both the assessor and patient are aware that this is likely to be the only contact between them, further reducing the likelihood of frank disclosure of trauma and abuse; this is strongly associated with invalid assessments and completed suicide in the future.[3]

Patients also find repeated disclosures of personal details to multiple mental health staff frustrating and traumatic,[4] along the lines of 'why don't you look up the notes before speaking to me?'. Similar to the experience of repeated police interviews under implied caution ('anything you say might be used for a future Mental Health Act assessment'), patients are (perhaps rightly) suspicious that the assessors are looking for discrepancies in the history to undermine the reliability of the person's account leading to suicidal thinking and/or self-harming behaviour, thereby making it easier to discharge (or dismiss) the patient seeking help.

Professor Morgan touches on in-patient ('never event') suicides,[5,6] mainly involving patients who have either absconded or been given planned home leave, as major improvements to ward design (including shaving off door edges and securing windows, door handles and toilet equipment) have now taken place. He does not, however, suggest practical changes in ward policy, for example, the potential benefit of a face-to-face review within 24 h of being placed on home leave in order to check on basic needs (elegantly summarised by Maslow), as well as potential toxic relationships with close family members, who might be either over-controlling or otherwise pessimistic on the prospects of the patient moving from being a burden (a variation on therapeutic nihilism and malignant alienation, not often discussed in the literature).

Finally, the issue that I, as a clinician, struggle most with when debriefing assessors or looking at longer-term suicide mitigation is that suicide risk assessment is used primarily as a defensive tool by the assessor, possibly aided by the patient, who does not wish to upset the assessor or get him/her into trouble in the future. So, the 'protective factors' often highlighted in the assessment are documented without due diligence on how stable or permanent these are.

On occasion, a suicidal person will 'blurt out' a suicide plan he/she has been considering. Often, this communication is with a staff member of low rank, for example, a ward domestic or student nurse, simply based on their compassionate nature and their not being part of the 'assessment brigade'. Typically, these patients will subsequently deny that they will carry out this plan, and at times they will deny ever having disclosed such a plan, but, given the circumstance or opportunity, they may use the plan. Alternatively, a person who has failed with a plan will deny wanting to repeat the action (for example, an overdose) but could use this as a learning experience to organise a variation or plan more violent methods such as jumping or hanging.

As Professor Morgan rightly states, an assessor needs to compassionately (and non-judgementally) ask whether alternative means have been considered following a failed suicide attempt. This is genuinely hard work and especially emotionally draining. Therefore, it is essential for staff assessing suicidal patients to be debriefed supportively and given sufficient time off (at least undertaking other duties) to regain their emotional composure.

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Response to Dr de Silva's letter

02 December 2020

Dr de Silva's wide-ranging review of suicide prediction strategies is very welcome: it includes a number of useful new ideas on how our predictive efforts can be taken forwards. I do not wish to take issue with any of them. My own paper, however, focuses more narrowly on two specific issues. The first highlights the way in which ongoing variation in severity of intent, usually due to the random and unpredictable occurrence of stress-related events, can confound our predictive efforts, and I suggest how we might circumvent this. The second aims to show that, in spite of attempts to dismiss its value, the assessment of suicidal ideation can have a useful role in the prediction process, provided it is applied correctly and used appropriately. My approach is in the nature of risk assessment, which has been criticised by some as being too dependent on negative issues. I hope I have shown that by helping to identify future hazards and so anticipate ways of dealing with them, this is not just a negative process. A capable clinician should surely be able to ensure that such assessment does not compromise the establishment of a good trusting relationship with the patient. My overall hope for the future of suicide prevention is that polarised views, in which different approaches are seen as either good or flawed, will not prevail. Good points from each and every approach can then be incorporated into an overall synthesis of preventive strategy that can be used in clinical practice.

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