Risk Assessment in Psychiatry: Critical Issues

Dr Raman Deep,

Professor, Department of Psychiatry, AIIMS, New Delhi

Learning Objectives & Scope

- Why to assess risk?
- Fundamentals of risk assessment
- How to assess suicidal risk?
- How to assess risk of violence?
- Approach and guidance questions
- Determination of overall level level
- Communication and documentation

Need for Risk assessment

- It is the first step towards risk mitigation or risk reduction
- Helps in managing the risk, including the need for hospitalization
- Assessment often captures the ambivalence and internal debate that often characterizes a suicidal individual
- A formal risk assessment also helps in proper communication of the risk to family members (or other health professionals)
- Carefully documented risk also assists in legal issues in court

Risk assessment as a core competency in psychiatry

- One of the core competencies to be acquired during residency training
- Often asked during the practical examination or long case viva
- Risk evaluation may have to be made across a variety of settings such as OPD, IPD, ED or other medical wards (CL)
- Available time and framework used may slightly differ across settings, but the broad principles and basics remains the same
- Clinical challenge in complex cases
- It can also be anxiety provoking, and need to manage one's own anxiety

Approach to risk assessment

- Unstructured clinical assessment
- Use of actuarial tools or scales
- Structured clinical assessment *(recommended)*

General principles

- Physical safety of the patient should be ensured first
- Provided there is no imminent risk, it is a good practice to involve patient in the risk assessment process and explore their subjective perspectives
- Patients with very high suicidal intent may conceal warning signs of imminent suicide.
- Clinician should also gather information from collateral sources and family members
- Privacy and wishes of the pt should be respected (to the extent it is reasonable)
- Communication is not privileged or confidential in case of risk of harm to self/others
- Interview style must be calm, objective, non-judgemental, and empathic
- Effort must be made to establish rapport, to extent possible
- The risk is dynamic and therefore, risk assessment is warranted periodically
- In case of doubts, discuss with a senior colleague or more experienced clinician

Risk assessment interview

- Risk assessment is often preceded by a psychiatric evaluation (detail workup) aimed at making diagnosis and establishing psychopathology
- Primary aim of risk assessment interview is to ascertain the current risk
- A note must be made about patient's degree of cooperativeness for the interview
- The detail work-up would already have evaluated some areas that are of help :
  - Presence of psychiatric diagnoses (e.g. psychosis, bipolar or depressive disorder, borderline personality)
  - MSE findings –hopelessness, pathological guilt, prominent anxiety or psychotic symptoms
  - Presence of (current and past) suicidality and self harm
  - Problematic substance use or recent change in pattern of substance use
  - Trait Impulsivity
  - Personality traits (emotionally unstable, anxious avoidant)
  - History of suicidal behaviors in biological relatives
  - Psychosocial stressors, lack of social support (e.g. living alone) or childhood trauma
  - Terminal or incurable medical illness

Approach and guidance questions

- Patients can be reluctant to share their innermost thoughts of self harm
- A clinician in early part of training may feel ‘shy’ to start with exploration
- Clinicians should include direct questioning about suicidality
- Evidence supports that it might be a relief for a patient suffering alone to be able to express their death wishes to someone (without inviting panic or rebuke)
- Some patients may under-report or deny the risk on direct questioning
- Appropriate attention must be paid to ***non-verbal communication and behaviors***, besides clinical history and alternate sources of information

Approach and guidance questions

- One can begin with exploratory statements such as :
  - ❖ We routinely explore for certain areas in pts with major depression. You may find it unnecessary, but I am going to ask you a few questions, and you can give me response that best suits your condition
  - ❖ People who are dealing with mental health issues may sometimes have thoughts or ideas about death or dying. Have you ever experienced these thoughts?
- If an affirmative response to above, clinician may move next to asking about ‘passive death wishes’ to ‘active suicidal ideation’ and finally to ‘suicidal plans and acts’
- The questions are modified as per the patient’s clinical condition and cultural context
- If patient has psychotic symptoms, then questions should be asked to explore content of voices, patient’s response to voices, degree of insight and coping methods, etc

Guidance questions (to identify suicidality)

Screening for suicidal ideation

- Do you think that life is not worth living or there is no use of living anymore?
- Do you think that things won't get better in future?
- Do you wish that you sleep and never wakeup in the morning?
- Do you wish that you die in an accident or mishap happens to you?
- Have you thought about harming yourself too?
- Have you thought (or google-searched for) any way to harm self ?
- Have you taken any action recently on that ?

Risk assessment interview

Risk assessment interview in pts with *current suicidal ideation* to cover and document the following important areas:

1. Frequency, intensity, duration and perceived controllability of suicidal ideations
2. Any intent or plans to act (or any suicidal thoughts reflecting a method to kill oneself)
3. Any preparatory behaviors (e.g., writing a suicide note or legal will or meeting long-lost relatives)
4. Access to suicide methods, including firearms (e.g., in case of police personnel)
5. Any situational triggers or antecedents (if any)
6. Patient's motivations for suicidality (e.g., loss or failure, command hallucinations, reunion with dead ones, delusional beliefs of rebirth or re-incarnation, bleak and pessimistic views of future)
7. Reasons for living (e.g., sense of responsibility to others, strong religious beliefs deterring suicide)
8. Any intended or actual action by patient (e.g. disclosing to others around, seeking treatment etc)
9. Perspectives about future, including plans for future
10. Any actual, aborted or interrupted attempts

Risk assessment interview

Additionally, for pts with current suicidal attempt:

11. Circumstances surrounding the attempt, including degree of planning involved
12. Potential lethality of attempt (choice and type of method, perceived lethality)
13. Actual damage incurred during the attempt
14. Availability of rescue measures (rescuability)
15. Patient's response after the act (or after being rescued)

Guidance questions (for patients with suicidal ideations)

- How often do you have such thoughts? how long do they last?
- How intense on a scale from 1 to 10?
- Are they overwhelming? Degree of perceived control ?
- Are there any particular events or situations that exacerbate these thoughts ?
- Have you ever almost acted on them?
- Did you have a specific plan to harm yourself?
- Did you tell anyone about your thoughts or plans?
- What are the reasons for not wanting to live ?
- What stopped you from going ahead with the suicidal act?
- Have you procured any lethal means ?
- What do you do when these thoughts become intense?
- How do you view future? Do you think things can get better in future?

Guidance questions (for patients with suicidal act)

- What were circumstances surrounding the attempt ? (When, Where, Who, What)
- What was your intent at the time of (overdose)?
- Did you make any preparation in advance? What kind of plans? For how long?
- Why did you choose this particular method?
- How do you feel after being rescued?

Risk assessment interview: exploration for risk factors

- Clinician pays special attention towards risk factors that are potentially modifiable, can change with time or are amenable to change by interventions
- Risk factors need to be ‘contextualized’ for a particular person to make a better sense of the individualized risk
- Each of the potential risk factors for suicidality must be explored and not simply ticked away as yes or no
- The degree of emotional salience assigned by patient to various factors/events must also be assessed

Risk assessment interview: exploration for risk factors

Some of common risk factors (as established in clinical-epidemiological research)	
Static (non-modifiable)	**Dynamic (or modifiable)**
Age and gender	Psychopathology (e.g. delusional guilt)
Widowed (or divorced) marital status	Morbid or illness episodes, exacerbations
Past history of suicidal attempt/s	Ongoing alcohol or substance abuse
Death by suicide in biological relatives	Psychosocial stressors (e.g. conflicts)
Presence of a medical illness, especially in intractable or terminal illness	Poor coping (or problem-solving) skills
Life event e.g. death of a loved one	Poor compliance to treatment
History of abuse	Lack of purpose in life
Impulsive traits in personality	Lack of therapeutic alliance or rapport

Risk assessment interview: exploration for protective factors

Some of common protective factors
Strong social support systems (presence, accessible, healthy)
Religious commitment.
Sense of purpose in life
Sense of responsibility towards others
Life satisfaction
Intact reality testing
Problem-focused coping skills
Fear of suicide or death (suggests that patient has not yet habituated to the idea of death, good sign)
Good therapeutic alliance

Guidance questions (for protective factors)

- Even though you've had a very difficult time, somethings have kept you going. What are those?
- What are your reasons for living?
- Are you hopeful about the future?
- Can you rate your hopefulness on a 1–10 scale (10 being most hopeful)?
- In the past, what has kept you going in difficult times like this?
- Do your religious or spiritual beliefs help you to tide over the difficult times? Can you elaborate?
- Who do you rely on during difficult times?
- Has treatment been effective for you in the past?

Risk assessment interview: exploration for protective factors

- The protective factors can act as buffer between suicidal ideas and behavior
- Interventions with chronically suicidal patients often focus on enhancing the social support and other protective factors
- Mere presence of protective factors may not be enough to protect an individual
- The protective factors should be ascertained in the context of that individual and not presumed (e.g. family can act both as a source of stress or support)

Risk assessment interview

- Exploration under each theme must be done **systematically** and not as a checklist
- Best to start with **open-ended questions**, and gradually move towards closed-ended (yes/no) questions
- Clinician must also explore for time during which intensity of suicidal ideation was worst over their lifetime, and ascertain the course of suicidality in past
- Look for any evidence pointing to an escalation of potential lethality of suicidal behaviours (e.g. from cutting wrist to hanging to jumping from high rise)
- The pt's expectation of lethality of method must be taken into consideration
- Clinician must ask questions about **reasons to live**, and observe for the spontaneous responses provided by the person
- Role of interviewing techniques in elicitation of information

Risk formulation & determination of risk level

- Overall risk of suicide is an expert evaluation of the entire interview and various themes covered in that
- A clinician cannot possibly anticipate all factors, but must make an effort to cover those comprehensively, and arrive at an estimated risk
- The overall risk level should be determined **after a careful weighing of all information, & a clear reasoning for the determination**
- A level of concern (i.e. high, moderate, or low risk) is assigned at the end
- Such categorization should be preceeded by detailed notes carrying a qualitative description of all relevant observations and findings towards risk assessment

Documentation and communication of suicidal risk

- Written documentation must be made in the clinical file
- If it is not documented, it is not done !
- Clinical records should be a clear indicator of the thought process of the clinician, and the reasons behind making the decisions about risk
- Risk assessment must be dated (time/date) and signed
- It is an ongoing process, and subsequent documentations must cover evidence of the patient's changes with treatment and adherence to safety plans put in place
- Communication of risk in clear, unambiguous and accurate terms to the legal guardians
- All contacts with family, friends, and the patient (phone calls, sessions), should be documented in records, including failed appointments or non-compliance

Suicidal Risk Assessment Tools: Is there a clinical utility ?

- **Columbia Suicide Severity Rating Scale (C-SSRS)** is commonly used instrument for assessment and monitoring at-risk individuals
- Three versions available
  - ❖Lifetime/Recent version (for baseline assessment)
  - ❖Since Last Visit version (for evaluation of change in suicide risk)
  - ❖Screener version (for triaging, often by non-specialists)
- The C-SSRS also has a **risk assessment page** that enlists risk and protective factors of suicidality. But, there is a need to contextualize the risk factors in light of current life situation and beliefs of a particular individual

Suicidal Risk Assessment Tools: Is there a clinical utility ?

- **Beck Scale for Suicide Ideation (21-item)-** clinician administered and self report versions
- **Modified Scale for Suicide Ideation (18-item)**
- **Self-Monitoring Suicidal Ideation Scale (3-item)** college students who are chronically suicidal
- **Suicide Intent Scale (15-item)**
- **Parasuicide History Interview (14-item) -** for non-suicidal self injury or parasuicidal behaviors
- **Suicidal Behaviors Questionnaire (SBQ-R)-**for borderline personality disorder with parasuicidal behaviors
- **Reasons for Living Inventory (46-item)**
- ***Item pertaining to Suicide Severity in HAM-D***
- Item of '***my future seems dark to me***' of Beck Hopelessness Scale

Systematic review
(Runeson et al, 2017)


RESEARCH ARTICLE

Instruments for the assessment of suicide risk: A systematic review evaluating the certainty of the evidence

Bo Runeson[1,2]*, Jenny Odeberg[3], Agneta Pettersson[3], Tobias Edbom[1], Ingalill Jildevik Adamsson[4], Margda Waern[5]

- Included a total of 21 studies evaluating a total of 15 instruments for suicidal risk
- Instruments with a sensitivity > 80% and a specificity > 50% were considered to have sufficient diagnostic accuracy
- **Most suicide risk assessment instruments were supported by too few studies to allow for evaluation of accuracy**


META-ANALYSIS

Tools to Detect Risk of Death by Suicide: A Systematic Review and Meta-Analysis

Natalie B. Riblet, MD, MPH[a,b]; Sarah Matsunaga, BA[c]; Younji Lee, BA[c]; Yinong Young-Xu, ScD[a,d]; Brian

- Included a total of 30 studies
- **Most instruments showed minimal utility to detect or rule out risk of suicide**
- A few instruments had better utility, such as **C-SSRS had a LR=10.3 (95% CI, 6.3–16.8) for patients discharged from ED at 3 month follow-up**
- However, the clinical utility of instruments depended on the **baseline suicide risk**

Risk assessment to risk management

LOW RISK	• **Out-patient follow ups, preferably weekly basis** • Periodic risk assessments to look for any worsening • Involve family members • Optimize medications- as per indication • Add CBT if not done yet/involvement of psychologist • Intervene for risk factors (e.g. co-occurring alcohol use) • Strengthening of social support networks/protective factors
MODERATE RISK	• High Risk Protocol • 24 hour vigilance & supervision by family/guardians • **Reduction of means to harm**
HIGH RISK	• **Advice for ward admission (written), refusal also documented** • Optimize the treatment – as per indication • Consider Modified Electroconvulsive Therapy (MECT) • Consider addition of drugs with anti-suicidal properties

Risk assessment to risk management

Psychiatric diagnosis is a major modifiable risk factor (Treat as per diagnosis)

Suicide and suicide attempts occur at an increased rate in individuals with psychiatric disorders (Knipe et al. 2019; Brådvik 2018)

Between 70%-90% of persons who die by suicide satisfy the diagnostic criteria for one or more mental disorders

Immediate post-discharge period is known to carry a high chance of increasing the suicidality

Pre-discharge planning must be meticulously done to include living arrangements, follow-up frequency, anticipated stressors, plan for joining work and plan for crisis

Risk of suicidality must be re-assessed before and immediately after discharge in next follow-up

Is risk assessment warranted in parasuicidal attempts ?

- Both parasuicidal and suicidal attempt has intentional self-harm, but intent differs
- A gentle exploration must be done regarding patient's intent or motives
- A parasuicidal attempt is often a cry for help, or a means to seek attention from others or is a way to reduce emotional numbness by inflicting pain or cuts
- Some amount of dimensionality exists between two concepts
- It may not be possible to clearly distinguish a parasuicidal from suicidal attempt, especially at the first contact
- Suicidal patients may also deny any intent to die in an attempt to mislead doctor
- Accidental death may occur (due to underestimation of lethality or delayed rescue measures)
- **Risk assessment must, therefore, be made in all cases presenting with self harm**

Alternate Models of Suicidal Risk Assessment

Collaborative assessment and management of suicidality (CAMS)

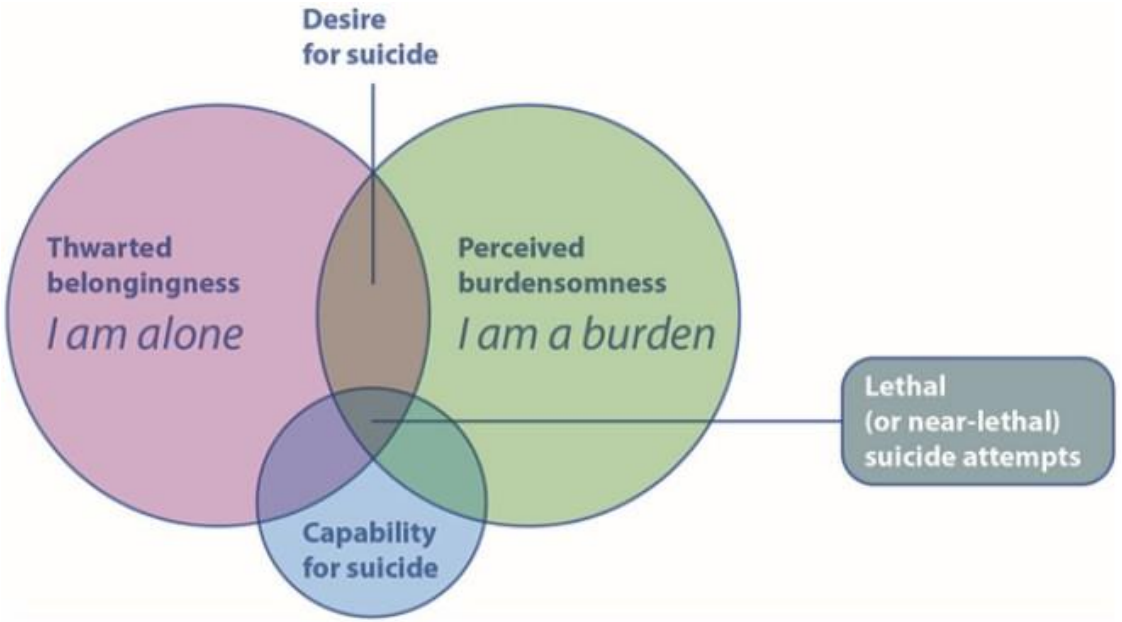
- Practical and empirically based approach where clinician and patient collaborate together to address suicidality in follow-up periods, and it uses both
  - ❖ qualitative (e.g. sentence completion)
  - ❖ quantitative patient ratings on six major areas for risk of suicide
  - ❖ quantitative patient ratings on forms for Reasons for wanting to live and Reasons for wanting to die (2 Reasons scales)
  - ❖ Case resolution forms

CAMS- Jobes and Drozd, 2004

Alternate Models of Suicidal Risk Assessment

Inter-personal theory of suicide (Joiner's)

1. Thwarted belongingness
2. Perceived burdensomeness
3. Acquired capability to enact an attempt



Orden, 2010, Joiner 2005

Psychological narratives & cognitive distortions in suicidal individuals

- Dichotomous (black-white) thinking
- Cognitive rigidity and constriction
- Perfectionistic standards toward self and others
- High levels of self-criticism
- Retrospective falsifications, overgeneralizations
- Impaired problem-solving and poor problem-solving confidence
- Ruminative process - feeling “locked-in” to their current perceptions, unable to imagine alternatives
- More present-oriented and view death in a more favorable light
- Have difficulty generating reasons for living
- Narratives: I can't stand being so depressed anymore. I can stop this pain by killing myself, Suicide is the only choice I have

Challenging scenarios

- ‘Time-contingent suicide’ ?
- ‘Suicidal threats’ as manipulative behaviors ?
- Euthanasia requests ?
- Is there a ‘rational suicide’ ?

Suicidal risk assessment: take-home points

I. Suicide risk assessment must incorporate a comprehensive evaluation of current and past suicidal behaviors, psychiatric diagnosis, comorbid conditions, family history, personal history besides a detailed evaluation of potential risk and protective factors

II. Clinician must gather information based on a **combination of methods** as below
   a) Psychiatric work up
   b) Suicidal risk assessment interview
   c) Behavioral observation & corroborations from family
   d) Clinician-administered instrument (with/without a self-report scale)

III. Standardized tools or scales may be used to <u>supplement, but not to replace or substitute</u> clinical risk assessment (wherever feasible)

Violence risk assessment (Risk of harm to others)

- Violence risk assessment serves a two-fold purpose i.e. predicts the possibility of an adverse outcome and identifies the potential factors contextualized to that individual to help mitigate risk

- Clinical, legal and societal implications

Risk Assessment for Harm to Others

- The broad principles of risk assessment remain the same as discussed before
- Approach needs to be customized across different types of settings and patient populations.
- Risk of harm to others is often assessed in casualty or in-patient ward settings for patients with an aggressive or threatening behavior
- Risk assessment might also be required for an occasional OPD patient who may talk about desire to harm a person or group of persons.
- Individuals may also be referred by judiciary or brought by authorities after a threat of violence
- In such scenarios, the clinician may explain about the purpose, processes as well as potential benefits of cooperation (this may also reduce hostility towards clinician)
- Risk assessment with respect to clinical settings (rather than forensic settings) is discussed here, though basic principles remain the same

Safety considerations

- Stay at safe distance (oval zone of 4-6 feet) at the time of patient interview
- Standing across a table may provide a barrier
- Never turn your back to patient
- Make a mental note of an quickest/easy exit beforehand
- Scan the environment for any objects that may be thrown or used for harm
- Safe environment (remove access to breakable items objects)
- Low environmental stimulation in patient vicinity (noisy/crowded)
- Non-threatening posture (Thinker’s stance)

Safety considerations

- Always introduce yourself and try to address pt by name (or as appropriate)
- Ask permission to talk or interview
- Use a calm and even tone, no visible signs of impatience
- Be objective, non-judgemental
- Understand the goals of aggressive behaviour (if any) and elicit concerns
- Ask the (reasonable) wishes, if any, of patient
- Ask the security staff to wait at a distance for physical restraint, especially for patients with past violence
- Instruct the nursing staff to keep the injectable handy, if intervention is required

Safety considerations

Recognize premonitory signs of imminent violence

- loud talking, shouting, brisk pacing
- banging the fist and feet on table or window
- clenched hands or jaw
- authoritative or intimidating posture
- emotionally aroused state (e.g. fearful or aggressive)
- profanities, abuses, overly intimidating language
- accusing clinicians of conspiring against them
- Invading personal space
- Inability to comply with directions and/or reasonable limit setting

Their presence indicates the need to immediately stop the interview and ensure safety
At the same time, other relevant risks (such as self-harm, absconding, etc) may also be anticipated

Clinical enquiry into risk

- Prior to start of an interview, the clinician must ask permission and observe for willingness
- The duration, frequency, severity, and recency of violent thoughts or behaviour should be assessed
- Any specific plans or preparatory behavior must be noted, “I will go to my office tomorrow and confront all those who conspired to expel me. I will also take my knife along, just in case”.
- Further, if there is history of violent behaviours, the interviewer should try and look for any repeating patterns or situations that lead to these escalations
- Clinician can explore using questions such as:

  “Are you angry at someone?”

  “Do you sometimes wish to punish or take revenge for the wrongdoings?”

  “Have you thought of any ways to do that?”

  “Have you made any preparation towards that?”

Clinical enquiry into risk

Psychiatric (diagnostic) interview

- Less intrusive, non specific questions
- Frequent reassurances
- Purpose is to ascertain the differentials to guide the initial treatment

Structured violence risk assessment

  - clinical exploration about current mental state
  - ascertain the specific threats, if any and their nature
  - consider violence ideation, intent, plan, means, access, wish for help
  - details on lifetime instances, and remorse, if any, for those events
  - poor impulse control, other risk factors, protective factors

Exploration for risk factors

Static (non-modifiable) risk factors	Dynamic (or modifiable) risk factors
History of violence	Easy access to lethal means (e.g. guns)
Antisocial personality disorder	Negative affect(e.g. irritability)
Narcissitic personality disorder	Psychosocial conflicts, unemployed, or any real, perceived or symbolic loss
Trait impulsivity /history of poor impulse control	Current alcohol or other substance use
Male gender	Psychiatric illness, exacerbations
Age (<35 years)	Low insight into illness
	Impaired judgment or reality-testing

Exploration for protective factors

- The protective factors must also be assessed
- Instruments such as Structured Assessment of Protective Factors for violence risk has been used divide those into :
  - *internal factors* (e.g. empathy, coping skills)
  - *motivational factors* (e.g. work, leisure activities, motivation for treatment)
  - *external factors* (e.g. social network, intimate relationships)
- Apart from this, the individual should also be asked about the reasons that have stopped him from committing violence in past

Determination of violence risk and its documentation

- The overall risk level should be determined after a careful assessment of all factors, and a clear reasoning for the determination should be documented.
- Prompt hospitalization should be considered for those with risk of harm to others
- If already hospitalized, a quick and efficient management of aggression and imminent violence is required by available treatment means
- The communication can no longer be considered privileged in cases with violence risk
- Additionally, if the risk of violence is identified to be directed at particular individual/s, then the clinician has a duty to take appropriate steps to protect them
- Clinician must keep updating self about the legal aspects and any judgements
- USA (Tarasoff vs Regents of UC): Tarasoff I- Duty to warn & Tarasoff II- Duty to protect

Legal aspects of risk assessment

- Involuntary Admission can be made as per provisions of MHCA (2017)
- Consent of legal guardian must be taken
- MHCA-Section 94 deals with "Emergency Treatment upto 72 hours", if risk of

  (a) death or irreversible harm to the health of the person; or

  (b) the person inflicting serious harm to himself or to others; or

  (c) the person causing serious damage to property where such behavior is believed to flow directly from the person's mental illness
- "Standard of Care" has to be used
- Take guidance from seniors and colleagues in the team

Evaluation in a paranoid patient

- It is important to be extremely tactful with paranoid patients because they are easily humiliated and suspicious
- When patients have abnormal perceptions, clinician must not try to correct or confront them but aim should be to clarify the experiences
- Avoid the temptation to use a rational logic to convince the patient with impaired reality-testing
- Termination of a clinical assessment may be necessary and is not a function of poor training or ineptness of clinician

Use of Clinical Instruments

Historical Clinical Risk (HCR-20) Violence Risk Assessment Scheme

- Well-researched and empirically guided risk assessment tool
- It places a higher emphasis on risk management and risk reduction compared to other actuarial approaches
- HCR-20, dispersed across three scales with 20 items (each item scored 0 to 2):
    I. **Historical scale (10 risk factors),** that focuses on past events, experiences, and psychiatric conditions (e.g., past violence, young age at first violence, major mental illness, psychopathy, personality disorder, childhood maladjustment)
    II. **Clinical scale (5 risk factors)**, that focuses on recent functioning (e.g., negative attitudes, psy symptoms, non-compliance, impulsivity)
    III. **Risk management scale (5 risk factors)**, which deals with factors such as feasibility of plans, stress, and support
- Recommendation that dynamic risk factors can be reevaluated periodically.
- The clinician makes a final summary risk rating (viz. low, moderate, or high) for violence risk , depending on the number of risk factors present, their relevance and the degree of intervention or risk management estimated to be necessary

Use of Clinical Instruments

Psychological Bulletin
2010, Vol. 136, No. 5, 740–767

0033-2909/10/$12.00 DOI: 10.1037/a0020473

The Efficacy of Violence Prediction: A Meta-Analytic Comparison of Nine Risk Assessment Tools

Min Yang and Stephen C. P. Wong
University of Nottingham

Jeremy Coid
University of London

- If the intention is to predict future violence, then the 9 tools are essentially interchangeable
- All have moderate level of accuracy at best
- The selection of tool to use in practice should depend on what other functions the tool can perform rather than on its efficacy in predicting violence

Violence risk assessment: summing up

- A thorough risk assessment is the cornerstone of effective risk management
- Clinician usually assesses the risk and protective factors, and also incorporates the information about the relative importance of these factors based on the examination of patient's life situation or context in a systematic manner
- Further, the individual's own perspective, current life situation, personality aspects, social support etc are also taken into consideration, in addition to lifetime and current psychiatric diagnosis
- The clinical tools are an aid and not to substitute expert judgement
- Risk to be clearly conveyed to family, and documented in clinical records
- Risk assessment should not be a one-time evaluation, but a periodic process
- Be mindful of the medicolegal implications and act according to the law of the land

Limitations of clinical risk assessment

- Risk assessment is not risk prediction
- Clinical studies have shown that sub-set of patients who died by suicide met their clinicians in the preceeding month and were graded as low risk
- Human behavior is complex, determined by multitude of dynamic factors
- Clinicians cannot make fully accurate predictions at all times, but must take care to avoid common errors such as
    - Dismissing the concerning statements prematurely
    - Inadequate exploration of risk
    - Relying only on the patient self-report motivated to get discharge from ward

Medicine is a science of uncertainty and an art of probability

(Sir William Osler, Aphorisms, 129)

Thank You