Latest methods to reduce suicide risk after psychiatric hospitalization

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Ironically, inpatient psychiatric care, the very thing that offers safety and stabilization to acutely suicidal individuals, leaves them at high risk of suicide after discharge. But a review of the latest research identifies practical prevention steps.

One of the ironies of suicide prevention is that inpatient psychiatric care, the principal means of assuring safety and stabilization to acutely suicidal individuals, leaves them at high risk of suicide after discharge. One source put it this way: "The risk of suicide is higher during the period immediately following discharge … than at any other time in a service user's life."[1] Post-discharge risk even accrues to patients not suicidal at admission.[2]

There is little data on suicides after a psychiatric hospital discharge in the US, though suicides that occur within 72 hours after psychiatric hospitalization are tracked by The Joint Commission. Such deaths rose from fewer than 60 in 2005 to just over 100 in 2008.[3] These "sentinel events" trended downward through 2010, which was good news given that total US suicide numbers rose for the same period. However, suicide victims who were inpatients within days of their deaths should have better prospects for survival.

This well-documented risk does not seem to have attracted much attention from providers or public policy makers and administrators.[4] A greater concern is that patients and families may not be aware of the possible danger that may follow some consumers home. The problem of suicide risk after an inpatient psychiatric stay and what can be done about it warrant examination.

What is the source of post-discharge suicide risk?

Reasons for suicides after hospitalization include re-exposure to community stressors, non-adherence, non-engagement with outpatient providers, relapse, and the return of insight regarding the consequences of the mental illness.[5] At discharge the protective factors the hospital offers - around-the-clock structure, supervision, caring, and support – are abruptly lost.

Myopic discharge planning can add to risk. Decisions based on "stabilization" may overlook risk factors that led to the admission as may discharge planning that focuses more on psychiatric diagnosis than suicidality.

Suicide risk assessment may not be as thorough prior to discharge as it is at the time of admission. This is problematic as many suicide risk factors specific to serious mental illness are not affected by inpatient treatment. High risk is associated with early stage of illness, good pre-

illness functioning, and frequent exacerbations and remissions.[6] Many consumers have a history of suicidal behavior, self-injury, suicide loss, and multiple prior admissions.[7]

Why do post-discharge suicides happen?

There is no evidence that inpatient care prevents suicide after discharge, nor any that it causes suicide. Discharge planning and pre-discharge risk assessment deficits are not causes, either. So what accounts for lethal suicidal behavior in some consumers at a time when they should be on a path to recovery?

The "Interpersonal Psychological Theory of Suicide"[8] gives insight into post-discharge suicide. This theory, developed by Thomas Joiner, PhD, posits that a potentially fatal suicide attempt requires: (1) a sense of burdensomeness, (2) a sense of loneliness and isolation; and (3) a sense of fearlessness about lethal self-harm. All three of these conditions rarely occur simultaneously, which is why there are comparatively few suicides. However, they, especially the first two, may be common in those with serious mental illness, and especially in those who have received inpatient psychiatric care.

Joiner asserts that an intense desire for death may come from the belief that one is a burden to others and/or the belief that one does not belong. Burdensomeness arises from a sense that one is a liability and not fulfilling expectations or obligations. This may lead to thinking that one's death may be more valued than one's life. Failed belongingness may flow from a strong unmet need for social relationships and a perception that one is not cared for by others. These variables may be exacerbated by hospitalization and may persist in the community.

More than a desire to end one's life is necessary for a suicide, Joiner adds. An individual must also be able to take his or her life. This requires overcoming fear, pain, self-injury, and the instinct for self-preservation. This ability is acquired through experiences such as abuse, trauma, and a history of violence and self-harm. It is a byproduct of past attempts and may also be developed by mentally practicing a suicide plan and rehearsing it by holding means such as a weapon or pills.

The desire to die may lift during hospitalization, but the capability for lethal self-harm is permanent. Past attempts, abuse, trauma, and violence create a risk baseline that may escalate after discharge. Risk may be amplified by weak supports, rejection by others, and being faced with seemingly irresolvable psychosocial or environmental stressors, as well as folding relapse, resuming alcohol or drug use, and limited engagement by outpatient providers.

What can be done about post-discharge suicide risk?

Many sound recommendations for addressing suicide risk after hospitalization have been offered. Immediate treatment, follow-up, and closer monitoring of at-risk consumers returning to the community are most often urged.[9]

A recent review of the National Suicide Prevention Strategy included this recommendation: "Expand efforts to provide effective follow up care after inpatient discharge of suicidal persons."[10] Another national report was more specific: "Adopt nationally recognized policies and procedures that best match patients at risk for suicide to follow-up services that begin at or near the time of discharge from … an inpatient psychiatry unit."[11]

A national suicide prevention organization issued a broader advisory:[12]

- Pre-discharge assessment of risk at admission and risk acquired during stay.
- Identify sources of support and willingness and ability to provide support.
- Give patient and family instruction on suicide risk at discharge and thereafter.
- Give instruction on accessing crisis intervention and other sources of help.

Bumgarner and Haygood call for the use of a "risk reduction pathway" involving a "bundle" of suicide prevention practices provided to every patient, which at discharge would include:[13]

- Suicide risk assessment to inform the discharge decision
- Communication of risk/prevention measures to patients and family members
- Follow-up with patients after discharge
- Supports and services in place after discharge

Other resources that come to mind are:

- Preparation of personal suicide prevention of safety plans at discharge.
- The availability of peer-run warm lines for use by newly discharged consumers.
- Access to therapies that have demonstrated suicide prevention potential (e.g., Cognitive Behavioral Therapy).
- Peer-led or co-led support groups for those who have made suicide attempts or had an acute episode of suicidality.
- Training peer specialists as "gatekeepers" to identify possible warning signs of suicide in other consumers.

Inpatient providers must do more to reduce the risk of “outpatient” suicide. Montgomery County Emergency Service, a 73-bed nonprofit psychiatric hospital, has inaugurated a number of easy-to-replicate practices in recent years. These include a range of suicide prevention education materials for consumers and families, a peer-led inpatient suicide prevention support group, “special discharge instructions” on suicide risk, and tighter pre-discharge risk assessment.

Community-based providers must also help make post-discharge suicide what the National Action Alliance for Suicide Prevention recently called a “never event.”[14] In this regard, the Alliance has called for suicide risk screening to be universal in all behavioral health care settings and that suicide risk be seamlessly addressed along the care continuum until eliminated. This would extend a “risk reduction pathway” from inpatient admission to recovery.

In addition to reducing consumer mortality, a post-discharge suicide prevention effort may reduce readmissions and involuntary hospitalizations, both of which are driven heavily by suicidal behavior. Of course, it can also improve recovery prospects for inpatients while helping them maintain the hopeful outlook needed to motivate and maintain greater personal wellness.

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