

Suicide Risk Assessment Forms: Form Over Substance?

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Suicide risk assessment is a core competency that informs patient treatment and management.¹ It is a process of analysis and synthesis that identifies, prioritizes, and integrates acute and chronic risk and protective factors into an overall assessment of the patient's suicide risk.

Psychiatrists assess suicidal patients who present life-threatening emergencies. Unlike other physicians, psychiatrists do not have laboratory tests and sophisticated diagnostic instruments to assess patients at risk for suicide. For example, when evaluating an emergency cardiac patient, the physician orders several diagnostic tests and procedures (e.g., electrocardiogram, serial enzymes, imaging, and catheterization) to provide clinical data that are analyzed and synthesized into an overall treatment and management plan. The psychiatrist's diagnostic instrument is systematic suicide risk assessment.

Suicidal patients can evoke a variety of troubling emotions in the clinician that cause anxiety, sleep disturbances, and distraction. Countertransference anger, hate, and a reaction formation of solicitude toward the suicidal patient can threaten the clinician's ability to assess and treat the patient competently.² A patient's suicide is devastating, arousing powerful feelings of grief, guilt, betrayal, anger, depression, and loss of clinical confidence.³ Charles and Kennedy⁴ have described the serious personal and professional consequences of a lawsuit following a patient's suicide. Thus, clinicians may resort to use of suicide risk assessment forms as a risk management technique, in the illusory belief that a form can provide a defense or deterrence against a malpractice

suit. Unfortunately, assessment forms merely cast a spell of reassurance, often masquerading as competent clinical assessment and judgment. The clinician is left with the false notion that further clinical assessment of suicide risk is unnecessary, paradoxically exposing the clinician to increased liability risk.

In suicide malpractice cases, plaintiffs' attorneys will closely scrutinize a suicide risk assessment form. Invariably, the patient who attempts or completes suicide is alleged to have displayed risk factors not included on the form. The attorney's expert will testify that, instead of relying on an assessment form, had the clinician performed a competent suicide risk assessment, the patient's increased suicide risk would have become apparent.

Fantasy Forms

Suicide risk assessment forms [hereafter referred to as form(s)] are endemic. They are created by mental health professionals who have a wide variety of training and experience. Of the plethora of current forms in existence, no two are alike. Many forms soon disappear, often after a patient's suicide, only to be replaced by another form with a brief half-life. Some forms become institutionalized, achieving a long life, despite multiple occurrences of suicides.

Forms do not possess psychometric properties (i.e., tested for reliability and validity). Some forms are designed to be numerically scored and totaled to reach an overall assessment of suicide risk. The resulting score is an illusion of accuracy, further misleading the clinician.

Risk assessment forms are favored by clinicians who treat patients in inpatient settings where rapid patient turnover and short lengths of stay occur. Seriously ill inpatients at high risk for suicide often evoke anxiety among the clinical staff, who then

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place their confidence in check-off forms. Similarly, in busy outpatient medication management practices, assessment forms are preferred because they can be quickly filled out during a brief visit. Checklists are often used in emergency departments, but usually require an accompanying documented narrative describing the suicide risk assessment process. It is much easier to use a checklist than to conduct a thorough suicide risk assessment. Unfortunately, there are no shortcuts or quick fixes in conducting a competent suicide risk assessment.

Another fundamental flaw of risk assessment forms is the absence of a process of analysis and synthesis. The clinician is not required to identify, prioritize, and integrate risk and protective factors into an overall assessment of the patient's suicide risk. Form trumps substance.

Another basic limitation found on many forms is the failure to determine the presence or absence of protective factors. Such factors require the same thorough assessment as do risk factors. A clinical assessment that considers only risk factors is incomplete and flawed.

Forms often contain impressionistic risk factors that the creator(s) erroneously believes to be reliable indicators of suicide risk. Some forms seem to be created out of thin air. For example, emotional pain, insight, and self-hate, perhaps applicable to a specific patient, are not evidence-based, general suicide risk factors.

Forms often display a paucity of evidence-based suicide risk and protective factors. For example, psychiatric diagnosis, an important suicide risk factor, is often omitted. Other important evidence-based risk factors may be glaringly absent: psychosis, melancholia, eating disorders, hopelessness, anxiety/agitation, insomnia, panic, impulsivity, anhedonia, substance abuse, recent interpersonal loss, comorbidity, and the presence of firearms in the home. In contrast, so-called shotgun forms include a bewildering list of suicide risk factors (some relevant; many not), that produce eye-glazing, robotic check-offs denoting their presence or absence. No documented narrative accompanies the checklist.

Patient self-assessment instruments are notoriously treacherous, especially when administered to inpatients at high risk for suicide. A clinical suicide risk assessment with documented narrative should accompany the self-assessment. Any discrepancies between the two assessments require exploration

with the patient. Some suicidal patients may reveal more on a form than in an interview.⁵ However, approximately 25 percent of patients at risk for suicide do not admit their suicidal ideation to the clinician.⁶ The assumption that the patient is truthful and wants to live cannot be blindly trusted. Some suicidal patients see the clinician and staff as the enemy and an obstacle to their intent to die.⁷ Also the self-assessment may be falsified to obtain discharge and to pursue an unhindered suicide. Even if the patient answers truthfully, self-administered suicide scales are overly sensitive and also lack specificity. For example, suicide risk factors are present in many depressed patients who do not attempt or complete suicide.⁸

Discrepancies can arise between checked-off suicide risk factors and the overall conclusion of suicide risk. For example, the clinician may check several moderate- and high-risk factors but conclude that the overall suicide risk is low or nonexistent. The reasons for the discrepancy are not explained. The discrepancy is often the result of the clinician's denial and anxiety-reducing wishful thinking. Mechanical, obligatory form completion ill serves the patient and the clinician. Moreover, the use of a form puts the clinician on notice that a clinical assessment must also be performed.

General risk factors listed on the forms, derived from community-based psychological autopsy and cohort and case control studies, may not capture the suicidal patient's unique, individual suicide risk and protective factors. For example, a schizophrenic patient who had a severe stutter would begin to speak clearly whenever she became acutely suicidal, a sign that the patient needed immediate hospitalization. As she improved, the stutter would gradually return, signaling that she could be safely discharged. Stuttering is not a recognized suicide risk factor, except in this patient. Also, most forms do not take cultural differences into account.

Assessment models may be used as teaching tools to help conceptualize the suicide risk assessment process.⁸ However, heuristic models may encourage the use of forms instead of clinical assessment, unless a caveat is given.

Psychometric Scales and Measures: The Science

The Joint Commission requires psychiatric facilities to use established tools to assess inpatients at

risk for suicide.⁹ Each facility is responsible for developing its own suicide risk assessment protocol. This requirement has led to a proliferation of suicide risk assessment forms, some derived from a single structured and semistructured clinical and research scale.

Commonly used standardized clinical scales include, for example, the Hamilton Rating Scale for Depression (Ham-D), the Beck Depression Inventory (BDI), and the Inventory of Depressive Symptomatology (IDS).¹⁰ Research scales with psychometric properties include The Columbia Suicide History Form (CSHF), which determines lifetime suicide attempts; the Beck Scale for Suicide Ideation (SIS), based on characteristics of suicide ideation; the Suicide Intent Scale (SIS), which identifies the wish to die; the Harkavy Asnis Suicide Survey (HASS), which detects suicide ideation and behavior; and the Beck Hopelessness Scale (BHS), which reveals negative attitudes about the future. Research scales and psychological instruments are not routinely used in clinical practice. However, the standardized suicide risk factor components of clinical and research scales are central to clinical assessment (e.g., suicide attempts, ideation, intent, and hopelessness).

The standard of care does not require that clinicians use psychological tests or checklists as part of the systematic assessment of suicide risk.⁵ A research or clinical scale cannot be a stand-alone substitute for clinical assessment of acute suicide risk.¹⁰ The scales and measures assess different domains of acute suicide risk. Even if all the scales were combined into a single risk assessment form, many other clinical risk factors would invariably be omitted. The variety of general and individual suicide risk factors cannot be captured by any form, no matter how elegantly constructed. (See Oquendo *et al.*¹¹ for a discussion of the utility and limitations of research instruments in assessing suicide risk.)

Clinical Assessment

No single suicide risk assessment method has been empirically tested for reliability and validity.⁸ Standard practice encompasses a wide range of reasoned clinical approaches.⁸ The clinician's duty is to perform a competent suicide risk assessment by using a reasonable method.

When substituted for clinical assessment, forms can increase the risk of missing a patient's suicidal

intent. Forms tend to be an event, whereas clinical assessment is a process. Some forms are completed on the patient's admission, others at discharge or at both times. How often patients at risk for suicide must be assessed depends on their clinical status. The best scales cannot perform the integrative function of clinical assessment and judgment. Structured and semistructured suicides scales, however, can complement clinical assessment.¹²

Malone *et al.*¹³ found that semistructured screening instruments improve routine clinical assessment in the documentation and detection of lifetime suicidal behavior. A documented brief narrative that describes the suicide risk and protective factors informing the overall assessment of risk is sufficient. The treatment and management interventions directed by the assessment and the effectiveness of the interventions should also be noted.⁸

Conclusion

Suicide risk assessment is a core competency. It is a process that identifies, prioritizes, and integrates suicide risk and protective factors into an overall assessment of the patient's suicide risk. The purpose of suicide risk assessment is to inform patient treatment and management. Assessment forms and checklists cannot perform this function. Clinicians who use assessment forms must do more. Using a suicide risk assessment form puts the clinician on notice that a competent assessment must be performed. Clinical assessment of suicide risk is still necessary. Clinical judgment cannot be abdicated in favor of suicide risk assessment forms. Forms are no substitute for spending time to know the patient.

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