Suicide risk assessment: where are we now?

A definitive way to identify patients who will suicide remains elusive

Patients who present in psychological crisis or after a suicide attempt are more than 50 times more likely than the general population to die by suicide in the following year. They require careful assessment and management. Numerous publications suggest, and some health department policies insist, that such patients should undergo a “comprehensive suicide risk assessment” in addition to a standard clinical assessment. Although most guidelines warn that suicide risk assessment does not substitute for clinical judgement, almost all also include long lists of patient characteristics that are claimed to enable identification of those patients at high risk of suicide. These lists are often fashioned into ad-hoc scales that purportedly stratify patients into categories of low, medium and high risk. However, it is simply not possible to predict suicide in an individual patient, and any attempt to subdivide patients into high-risk and low-risk categories is at best unhelpful and at worst will prevent provision of useful and needed psychiatric care. Here, we explain why this is so and outline what we believe clinicians should do instead.

Although patients presenting after suicide attempts or in crisis have a greatly increased probability of eventual suicide compared with the general community, fewer than one in 200 will actually die by suicide in the next 6 months. Suicide risk assessment is usually suggested as a way of determining who among these presenting patients should be offered different or more intensive treatment. However, the low base rate of completed suicide, combined with the lack of defining characteristics of people who proceed to suicide, makes this task impossible. Any useful further risk assessment would need to rely on a risk factor or a combination of risk factors that are consistently present, can be reliably assessed, and are very strongly
overrepresented in the few people who do eventually
suicide and yet rare or absent in those who do not. There is
no evidence that such a risk factor or combination of risk
factors exists. In 1983, the author of a large, well conducted
prospective study of suicide lamented that “we do not
possess any item of information or any combination of
items that permit us to identify to a useful degree the
particular persons who will commit suicide”. Thirty years
later, nothing has changed: a similarly large and methodo-
logically sound prospective study of psychiatric inpatients
found that only 12% of suicides occurred among high-risk
patients, and that fewer than one in 400 high-risk patients
suicide.5,7

The list of generally accepted suicide risk factors is long
and includes male sex, old age, divorce, medical illness,
substance use, past suicide attempts and guilt. The most
often cited risk factor for future suicide is expressed sui-
cidal ideation.3,4 However, among psychiatric patients,
expressed suicidal ideation does not discriminate between
suicide completers and non-completers.8 Presumably this
is because thoughts of self-destruction are very common in
this group and because many people intent on suicide will
not disclose that intent. Other intuitively appealing candi-
date characteristics include depressed mood and hopeless-
ness. These, too, are almost universally found in the risk
factors nominated in suicide risk assessment guidelines.3,4
However, not only are they very common in patients
presenting with psychological problems, but most people
with depressed mood will also feel hopeless, and vice
versa; therefore, the combination of these risk factors
offers little additional discriminative ability.

In recent decades, an enormous amount of research has
gone into finding the magic combination of risk factors
that acts as a sensitive and specific discriminator.5,6,9,10
Almost every study of completed suicide is retrospective,
examining dozens, sometimes hundreds, of characteristics
recorded in the medical records of both patients who
suicided and controls, searching for factors or combina-
tions of factors that were present more often in the
patients who died.11,12 Such studies are likely to yield
chance findings that appear to be significant, and they
could identify some potentially reproducible associations
with suicide. However, meta-analysis finds contradictory
results between studies, leaving very few candidate risk
factors among all the studies examined.11-13 Moreover,
even a combination of reproducible risk factors still fails to
provide a useful way of identifying high-risk patients. We
examined studies investigating risk factors for completed
suicide within a year of inpatient psychiatric treatment.
Even making assumptions that optimise the power of
suicide risk assessment, we estimated that while some
patients could be categorised as “ultra-high-risk”, as few
as 3% of these would go on to suicide in the year after
discharge. Meanwhile, about 60% of people who did
eventually suicide during the same period would have
been categorised as being at lower risk.11

In original research and in meta-analyses, no generally
accepted risk factors individually or in combination provide
any useful way of further categorising patients who present
in crisis. We understandably want to identify those who
will later kill themselves — but this is simply not possible.

Here and now, clinicians should not be conducting
“comprehensive suicide risk assessments”. They should be
conducting comprehensive clinical assessments of each
patient’s situation and needs. Suicidal ideation, for exam-
ple, is not useful as an indicator of the likelihood of future
suicide, but it is an invaluable sign of a person’s inner
despair. So-called risk factors like depression, hopeless-
ness and substance misuse are far too common and non-
specific to be useful indicators of suicide risk, but they can
be seen as symptoms of mental illness and important
pieces of a revealed inner life that, taken together, give us a
better understanding of the individual person and guide us
in what needs attention and discussion.

This is not to say that we should abandon patient safety.
Bolstering family or social support, restricting access to
lethal methods of suicide or making a crisis plan are steps
that should be taken for all patients in psychological crisis
—not just those whom we imagine might be more likely
to suicide than others.

We cannot prevent tragedy by trying to identify those
few souls who will be consumed by it. We must instead
gather a comprehensive picture of each individual patient,
and use this to tailor optimal management for the patients
and families needing our care.

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