarly, Carter et al. (2017) found that most suicide risk tools had a positive predictive value below 5%, meaning that the vast majority of those categorized as high-risk would not die by suicide. Baston (2024) argues that suicide risk assessment is necessary as long as medical resources are limited, so that those at high risk have priority over those at low risk. There is also frequent conflation of suicide with non-suicidal self-injury (NSSI), although the overlap between these behaviors is limited. Empathic inquiry into an individual's distress, hopelessness, and reasons for living is increasingly considered more clinically valuable than risk stratification. (Gelder et al 2005, Dazzi et al 2014). So, there is very tough task to assess or evaluate suicide risk.

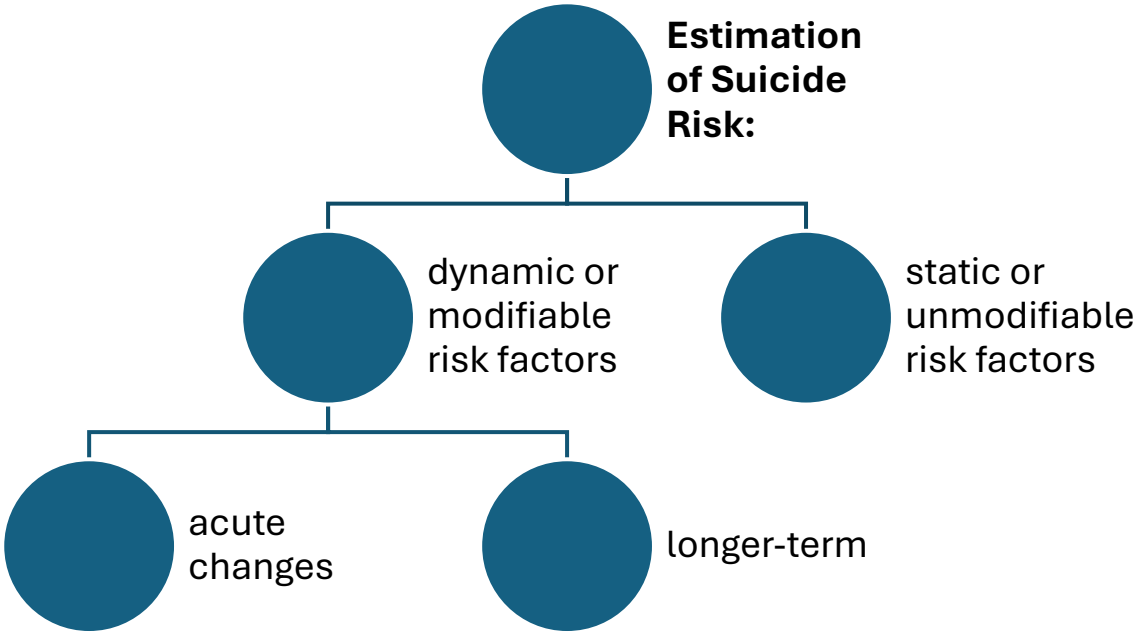
Components of a suicide risk assessment: There are five components of a suicide risk assessment: [i] identifying risk factors and protective factors, [ii] conducting a suicide inquiry, [iii] determining risk level [iv] interventions, and [v]documenting a treatment plan. According to Simon (2002) suicide risk assessment and formulation consists of a patient's static and dynamic risk factors, risk-reducing protective factors, and courses of action that mitigate risk. The quality of the information gathered from the patient is influenced by the therapeutic alliance and the patient's level of cooperation. When the patient is guarded or circumspect, this reduces the validity of the patient's answers and increases the risk. These are the current presentation of the client/patients, which is important to assess for the suicide risk as well as its management - [a] Thoughts, plans, or intention of suicide or self-harm.[b] suicidal ideation: The worst moment of an individual's life are a stronger predictor of death by suicide (Silverman et al 2014). [c] Suicidal behaviour [d] Planned method of suicide and the patient's expectation of the lethality of that method [e] Accessibility of firearms [f] Hopelessness, impulsivity, anhedonia, panic attacks, or anxiety.[g] Reasons for living and plans[h] Alcohol or other substance use [i] Thoughts, plans, or intentions of violence towards others

Apart from current presentation of the client/patients, psychiatric illness, psychosocial situation, Strengths and vulnerabilities and Protective factors also play important role in suicide. The assessment and information about these factors are also important. (i) Psychiatric illness: like current signs and symptoms of psychiatric disorders, including mood disorders, schizophrenia, substance use disorders, anxiety disorders, and personality disorders. Previous psychiatric disorders, including the course of the illness, and treatment/hospitalizations - [a] Previous suicide attempts, including why, when, and how [b] Aborted suicide attempts [c]Other self-harming behaviors [d] Medical diagnoses and treatment, including history of surgery, head trauma, and

hospitalization [e] Family history of mental illness, substance use, and suicide or suicide attempts. (ii) Psychosocial situation-[a] Acute crises [b] Chronic stressors such as relationships, domestic violence, financial status, history of sexual or physical abuse, or neglect [c] Employment status [d] Living situation and presence of children [e] Quality of family relationships [g] Cultural and religious beliefs about suicide. (iii) Strengths and vulnerabilities-[a] Coping skills [b] Personality traits [c] Past responses to stress [e] Ability to reality test [f] Capacity to tolerate psychological pain [g] Ability to satisfy psychological needs. (iv)

Protective factors: [a] Good social support and a social network [b] Religious beliefs [c] Reasons for living [d] Responsibility for young children [e] Problem-solving and effective coping skills[f] Current engagement in treatment[g] Hopefulness[f] Treatment with evidence-based therapy

Suicide risk is broadly categorized into two types: static or un-modifiable risk factors and dynamic or modifiable risk factors. There are two types of dynamic risk factors: acute crises or changes that can be mitigated or modified by brief interventions, and longer-term conditions that are usually difficult to modify with short-term interventions, such as inpatient hospitalization and medication changes (Fazel et al 2020, Favril et al 2023, Steele et al 2018, Turecki et al 2016). So, there is important to assess both the risk.



[1]Dynamic/clinically modifiable risk factors (short-term): [a] Social isolation[b] Unemployment [c] New diagnosis of a chronic or terminal illness [d] Access to lethal means, especially firearms[e] Acute psychiatric illness [f] Relationship conflict [g] Legal problems[h] Family-related conflict [i] Anxiety and agitation[j] Hopelessness and feelings of failure[k] Perceived worthlessness or burdensomeness on family/friends [l] Insomnia [m]Current thoughts of suicide: frequency, intensity, and duration[n] Current plan for suicide[o] Preparatory behavior for suicide [p] Current or recent alcohol or substance abuse[q] Feeling trapped[r] Recklessness and impulsivity [s] Recent life events such as bereavement, divorce, loss of social support, financial crises, traumatic events, and other interpersonal stressors

[2] ***Static/un-modifiable risk factors:*** [a] Demographic factors, including age (some risk factors are age-stratified), male sex, white race, and less than a high school education and low socioeconomic status [b] Discharge from inpatient psychiatric treatment within the past week, month, and year[c] Family history of mental disorders, suicide attempts, or suicide [d] Loss of a parent in early childhood due to suicide [e] Sexual minority status (particularly for adolescents and young adults) [f] Adverse childhood experiences such as physical and emotional neglect, verbal abuse, physical abuse, sexual abuse, parental loss, parental incarceration, or living with a household member with mental illness or substance use disorder [f] Previous suicide attempt of client/patients—people with multiple attempts may be a different group from those who report suicidal ideations or have a single suicide attempt [i] History of self-harm [j] Non-suicidal self-injurious behaviors: Higher frequency and different methods confer higher risk [k] Any mental disorder, including bipolar disorder, depression, anxiety, schizophrenia, substance use disorders, and eating disorders, especially with increased impairment, any personality disorder, especially borderline personality disorder. People with schizophrenia, depressive symptoms, positive symptoms, insight about the illness, young age, and being male confer a higher risk. [l] Involvement with the criminal justice system or receiving state care in childhood [m] Arrests/incarceration; a higher number of arrests increases the risk [n] Military service [o] Medical conditions, including epilepsy, traumatic brain injury, and chronic or terminal illness.

Common tools: There are several tools publicly available. Each tool has different methods of scoring for suicide risk. The purpose of the assessment is to determine next steps. Some evidence-based assessment tools that can be used to assess risk of suicidal ideation or behaviours in individual patient, while others are for general population .The commonly used instruments are in suicide risk assessment include:

[I] **Ask Suicide-Screening Questions (ASQ) Toolkit:** For medical settings, one of the biggest barriers to screening is how to effectively and efficiently manage the patients that screen positive. Earlier in the year 2008, NIMH led a multisite study to develop and validate a suicide risk screening tool for youth in the medical setting called the Ask Suicide-Screening Questions (ASQ). After that, in the year 2014, another multisite research study was launched to validate the ASQ among adults. The ASQ consists of four (yes/no) questions and takes only 20 seconds to administer. The screening identifies individuals that require further mental health/suicide safety assessment.(Horowitz et al 2012).

[II] **Brief Suicide Safety Assessment for Patients Who Screen** Positive (BSSA): The BSSA is the middle step of the 3-tiered clinical pathway and its help the clinician decide whether it is safe to send the patient home, or whether there is a need for immediate intervention. This is different from the screening tool, which simply identifies risk. The BSSA is a brief conversation with the patient that assists in further triage by evaluating their personal risk and protective factors (eg, frequency of suicidal thoughts, plans, psychiatric symptoms, suicide attempt history, reasons to live, social support).The assessment can be performed by anyone with advanced training and has been trained in how to administer the specific assessment tool. This assessment tool can be used by a trained mental health professional or a non–mental health clinician who is trained to evaluate suicide risk (e.g., physician, nurse practitioner, physician assistant). Training on how to conduct the BSSA can be found in the ASQ Toolkit.

[III] **Columbia-Suicide Severity Rating Scale (C-SSRS):** C-SSRS is a unique suicide risk assessment tool that supports suicide risk assessment through a series of simple, plain-language questions that anyone can ask. The answers help users identify whether someone is at risk for suicide, assess the severity and immediacy of that risk, and gauge the level of support that the person needs. Users of the C-SSRS tool ask people: [A] Whether and when they have thought about suicide (ideation) [B] What actions they have taken—and when—to prepare for suicide [C] Whether and when they attempted suicide or began a suicide attempt that was either interrupted by another person or stopped of their own volition (Posner et al 2011). C-SSRS is a questionnaire used for suicide assessment developed by multiple institutions, including Columbia University, with NIMH support. The scale is evidence-supported and is part of a national and international public health initiative involving the assessment of suicidality. Available in 103 different languages, the scale has been successfully implemented across many settings, including schools, college campuses, military, fire departments, the justice system, primary care and for scientific research.

The C-SSRS is comprised of four sections presenting 18 items that aim to predict potential suicide risk in both suicidal and non-suicidal individuals. The sections are-[i] Section 1 deals with the severity of ideation (**severity subscale**), rated from 1 to 5, where 1 = wish to be dead, 2 = non-specific active suicidal thoughts, 3 = suicidal thoughts with methods, 4 = suicidal intent, and 5 = suicidal intent with plan.[ii] Section 2 comprises the **intensity subscale**, including 5 items, each of them rated on a 5-point ordinal scale: frequency, duration, controllability, deterrents, and reason of suicide ideation.[iii] The following section consists of the **behavior subscale**, which is rated on a nominal scale that includes actual, aborted and interrupted suicide attempts, preparatory behavior, and non-suicidal self-injurious behaviour.[iv] The fourth and last section is considered to be the lethality subscale. This section assesses the actual lethality of suicide attempts, which is rated on a 6-point ordinal scale. When this subscale scores zero, then potential lethality is rated on a 3-point ordinal scale.

This scale presents well thought aspects to provide a good and accurate assessment of individuals that are or are not at risk of suicide, which makes it a good instrument for clinical assessment and enables the choice and use of effective strategies in the health field.

[IV] **Scale for Suicide Ideation (SSI)(Beck et al 1979) :** The psychometric properties of the Scale for Suicide Ideation—Current (SSI-C; Beck et al 1979) and the Scale for Suicide Ideation—Worst (SSI-W; Beck et al 1997), were explored. These 19-item clinician-administered scales measure current suicide ideation (SSI-C) as well as suicide ideation at its worst point in the patient's life (SSI-W).The Beck Scale for Suicide Ideation (BSI) comprises three sections that aim to

assess severity of suicide ideation. [i] The first section of the BSI presents five questions about the wish to die: 1) wish to live, 2) wish to die, 3) reasons to live, 4) wish to commit suicide, and 5) self-protection in case of a life threatening event. In this first part, when questions 4 and 5 score zero, the interviewer should skip section 2 and proceed to section 3.[ii] Section 2, with questions from 6 to 19, focuses on suicide ideation: 6) periods of suicide thoughts, 7) suicide thoughts, 8) acceptance of the suicide ideation, 9) control over committing suicide, 10) deterrents for suicide (such as family, friends), 11) reasons to commit suicide, 12) a specific plan of how to commit suicide, 13) accessibility to a method or specific opportunity to commit suicide, 14) courage or capability to commit suicide, 15) the wait to attempt suicide, 16) preparations to commit suicide, 17) a suicide note, 18) thoughts of what should be done after suicide, and 19) hiding the wish to commit suicide from people. When section 2 questions are covered, the interviewer is directed to the next section.

[iii] The third and final section presents only two questions, related to the suicide attempt (questions 20 and 21): 20) suicide attempt, 21) intensity of the wish to die related to the suicide attempt.

Despite being widely used and considered a good reference to assess patients with suicide risk based on their wish to die, suicide ideation and suicide attempts, a breach that has been considered is the fact that the BSI is commonly applied to patients who already are at risk of suicide. It is important to mention that the BSI is widely used by healthcare professionals as a supportive tool for clinical assessment, as it comprises aspects that effectively evaluate the suicide context. The SSI administered by trained psychiatrist. It allows doctors to choose, from a range of investigation paths, the one that will suit the assessed individual in order to deliver the best care and treatment, while the BSI, its self-administered counterpart, includes 19 items rated on a three point likert scale.

Difference between BSI and Scale C-SSRS

	The Beck Scale for Suicide Ideation (BSI)	**Columbia-Suicide Severity Rating Scale (C-SSRS):**
1	BSI is commonly used only in patients who are already at risk of suicide.	The C-SSRS seems to be more accessible, as it can be used in individuals considered or not to be at suicide risk, in order to assess their potential risk for suicide.
2	It is divided into three sections with more objective questions, which simplifies its use by healthcare professionals.	It is divided into four sections and the questions in the C-SSRS are longer than the ones in the BSI.
3	BSI can be self-administered	whereas the C-SSRS cannot
4	Even though the BSI is also known to have been adapted to many languages, there is no easy-to-access website available listing the countries/languages in which the BSI has been validated. This makes BSI less accessible,	C-SSRS has been adapted to over 100 countries, and this information can be easily consulted on line, e.g., in a website.

Both scales present good psychometric evidence in their original versions and cross-cultural adaptations, the BSI appears to be easier to apply, whereas the C-SSRS is more accessible.

[V] **Suicide Intent Scale (SIS)(Beck et al 1974) :** SIS is an instrument using15-items designed to examine the factual aspects of the suicide attempt; such as the patients thoughts and feelings and the circumstances at the time of the suicide attempt..

[VI] **Modified Scale for Suicide Ideation (MSSI): Miller et al (1986)** developed a modified version of the MSSI for use by paraprofessionals. Modifications included prompt questions, a standardized sequence of administration, modification of the rating points, development of initial screening scores, and selection of items based on internal consistency and relationships with clinical ratings. The MSSI (a) demonstrated excellent internal consistency and inter ratter reliability, (b) correlated highly with experienced clinician's ratings of suicidal ideation and risk, and (c) discriminated between suicide attempters and non-attempters prior to hospitalization.

[VII] **Suicidal Affect Behavior Cognition Scale** (SABCS) (Harris et al 2015): The SABCS was developed to assess suicide risk. It includes items on death-related affect, wish to live (WTL), and wish to die (WTD); suicidal behaviors; suicidal cognition, debate and ideation; and prediction of future suicide attempts. This self-report measure has 6-items rated with various responses.

[VIII] **The Suicide Behaviors Questionnaire-Revised** (*SBQ-R,* Osman et al 2001): *SBQ-R* is a psychological self-report questionnaire designed to identify risk factors for suicide in adolescents and adults. The four-item questionnaire asks about four constructs within the suicidal behavior domain: lifetime ideation and attempt, recent frequency of ideation, suicide threats, and self-assessed likelihood of future suicidal behavior. The four items are rated on Likert scales of varying lengths, resulting in total scores between 3 and 18.

[IX] **Reasons for Living Inventory** (RFL) (Linehan et al 1983): The Linehan Reasons for Living Inventory (LRFL) is a multidimensional inventory composed of 48 items with six dimensions. The RFL consists of six subscales/primary reasons for living: Survival and Coping Beliefs, Responsibility to Family, Child-Related Concerns, Fear of Suicide, Fear of Social Disapproval, and Moral Objection. Survival and Coping Beliefs (e.g., "I believe I can find a purpose in life, a reason to live"), Responsibility to Family (e.g., "It would hurt my family too much and I would not want them to suffer. The items are rated on 6-point Likert type scales based on how important each reason would be for living if suicide was contemplated.

[X] **Suicidal Ideation Attributes Scale (**SIDAS, Van Spijker et al 2014): The SIDAS is designed to screen individuals in the community for presence of suicidal thoughts and assess the severity of these thoughts. It consists of five items, each targeting an attribute of suicidal thoughts: frequency, controllability, closeness to attempt, level of distress associated with the thoughts and impact on daily functioning. Responses are measured on a 10-point scale. Items are coded so that a higher total score reflects more severe suicidal thoughts.

[XI] **4 P's:** The P4 screener assesses suicide risk by asking about the "4 P's": [i]. Past suicide attempts, [ii]. A Plan [iii] Probability of completing suicide and [iv]. Preventive factors. Most participants in clinical trials of depressed medical patients who acknowledge thoughts of self-harm are ultimately classified as low risk by the P4 screener.(Kroenke et al 2001, Kroenke et al 2009a, Kroenke et al 2009b).

[XII] **Sheehan Suicidality Tracking Scale** (Sheehan-STS, Coric et al 2009): The Sheehan-STS is a prospective, patient self-report or clinician-administered rating scale that tracks both treatment-emergent suicidal ideation and behaviors.

[XIII] **The Nurses' Global Assessment of Suicide Risk** (NGASR, Cutcliffe & Barker,2004): The NGASR appears to provide a useful template for the nursing assessment of suicide risk, especially for the novice**.**

There is no single recommended method to screen for suicidality (Gaynes et al 2004). There are several longer scales such as the Beck Scale for Suicidal Ideation (21 items), the Columbia Suicide Severity Rating Scale (18 items), the Sheehan Suicide Tracking Scale (8 items), and the Nurses' Global Assessment of Suicide Risk (15 items). In addition to the length of the scales, their scoring is more complicated, and they have often been tested in psychiatric rather than in general medical populations. A few studies have used more complex algorithms to assess suicidality (Oyama et al 2004, Brown et al 2001). A simpler algorithm that helped inform the P4 screener was developed by Cole and colleagues. Through the analysis of the components of each scale, it has observed that some aspects are contemplated by one or the other instrument, but are not present in both. Therefore, the

development of a new tool to assess suicide risk and capable of solving the breaches identified in these scales is suggested. There is need to develop a new tool capable to widely and completely evaluating all psychopathological aspects of suicidality, including the wish to die, suicide ideation, suicide attempt, severity and intensity of ideation and suicidal behavior. Such instrument should encompass few sections with more specific and less extensive questions, so as to enable a better understanding for both interviewee and interviewer. Fazel et al (2024) have developed structured, data-driven models to assist suicide risk assessment. These include the Oxford Mental Illness and Suicide tool (OxMIS) and the Oxford Suicide after Self-harm tool (OxSATS), which combine demographic and clinical data to produce probabilistic estimates of suicide risk. These tools show promise in supporting clinical decision-making and may reduce reliance on subjective judgment, while there were some study indicated that suicide risk assessments lack predictive accuracy and do not improve clinical outcomes. Clinicians doing suicide risk assessments may be putting their "own professional anxieties above the needs of service users. (Simon,2006., Bryan & Rudd,2006., Chan et al 2016).

Conclusion

There are so many instruments found to be used by healthcare professionals in the detection and assessment of suicide risk. The BSI and the C-SSRS were the two most frequently mentioned as a standard tool for the clinical evaluation of individuals that are or are not at risk of suicide. Both were frequently used and equally important. The BSI was found to be easier to apply while the C-SSRS more accessible across countries, while the BSI and the C-SSRS present limitations related to the individual to be assessed and it was not yet possible to identify a gold standard.

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