Lifetime risk of suicide in people with schizophrenia lower than commonly reported


What is the lifetime risk of suicide in people diagnosed with schizophrenia?

The method of analysis used by this paper addresses the shortcomings of using either proportionate mortality rate or case fatality rate alone to estimate lifetime suicide risk. The proportionate mortality rate overestimates the risk of suicide, particularly in studies with a short follow up, as it assumes that suicides occur at the same rate over time relative to the total number of deaths. The case fatality rate may underestimate suicide prevalence as some suicides will inevitably be missed if not all subjects are followed up until they die.

Q What is the lifetime risk of suicide in people diagnosed with schizophrenia?

The systematic review by Palmer et al provides the most accurate estimate to date of the risk of suicide in schizophrenia. Their meta-analysis uses both proportionate mortality and case fatality (the percentage of the original sample who died by suicide) and estimated the risk to be substantially lower at 4%.

For several decades, the literature has quoted the lifetime risk of suicide in schizophrenia as 10–15%. The most frequently cited reviews is that of Miles et al who examined mortality reports published between 1931 and 1975, and estimated the lifetime risk to be 10%. This figure was subsequently challenged by Inskip et al who analysed 29 studies using proportionate mortality (the percentage of the dead who died by suicide) and estimated the risk to be substantially lower at 4%.

The estimate of lifetime risk of suicide in schizophrenia is thus lower than was formerly thought, with greatest risk in the first few years of illness. This information, together with knowledge of risk factors for suicide in schizophrenia (previous depression, previous suicide attempts, drug misuse, agitation, fear of mental disintegration, poor adherence to treatment, and recent loss), should help mental health services focus on those at highest risk. Targeting of affective symptoms, substance misuse, and compliance, particularly in the first few years of the illness, would appear to be important in suicide prevention.

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