Suicide risk assessment in general practice

Confronting the limitations

MATTHEW LARGE MB BS, FRANZCP, DMedSci
HANNAH MYLES MB BS

Although suicidal ideation and suicide attempts are common, suicide is rare. GPs have traditionally assessed suicide risk factors as a basis for predicting and preventing suicides, but recent meta-analyses have shown the limitations of this approach.

It is not uncommon for a person who has died by suicide to have recently seen a primary care doctor,[1,2] and it is widely assumed that GPs have an important role in suicide prevention. Several peer-reviewed publications and GP organisation guidelines suggest that GPs perform a 'suicide risk assessment' to identify patients who need more care, referral to specialist services or even hospitalisation.[3-7] However, GPs will struggle to find an appropriate suicide risk scale or method to meet this expectation because there are no accepted methods of assessing suicide risk in any setting.

Most patients will have at least one risk factor for suicide, such as being male, older age, Indigenous, being a member of the lesbian, gay, bisexual, transgender or intersex (LGBTI) community, living alone or in a rural area, having social disadvantage or current social problems, being depressed, abusing alcohol or other drugs, or being physically unwell. Furthermore, suicidal thoughts and behaviours are quite common. The 2007 National Survey of Mental Health and Wellbeing found that 13% of people in Australia had experienced suicidal ideation during their lifetime and that 3.2% had made an attempt.[8] The one-year prevalence for suicidal ideation was 2.3% and 0.4% for a suicide attempt.[8] By contrast, suicide is rare, with a one year prevalence of 0.0126% in Australia in 2015.[9]

These figures highlight the difficulty of trying to use common characteristics to predict rare catastrophes.

The reality is that suicide risk assessment does not work.

Recent meta-analyses have provided an overall appraisal of the uselessness of suicide risk assessment and what they found is summarised below.

- A mere doubling of the already rare incidence of suicide among people with suicidal ideations and behaviours.[10,11]
- A similarly modest association between suicidal intent and suicide among people presenting with self-harm (a weak risk factor for suicide);[12] to put this in context, the association between being male and suicide in Australia is more than threefold higher.
- People with depression and suicidal ideas are at little or no increased risk of suicide compared with depressed people without suicidal ideas.[13,14]
- Less than one in 400 people who express suicidal ideas will die by suicide in the next year.[14]
- As many as half of all suicides will be missed by high-risk classification.[15]
- Of high-risk patients, 95% will not die by suicide[15,16]
- Being placed in a high-risk group on the basis of multiple risk factors does not add to the strength of a risk assessment based on fewer factors.[15]

The various authors of the meta-analyses concluded that:

- the presence of suicidal thoughts and behaviours provides a marginal improvement in diagnostic accuracy above mere chance[10,11]
- the use of risk scales or an over-reliance on the presence of risk factors might provide false reassurance and are potentially dangerous[12]
- classification of a patient as being at high risk of suicide is not clinically useful as the basis of allocation of further care measures[16]

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Dr Large is a Senior Psychiatrist at the Mental Health Service, The Prince of Wales Hospitals; and Conjoint Professor in the School of Psychiatry, Faculty of Medicine at UNSW Sydney, NSW.
Dr Myles is Senior Psychiatry Registrar, Country Health, Adelaide; and a PhD student in the School of Psychiatry, the University of Adelaide, Adelaide, SA.
SERIES EDITOR: Professor Phillip Mitchell AM, FASSA, MB BS, MD, FRANZCP, FRCPsych, Head, School of Psychiatry, Faculty of Medicine, UNSW Australia; and Professorial Fellow, Black Dog Institute, Sydney, NSW.

- a robust method of rating suicide risk remains elusive.[15]

How then can GPs help prevent suicide without recourse to unworkable and unrealistic expectations about prediction?

Assessment

GPs will naturally be concerned about some patients' potential for suicide, and usually this will be because the patient has expressed suicidal ideation or has made a suicide attempt. However, suicide cannot be predicted by performing a suicide risk assessment; there is no method for assessing a suicidal patient that is suitable for all circumstances and not every patient needs to see a specialist mental health clinician. For a significant number of patients, statements about 'wanting to die' are an expression of distress and a request to the GP for assistance.

Assessing a suicidal patient is time consuming. The GP's main aim should be to understand the person's situation. This can be done only by considering their history and mental state, which might involve discussion with family and/or friends.

The assessment should be therapeutic, and the patient should be allowed to articulate their distress, while potential areas for treatment and intervention are identified. If it is a new patient, the GP can try to portray themself early on in the consultation as a warm, friendly, open person with the experience and authority to help. Identifying and addressing modifiable factors associated with suicide (such as depression and substance abuse) should be undertaken but the rationale is rarely specifically to prevent suicide. An exception might be the identification of potentially lethal methods of suicide, such as access to firearms.

Management

The variety of suicidal patients leaves little room for generalised advice about their management. However, these general principles apply:

- perform a thorough assessment with empathic listening
- offer evidence-based treatment options that are available in your setting to address the modifiable factors (e.g. drug and alcohol misuse, acute mental illness, psychosocial stressors)
- negotiate a treatment plan based on the patient's wishes
- assess the patient's decision-making capacity before any involuntary treatment is embarked upon
- document the consultation carefully
- monitor for negative counter-transference and seek supervision from peers.

Management of the patient begins at the start of the consultation. All suicidal patients will be distressed; many will feel stigmatised and ashamed. All patients who exhibit suicidal thoughts or behaviours warrant understanding, assistance and treatment irrespective of perceptions of what they might or might not do in the future.

The GP should offer understanding, reassurance and hope without judgement, and be aware of any personal anxiety or negative feelings towards the patient. The GP might feel hopeless about their ability or the ability of the medical system to help. These feelings are common; it is advised that GPs accept these feelings while being careful to keep them from affecting their demeanour and interactions.

The treatment plan should be the result of informed discussion about options, and should be individualised, negotiated and, where relevant, discussed with the patient's family and/or friends. No patient should go home without some sort of management plan.

Sometimes patient views on their care will oppose the suggested management plan. In these circumstances, it is appropriate to assess their decision-making capacity, remembering that, as part of this, the GP must do everything possible to support the patient's ability to make decisions. Even then, some patients with decision-making capacity will still make decisions that the GP might regard as foolish or even dangerous.[17,18]

GPs will differ greatly in their thresholds for referral of patients to psychologists, psychiatrists or public mental health services. A GP with time and interest or one familiar with the patient might need little outside help. On the other hand, patients' requests for a specialist referral, and anxiety in the family and friends, or even in the doctors themselves, might trigger a referral.

Involuntary hospital admission is a last resort. GPs should be mindful that suicide rates among psychiatric inpatients are high and that the trauma and stigma of hospitalisation might even precipitate some suicides.[19,20] That said, there is no doubt that some people do benefit from (even involuntary) psychiatric admission, and that admission can represent the most effective management option most consistent with the protection of patients' rights. Whether or not the patient is admitted, GPs should carefully document their reasoning for using, or not using, mental health legislation. Documentation should not focus on 'risk', but clearly articulate the patient's preferences, their capacity and the GP's reasoning regarding options for safe and effective care.[21]

Documentation should be succinct, but not perfunctory. It should include any underlying psychiatric or medical conditions, the patient's personality style, their strengths and resources, their ability to make choices and the choices they have made. Sometimes a specialist opinion will be needed.

Conclusion

Patients who present with suicidal thoughts and behaviours warrant careful attention. Not all suicides can be prevented, but a thorough and sympathetic assessment leading to an agreed treatment plan can help almost every patient. MT

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References

A list of references is included in the online version of this article (www.medicinetoday.com.au).

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