Suicide risk assessment

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In a Personal View published in August, 2022, Hawton and colleagues[1] show the predictive limits of suicide risk assessment and call for a more comprehensive and therapeutic approach to assessing, formulating, and managing risk of suicide. Their article critiques risk prediction (risk assessment) and offers an alternative, described as "therapeutic risk assessment and formulation".[1] We believe that the authors' criticisms of risk assessment are not comprehensive enough and that the solution they suggest—assessing suicide risk using their own list of risk factors—has the same inherent flaws as other methods.

Hawton and colleagues[1] overlook what we see as the primary problem. They focus on three difficulties with suicide risk assessment: the limitations of clinical judgment about suicide; the unreliability of self-reports of suicidal ideation; and the poor performance of suicide risk scales. Although all these criticisms are valid, risk assessment could still be a viable way of stratifying groups of people at different likelihoods of suicide if there were a range of risk factors that could be used to usefully define risk categories. However, none exist.

In 2017, Franklin and colleagues[2] published a comprehensive meta analysis of more than 3000 risk factors for suicidal thoughts and behaviours. Their conclusion was that "prediction was only slightly better than chance".[2] Broad groups of risk factors—including family history, psychopathology, previous suicidality, social factors, physical illness, and demographics—were only weakly associated with death by suicide, as were the top five suicide risk factors of prior psychiatric hospitalisation prior suicide attempt, prior suicide ideation, low socioeconomic status, and stressful life events.

However, even accepting the weakness of risk factors and groups of risk factors, suicide risk assessment might have use if multiple risk factors and warning signs could be usefully aggregated by suicide prediction modelling. Two major studies have now assessed the statistical power of suicide prediction models. Belsher and colleagues[3] examined 64 models and found that the "accuracy of predicting a future [suicide] event is near 0", and Corke and colleagues[4] analysed 102 suicide prediction models and their performance was not much better. Corke and colleagues[4] also tested whether strong prediction could be obtained by using a larger number of risk factors, but found no evidence that models using many risk factors worked any better than those using as few as two.

As no individual risk factor or combination of risk factors has been shown to impart predictive utility, it is confusing that Hawton and colleagues[1] recommend risk assessment should be done essentially on the basis of a clinical consideration of multiple suicide risk factors as listed in their paper. Even if their selected criteria were supposedly met, suicide would remain an unpredictable and unlikely outcome.

We appreciate the authors highlighting means restriction as an evidence-based suicide prevention measure. We also endorse their compassionate approach to the therapeutic encounter, using "genuine listening and validation" with "warmth and thoughtful curiosity".[1] However, this style of engagement would be commended in any clinical situation and is not specific to suicide. By focusing on suicide risk, Hawton and colleagues[1] might inadvertently be compounding an unhelpful anxiety-based response to the elevated suicide rate all psychiatric patients have.

The fundamental unpredictability of suicide should be acknowledged. Acceptance of this concept would allow clinicians and patients to continue with mental health care without the exaggerated perception of hazard and the unrealistic expectation of control that suicide risk assessment entails. We have written elsewhere what a positive alternative approach to helping distressed people might look like.[5] It is not dissimilar to the kind of therapeutic encounter that Hawton and colleagues[1] propose, but with the attention removed from suicide risk assessment and broadened into a wider and productive clinical concern.

MML and CJR regularly give evidence in legal hearings after suicides. CAS declares no competing interests.

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