F. Determine the Appropriate Care Setting

F1. Matching Care level to Level of Risk

Choose the appropriate care setting that provides the patient at risk of suicide maximal safety in the least restrictive environment

BACKGROUND

A majority of identified suicidal patients are referred to acute or crisis settings (usually the nearest hospital emergency department) for assessment and care by designated mental health providers. In an urgent or emergent high-risk ''crisis'' presentation, the primary purpose of clinical evaluation is to make a determination that balances risk and protective factors. Can the patient be discharged with an adequate safety plan? or does the patient require admission to a higher level of care, on either a voluntary or an involuntary basis?

The difference in care settings reflects the actual or perceived level of safety that can be offered to both the patient and the clinicians involved in the care of the suicidal patient. Care settings include:

■ Inpatient hospital wards ■ partial hospitalization programs ■ outpatient specialty care clinics, ■ primary care clinics ■ emergency departments ■ and numerous care options in deployed situations.

Care also can be provided for the patient who has already attempted suicide and is now in an intensive care unit or medical ward for assessment and treatment of conditions related to the attempt.

The acutely high-risk suicidal patient should be immediately evaluated and treated for medical instability or intoxication and acute psychiatric symptoms, such as anxiety, agitation, insomnia, depression and psychosis. The patient's safety should be the primary concern and hospitalization should be taken into consideration. With the patient's consent family members and, if necessary, social services should be involved in the treatment plan.

RECOMMENDATIONS

1. Consider hospitalization for patients at high acute risk for suicide who need crisis intervention, intensive structure and supervision to ensure safety, management of complex diagnoses, and delivery of intensive therapeutic procedures.
2. The inpatient psychiatric hospital setting is particularly suitable for the treatment of acute risk for suicide rather than chronic risk.
3. An individualized treatment plan should be determined to meet the patient's needs and aimed to allow as much self-control and autonomy as possible, balanced against the risk level.
4. Although suicidality may persist, the treatment goal is to transition the patient toward a less restrictive environment based on clinical improvement and the assessment that the suicide risk has been reduced.

DISCUSSION

Level of Risk: High Acute

Care Level: Emergency Department Evaluation with/without Hospitalization

The emergency department (ED) is an appropriate care setting for initial evaluation and short-term monitoring of patients at any severity level.

For the patients in the ED, the determination of whether to discharge to outpatient care, hospitalize, or monitor for a short period will depend on the assessment of the severity of the level of suicidality, the likelihood that acute psychiatric symptoms will resolve in a short time frame (for example intoxication), and the patient's capacity to follow through with treatment and safety plans required for outpatient management.

The ED is often the initial point of contact with the health system for many of these individuals, and it offers a unique opportunity to help people who have attempted suicide to begin to recover from the depression, hopelessness and other conditions and symptoms that led to their suicide attempt. Individuals who have attempted suicide are at increased risk for later dying by suicide. A reasonable estimate of non-fatal repetition is 15–16% at 1 year with a slow rise to 20–25% over the following few years (Owens et al., 2002).

The acutely high-risk suicidal patient should be immediately evaluated and considered for treatment for acute psychiatric symptoms, such as marked anxiety or agitation. The patient's safety should be the primary concern and hospitalization should be taken into consideration.

Hospitalization should be considered in patients at high risk for suicide to: assure their safety, manage complex diagnoses, and deliver emotionally intense therapeutic procedures. High-risk patients being considered for admission should be medically evaluated to determine medical stability and rule out evidence of toxic ingestion or other life threatening conditions.

The inpatient care setting is perceived as the highest level of care for patients at imminent risk of suicide. These are patients at high risk in which suicide is extremely likely in the very near future (hours), and immediate intervention may be warranted to prevent a suicidal act. In fact, no evidence exists to show that inpatient hospitalization is safer than any other care setting and patients remain at risk for suicide during their hospitalization. The main advantage of this care setting is the ability to have the patient in an environment that is engineered to diminish access to lethal means. This is achieved both through the design of the environment with special safety considerations to decrease the chances of patients engaging in suicides by hanging, overdose or cutting themselves and by increasing supervision of the patient. Inpatient settings are also helpful in that they may be able to more quickly initiate interventions that ameliorate acute psychiatric symptoms contributing to the patient's suicidality. Inpatient hospitalization is the preferred level of care for patients at imminent and very high risk for suicide.

Level of Risk: Intermediate Acute

Care Level: Partial Hospitalization or Intensive Outpatient Programs (IOPs)

A partial hospital setting is similar to the inpatient setting, with regard to intensity of treatment, but affords fewer specific safety measures and does not provide the same level of supervision as the inpatient ward. It does provide a consistent daily level of supervision and interventions aimed to treat underlying conditions, specifically the acute manifestations of psychiatric symptoms, and suicidality. This is an appropriate care setting for many patients at less than imminent risk for suicide who do not require continuous direct observation for safety.

Military members with their own on- or off-installation housing and Veterans who live independently may benefit from increased social support provided in a partial hospitalization setting, especially when such support is otherwise unavailable (as family or roommates).

Care Level: Outpatient or Integrated Mental Health

Outpatient specialty (behavioral health) care clinics, primary care clinics, and deployed settings with behavioral health clinicians may be appropriate for the initial evaluation of all severity levels of suicide if the clinics have an adequate plan for managing patients who may engage in suicidal or other harmful behaviors. If a clinic does not have an adequate plan or adequate personnel to enact the plan, patients should be referred to an emergency department for initial assessment. Behavioral health clinics and deployed settings with BH clinicians may be appropriate for management of patients at low risk and for

many at higher acute risk. Primary care clinics are appropriate settings for patients at low risk and for some patients at intermediate acute risk for suicide for both assessment and continued management.

Non-deployed Service members who are living with supportive military members in a dormitory or barracks; Veterans receiving care in a domiciliary or residential rehabilitation facility; and those benefiting from military or Veteran peer-to-peer support programs, may be appropriate for outpatient management even with moderate suicidality.

Level of Risk: Low Acute

Care Level: Primary Care Follow-Up and Reassessment

If a patient is low risk for suicide or once a patient has been returned to the low risk category, any of the following care settings are appropriate for care of his/her underlying condition and continued monitoring/assessment for recurrent suicidality:

- Primary care with or without embedded behavioral health
- Outpatient Behavioral Health Clinics
- Community Living Center (CLC)
- Residential Care Facilities
- Long Term Care Facilities
- Patient's home with family support and education

F2. Criteria for Transition to Less Restrictive Settings

BACKGROUND

Discharging a patient to a lower level of care is a clinical decision based on numerous factors unique both to the individual patient and to the treatment environment. As such, no "check box" algorithm could ever be totally comprehensive in describing this task. The following criteria are provided more as a framework from which to start rather than definitive guidance for all conceivable clinical situations. In some cases, where psychiatric symptoms are present, the level of care may be contingent upon where these symptoms can be safely stabilized. The final decision is based on clinical judgment and the experience of the provider.

RECOMMENDATION

1. A patient may be discharged to a less restrictive level of care from an acute setting (emergency department/hospital/acute specialty care) after a behavioral health clinician evaluated the patient, or a behavioral health clinician was consulted, **and all** three of the following conditions have been met:

   A. Clinician assessment that the patient has no current suicidal intent

   AND

   B. The patient's active psychiatric symptoms are assessed to be stable enough to allow for reduction of level of care

   AND

   C. The patient has the capacity and willingness to follow the personalized safety plan (including having available support system resources).

DISCUSSION

The stabilization of active psychiatric symptoms is a very important aspect in determining the decision of level of care for suicidal patients. Components of this decision include, but are not limited to, patients' ability to control their impulsivity, their ability to manage their emotional states, their ability to utilize

support systems and their ability to cognitively utilize information and skills that they have learned through treatment or already knew. For example, patients may recognize that they do not have complete confidence in their ability to manage their impulses, but a clinician could still elect to have them in a less restrictive care setting if they demonstrate the cognitive ability to utilize elements of their safety plan put into place to manage their impulsivity. Another example of operationalizing this concept is the patient who is intoxicated and suicidal in the ED. After the offending agent has cleared the patient's system, the patient may then have both adequate impulse control and cognitive ability to follow through with a safety plan.

Determining whether a safety plan is feasible in an acute crisis is another imperative in determining the correct care setting. The patient has to demonstrate that they have the necessary resources to enact the plan, is able to access these resources, has the capacity to manage the components of the safety plan and that means restriction is feasible.

The clinician must judge the patient's capacity and willingness to engage in a safety plan to determine the appropriate care setting. This must be done in a collaborative manner with the patient and other treatment team members, family members and/or command. This can be one of the most difficult issues for a clinician to determine as m any factors contribute to this decision. Biological, psychological and social factors need to be considered to determine capacity and willingness. Biological considerations include whether any substances or underlying medical conditions interfere with the level of cognition and the ability to understand and utilize data. Psychological conditions include the patients reported mood, observed affect, and observed level of psychological distress. Social considerations include assessment of the patient's connectedness to social supports, length of time the clinician has known the patient and how the patient has managed and resolved crises. If any of these areas cannot be fully assessed, the clinician should consider their evaluation to be incomplete and the patient remains at a high or imminent level of risk until these issues can be resolved.

Analysis of the answers to the following questions may help assess the patient's capacity and willingness to adhere to the personalized safety plan, and support the decision regarding the appropriate setting for continued care:

Early identification of warning signs or stressors *– Was the patient able to identify any warning signs and stressors? What triggered the stress? Did the patient engage in any strategies and interventions for managing the stressors? If so, how successful did the patient perceive feel the interventions were?*

Enhancing coping strategies (e.g., to distract and support*) – Did the patient utilize any coping strategies? If so, how successful were they?*

Utilizing social support contacts *– Did the patient appropriately utilize support systems to either avert this episode of suicidality or to ensure s/he accessed the system of care in an appropriate and timely manner?*

Professionals to call *– Are mechanisms in place to ensure that providers involved in the patient's care are available to be contacted or that professionals who can help with psychosocial issues such as spousal abuse, homelessness, etc. have been contacted?*

Minimizing access to lethal means *(e.g., large quantities of medication, weapons and ammunition) – Has the patient already engaged in behavior to limit access to means? Did s/he follow through on recommendations to limit access to lethal means?*

F3. Hospitalization

Despite insufficient evidence to demonstrate the effectiveness of acute hospitalization in the prevention of suicide, hospitalization is indicated in suicidal patients who cannot be maintained in less restrictive care setting.

BACKGROUND

Inpatient hospitalization is a common measure for maximizing safety for individuals who are imminently at risk for suicide. While it is a useful setting for initiating treatment interventions in a safe environment, hospitalization has not been demonstrated to prevent eventual death by suicide.

Indications for admission

The major criterion for admission to inpatient psychiatric care for the suicidal patient is imminent risk of danger to self. Once admitted, the patient needs to be managed in the least restrictive environment where his/her safety can be maintained (See Annotation G: *Securing Patient Safety*).

If psychiatric hospitalization is indicated, the next decision point is whether the hospitalization is voluntary or involuntary. If it is determined the patient will not voluntarily engage in care in the least restrictive environment, the clinician will need to utilize the local or state statutes which prescribe how to manage involuntary patients. Most guidelines provide at least a brief period, usually 48-72 hours, for clinicians to assess a patient and determine whether the court should be petitioned to continue hospitalization or if a less restrictive plan can be put into place.

The usual reasons for urgent hospitalization include acute suicide risk; acute violence risk due to mental illness; delirium; and acute unstable medical condition. Specialized treatments often best provided in an inpatient setting include:

- Electro-convulsive therapy (ECT)
- Close monitoring and daily titration of medications with the potential for disabling side effects or toxicity
- Constant staff observation as part of intensive behavioral treatment
- Close monitoring of behavior
- Close monitoring of conditions that require intensive monitoring

Once hospitalized, patients often continue to be at a high risk for suicidal behaviors. National Patient Safety Goals (NPSG) and their associated requirements have been published by the Joint Commission on Hospital Accreditation focusing on safe practices that healthcare organizations must implement and maintain. The NPSG establish evidence-informed requirements pertaining to critical aspects of care known to be vulnerable to medical errors and significant risks to patients. The NPSG are based largely, although not exclusively, on The Joint Commission's sentinel event database.

RECOMMENDATIONS:

1. Any patient with suicidal intent or behavior who cannot be maintained in a less restrictive environment requires hospitalization in order to provide an optimal controlled environment to maintain the patient's safety and initiate treatment.
2. A complete biopsychosocial assessment should be performed upon hospitalization to determine all direct and indirect contributing factors to suicidal thoughts and behaviors. Patient and family education should be provided on techniques to manage these factors.

RATIONALE

There is little data on the benefits and pitfalls of hospitalization for suicidal patients. It is an ethically challenging area in which to conduct research. As a result, much of the data focuses on risk factors and prevention of attempted and completed suicide, rather than treatment after it has occurred. Self-harm can result in social stigma, as can a diagnosis of a mental disorder, common among individuals who attempt suicide.

The aim of hospitalization is to provide immediate, short-term safety for suicidal individuals, and begin to implement treatment to reduce occurrence or recurrence of self-harming behavior, potentially related to a treatable condition. However hospital admission itself is associated with several potential risks, including stigmatization. This can be highly detrimental for some individuals who may already be dealing with extremely low self-esteem, by increasing their experience of being marginalized and alienated. The risks associated with hospitalization are not limited to the patient at high risk for suicide, but also to the potentially negative effect of hospitalization on the outcome for those diagnosed with major psychiatric disorders. For some, such as those with borderline personality disorder, inpatient admission has the potential to foster dependence, exacerbating their symptoms and risk for suicide.

Hospitalization generally occurs because a patient has a more severe disorder and has been evaluated to be at increased risk for suicide. For some patients hospitalization can result in increased distress. Suicide attempts and death do occur during hospitalization, even in the face of aggressive precautions.

It is reasonable to suggest that most people would place the benefit of reduced mortality over any risks such as stigma. What is unknown, based on current research, is whether hospitalization is more effective at ensuring safety, both in the short and long term, than partial hospitalization, intensive outpatient treatment, or some other form of community-based care. It is also unknown whether the use of involuntary hospitalization, while reducing risk in the short term, might increase risk over the long term, if the patient is unwilling to further self-disclose suicidal thoughts in the future.

Clinicians should consider the risks and benefits for each individual patient based on his/her specific assessment, diagnosis, contributing factors, and the most appropriate way to maintain safety while hospitalized.

Goals of Hospitalization

While every hospitalization is different, the following five issues should be addressed for patients admitted to a hospital for suicidality. These include:

- Diagnostic clarification to ensure an underlying psychiatric disorder and any co-morbid disorders can be adequately treated
- Increasing level of safety for the patient by being in a more closely controlled environment with increased supervision
- Initiating treatment after a timely assessment
- Responsive alterations of treatment for co-occurring disorders and/or treatment side effects, as indicated
- Comprehensive discharge planning

Diagnostic Precision

Inpatient hospitalization allows for a period of observation permitting a clinician to complete a more formal and intensive assessment (e.g., medication washout, assessment for and initiation of ECT, identification of medical disorders contributing to the psychiatric condition, and restricting substances abuse). It also allows for time to conduct a more thorough understanding of the stressors, co-morbidities and specific psychosocial risks contributing to both suicidal ideation and the underlying disorder through the intensive multidisciplinary assessment afforded patients upon admission to the inpatient unit. The inpatient setting also allows for collection of additional objective data regarding level of dysfunction and severity of symptoms as the symptoms will be observed directly rather than reported. The assessment of

co-morbidities should be considered broadly, taking into account co-morbid primary psychiatric conditions, medical conditions, substance use/abuse disorders and personality disorders. The treatment of potential underlying disorders for suicide should follow VA/DoD guidelines for the management of Mental Disorders (Major Depressive, Substance Use, Post Traumatic Stress, and Bipolar Disorders). The importance of adequate treatment of these disorders cannot be overemphasized.

Treatment Initiation

An inpatient psychiatric ward is a useful setting for initiating numerous psychiatric treatments. The first type of treatment offered is historically called "milieu" treatment, which refers to the structure and content of the day on a ward. Typically, the milieu consists of: meetings with the physician to diagnose, monitor symptoms and progress, manage medications and their side effects; various group therapies led by different therapists, such as a recreational therapist, art therapist and/or exercise therapist; meetings with social workers or psychologists for individual therapy, family/couples interventions/education and discharge planning; and meetings and groups run by the nursing staff focusing on how the ward runs and specific therapeutic topics. In general, the psychiatric hospital milieu may have an effect in helping patients to manage mental health issues while being in a safe environment. Patients are typically engaged in the most intense level of treatment available as the milieu and any additionally prescribed treatments transpire over the course of a full day in the hospital.

Maintenance of Safety

The main clinical focus for hospitalization is maintaining the patient's safety. This remains true regardless of whether the patient is admitted on a psychiatric unit or a non-psychiatric unit, and therefore, each of these types of units must be able to provide close and continuous observation of patients and safe environment of care.

Most hospitals require an initial period where the patient is under increased supervision, based on data that suggests suicidal behavior may be increased during the initial week of hospitalization.

DISCUSSION

Many clinicians assume that inpatient treatment is the most effective treatment for an individual who is suicidal or made a suicide attempt. While inpatient treatment is the standard of care, it has never been found efficacious in a clinical trial. Conducting randomized trials to evaluate the benefit of psychiatric hospitalization is difficult. To randomly assign an imminently suicidal individual to a non-hospitalized control group is not an ethically viable protocol. Comparing cohorts of admitted and non-admitted suicidal populations is unhelpful as the severity of the presenting situations may be very different. In fact, the Institute of Medicine concluded, "the effectiveness of brief hospitalizations is questionable" (Institute of Medicine, 2002, Reducing Suicide: A National Imperative National Academies Press).

Indication for Hospitalization

Clinical practice guidelines for managing patients at risk for suicide recommend considering the following variables in the decision regarding hospitalization or discharge of patients who have attempted suicide. These variables include : patient is psychotic; expresses persistent thoughts, plans, or intent; distress increases or patient regrets surviving; no support is available; current impulsive behavior, severe agitation, or refusal of help is evident; attempt was violent, near-lethal, premeditated, or precautions were taken to avoid rescue (American Psychiatric Association Practice Guidelines, 2003; Canadian Coalition for Senior's Mental Health, 2006; National Institute for Clinical Excellence 2011; New Zealand Guidelines Group (NZGG) and Ministry of Health, 2003; World Health Organization 2000).

Studies that compared records of patients hospitalized with those discharged from the emergency department after attempt have found that socio-demographic and clinical characteristics would appear to contribute more to the decision to hospitalize.

Owens et al. (1991) found that patients admitted were older, reported more physical ill-health, had expressed a threat or left a note more often, and had more frequently been hospitalized previously in psychiatric units.

Hepp et al. (2004) showed that hospitalization was associated with older age, use of lethal method, previous psychiatric hospitalization, and psychotic disorders. On the other hand, female gender, regular occupational activity, and adjustment and neurotic disorders were related with referral to outpatient treatment.

Goldberg et al. (2007) reviewed records for 257 patients presenting with suicidal ideation to a psychiatric emergency service. Hospitalization occurred for 70% of suicidal persons. Psychosis, past suicide attempts, and the presence of a suicide plan robustly predicted the decision to hospitalize suicidal persons seen in psychiatric emergency services. Diagnosis, pharmacotherapy, having a psychiatrist, and insurance subtype were unrelated to hospitalization decisions, suggesting that psychiatric emergency department staff perceive few alternatives to hospitalization when psychosis and suicide plans accompany suicidal ideation.

Baca-García et al. (2004) identified eleven variables that remained significant in a logistic regression model that explained hospitalization after a suicide attempt. Six variables were associated with increased probability of hospitalization: intent to repeat the attempt, plan to use a lethal method, low psychosocial functioning, previous psychiatric hospitalization, a suicide attempt in the previous year, and planning so that nobody would try to save their life after the attempt. Five variables decreased the probability of hospitalization: a realistic perspective on the future, relief that the attempt was not effective, availability of a method to kill oneself that was not used, belief that the attempt would influence others, and family support. In further analysis of patient's records, Baca-García et al. (2006) found that the main variables associated with the decision to hospitalize a suicide attempter were related to drug or alcohol consumption during the attempt, lack of family support, and attitude toward the attempt.

Miret et al. (2011) analyzed 840 clinical records of patients who had attempted suicide at four public general hospitals in Madrid (Spain). The logistic regression analyses showed that explanatory variables predicting admission were: male gender, previous psychiatric hospitalization, psychiatric disorder, not having a substance-related disorder, use of a lethal method, delay until discovery of more than one hour, previous attempts, suicidal ideation, high suicidal planning, and lack of verbalization of adequate criticism of the attempt.

Suominen et al. (2006) investigated the characteristics of 1198 suicide attempters to psychiatric hospitals and the factors affecting such referral during a 12-month period. They found that a quarter of patients were admitted. Factor predicting the admission were older age, psychotic disorder, mood disorder, lack of alcohol consumption preceding the attempt, somatic illness, suicide attempt on a weekday, and previous psychiatric treatment. In addition, the treatment practices of the hospital treating the suicide attempt also influence the treatment decisions to hospitalize.

Suicide risk appears to be an adequate explanatory variable for predicting the decision to admit a patient to a psychiatric ward after a suicide attempt, although previous hospitalization and other sociodemographic variables contribute to the decision to hospitalize patients at risk for suicide.

Beneficial Effect of Hospitalization

Systematic review by **Hawton et al. (1999**) showed no beneficial effect of general hospital admission following deliberate self-harm. It is important to note that only those attempters at low risk and without immediate medical or psychiatric needs were considered for discharge without treatment. The follow-up period of 16 weeks was relatively short.

Waterhouse et al. (1990) study assessed the effect of general hospital admission versus non-admission in a group of self-harm 'parasuicide' patients managed in an emergency room who had "no immediate medical or psychiatric treatment needs." The average length of admission in this study was 17 hours. There was insufficient evidence to determine if there was a clinically significant difference between general hospital admission and discharge on reducing the likelihood of repetition (RR = 0.77; 95% CI, 0.18

to 3.21). There was also no significant difference in hopelessness scores as measured after 1 week (mean 10.29, SD 5.68 versus mean 10.21, SD 4.97). However, the number of patients in each group was not reported for this outcome. At 4 months, there was no evidence of a difference in suicidal ideation scores between the two groups (SMD 0.28, 95% CI, -0.26 to 0.83). Only those who did not require hospital admission because of medical or psychiatric needs were included in the study, and the majority of patients were not randomized as they were considered to pose too great a risk to be assigned to the non-admission group. Therefore, the inclusion criteria in this study constitute an extreme bias.

Vander Sande et al. (1997) compared the impact of brief psychiatric inpatient admission followed by outpatient appointments and 24-hour access to the unit with treatment as usual. There was insufficient evidence to determine whether there was a clinically significant difference on reducing the likelihood of repetition of self-harm at 12 months (RR = 1.15, 95% CI, 0.67 to 1.98). The study reported one suicide in the treatment group and two suicides in the treatment as usual group.

Despite the lack of strong empirical evidence, it is widely believed that hospitalization is necessary to provide acute safety measures (**Nemeroff et al., 2001**; **Cornelius et al., 2004; Overholser, 1995).**

Potential Harm of Hospitalization

Hospitalization may be helpful in managing the acute stage but can potentially be more harmful than helpful for some patients in the long term. The surrender of freedom and independence can result in regression and hurt the therapeutic alliance, especially when involuntary (**Goldblatt, 1994**).

Psychiatric hospitalization is not without negative consequences to include increasing cost of health care, potentially impacting employment (for example the potential loss of a security clearance), direct cost to patient of hospitalization (not an issue if admitted to military or VA hospitals), lost wages that may contribute to reasons for admission and burden to the family of the patient. It should be used for specific treatment plans and where possible alternatives should be sought (**Comtois, 2002**).

Hospitalization for a mental disorder may result in lifetime of stigma, loss of civil rights in certain jurisdictions that may add more stressors to the patient already at high risk for suicide. Those hospitalized often perceive them as severely mentally ill which reduces their hope for the future and their participation in the treatment designed to increase their desire to live (**Comtois et al., 2006**).

Despite the identified areas of debate, hospitalization is the current standard of care for patient at imminent risk for suicide. Clinicians have a responsibility to consider the least restrictive environment where safety can be maintained and why only in instances of imminent concern for safety can a person be involuntarily hospitalized.

Suicide during Hospitalization

Hospitalized patients continue to be at a high risk for suicidal behaviors. Several review studies looked for characteristics of the patients attempting suicide while hospitalized. While suicides occurring during psychiatric hospitalization represent a very small proportion of the total number of suicides, better controlling the nature of the environment can prevent these events.

Bower et al. (2010) conducted a literature review of studies on inpatient suicides. In total, 98 articles covering almost 15,000 suicides were reviewed and analyzed. Rates and demographic features connected to suicides varied substantially between articles, suggesting distinct subgroups of patients committing suicide (e.g., depressed vs. schizophrenic patients) with their own suicide determinants and patterns. The review found that early in the admission is clearly a high-risk period for suicide, but risk declines more slowly for patients with schizophrenia. Suicide rates were found to be associated with admission numbers, and as expected, previous suicidal behavior was found to be a robust predictor of future suicide. Timing and location of suicides seem to be associated with absence of support, supervision, and the presence of family conflict. The authors concluded that for prevention of suicides, staff needs to engage with patients' family problems, and reduce absconding without locking the door.

One retrospective study of 522 acute psychiatric inpatients (**Stewart et al., 2012**) recommended risk assessment be completed as early as possible, and at-risk patients should be monitored for signs of withdrawal from ward activity, aggression, wanting to leave the ward without permission or non-compliance with medication to enable early intervention.

A review of literature by **James, et al. (2011)**, found substantial variation in the rates of self-harm and attempted suicide exists between studies evaluating the incidence of self-harm within inpatient settings. Patients were more likely to self-harm in private areas of the ward in the evening hours, and often self-harmed in response to psychological distress or elements of nursing care that restricted their freedom.

Although the risk of suicide remains during inpatient hospitalization, at least one British study (**Kapur et al., 2012**), demonstrated that from 1997 to 2008, the rate of in-patient suicide fell 1/3 from 2.45 to 1.68 per 10000 bed days. The largest reduction was seen in suicide by hanging, most likely attributable to improved inpatient safety measures.

Mills et al. (2012) reviewed all root-cause-analysis (RCA) reports completed of suicides and suicide attempts that occurred in ED in the Veterans Health Administration between 1 December 1999 and 31 December 2009. Hanging, cutting and strangulation were the most common methods. The most common anchor point for hanging was doors, and the most common implement for cutting was a razor blade. The most common root causes were problems communicating risk and being short-staffed. Based on these results specific recommendations were made for use of checklist to improve the mental health environment. A follow-up study (Watts et al., 2012) evaluated the effect of implementation of such a checklist (the Mental Health Environment of Care Checklist) and the process designed to remove suicide hazards from inpatient mental health. The implementation of the Checklist was associated with a reduction in the rate of completed inpatient suicide in VHA hospitals nationally. This reduction remained present when controlling for number of admissions (2.64 per 100 000 admissions before to 0.87 per 100 000 admissions after implementation; $P < .001$) and bed days of care (2.08 per 1 million bed days before to 0.79 per 1 million bed days after implementation; $P < .001$).

Inpatient Treatment Interventions

- While Dialectical Behavior Therapy (DBT) is a one-year treatment program, shorter adapted inpatient treatments have been developed and empirically evaluated (e.g., Bohus et al., 2004). Inpatient providers may consider DBT as one option of treatment for suicidal patients with Borderline Personality Disorder.
- The Collaborative Assessment and Management of Suicidality (CAMS: Jobes et al., 2005) model of care has been documented to have utility within an inpatient psychiatric environment (Ellis et al., 2009) as well as outpatient settings. Providers who work in an inpatient setting may consider utilizing CAMS in the assessment and management of their suicidal patients. One benefit of using CAMS in both outpatient and inpatient settings is related to the clear documentation of clinical care that such a tool provides.
- Inpatient Cognitive Behavior Therapy is a promising approach to the treatment of suicidal patients (e.g., Post Admission Cognitive Therapy [PACT]; Ghahramanlou-Holloway et al., 2012). The hospitalization period provides a unique opportunity to provide a targeted and brief suicide prevention treatment in the form of individual psychotherapy to the suicidal patient that can be continued after discharge.

F4. Partial Hospitalization, Intensive Outpatient Program (IOPs)

BACKGROUND

In general, partial hospitalization is not a specific treatment intervention for suicidality, but rather a specialized setting where such treatments can be provided. The advantages offered by choosing to place a patient with suicidality in this setting are the intensity of treatment, which approaches the same level as

the inpatient setting, and the ability to monitor the patients' response to treatment closely. Patients in this setting typically are only "on their own" during the weekdays from close of business one day until the beginning of the next morning and then for the whole weekend. If a patient is able and willing to engage in managing suicidal risk, most treatment modalities can be performed in a partial hospitalization setting.

Few studies have been performed to determine whether the effectiveness of treating a patient in the partial hospital setting is any better than routine outpatient care. One randomized trial conducted in day treatment programs (partial hospitalization setting) investigated the effect of a psychodynamic treatment approach on rate of suicide behavior in patients with specific diagnosis of personality disorder.

Overall, the results of studies on the psychodynamically oriented day treatment programs with patients diagnosed with personality disorders demonstrate promising results in terms of suicide outcomes. However, until these studies can be replicated with patients with other disorders and with other treatment approaches there is insufficient data at present to recommend that partial hospitalization is preferable to other settings.

RECOMMENDATIONS

1. There is insufficient evidence to recommend that partial hospitalization is preferable to other treatment settings for reducing the risk of suicide.

DISCUSSION

Suicidal patients with Borderline Personality Disorder are recurrently self-harming. They chronically think about suicide, threaten to carry it out, and make multiple attempts. Their suicidal behavior can become repetitive as they learn to 'work the system', returning to hospital whenever life gets too difficult (**Paris, 2004**). There is some evidence to suggest that these patients may benefit more from partial hospitalization (**Bateman and Fonagy, 1999**), and thus experience less stigma related to social rejection for being in inpatient treatment. Partial hospitalization may be particularly effective in BPD because it provides a highly structured program.

F5. Discharge Planning

BACKGROUND

Discharge planning begins upon admission and is defined as the activities that facilitate a patient's movement from one health care setting to another, or to home. It is a multidisciplinary process involving physicians, nurses, social workers, and possibly other health professionals. The goal of discharge planning is to enhance continuity of care and mitigate risk factors that could contribute to suicide post-discharge. .

Patients discharged from a psychiatric inpatient hospital stay are at increased risk for suicidal behavior upon discharge. The highest risk period for suicide attempts occurs within the first week of hospitalization and immediately upon discharge from the hospital through the subsequent 12 weeks. As such, discharge planning must be a comprehensive and well-coordinated effort to minimize this risk.

Several factors may contribute to the elevated risk of suicide after admission and discharge from a psychiatric hospital. The structure and restrictive safe environment of the acute care setting – around the clock observation, supervision, caring, and support – are abruptly lost at discharge. At the same time, re-exposure to risk factors such as inadequate social supports, rejection by others, facing unsolved psychological and social stressors, resuming use of alcohol or drugs, and limited engagement and follow-up by outpatient providers may increase the risk of a suicide behavior in the critical immediate period after discharge. In addition, the stigma surrounding psychiatric illness and the awareness of being mentally ill may diminish one's self-esteem and raise risk for reattempt.

Premature discharge may add to the risk for suicide post-discharge. Assessment at discharge that is more focused on stabilization of symptoms and improvement of underlying psychiatric condition(s) may result

in missing an enduring risk for suicide. Assessment may ignore or overlook risk factors that led to admission in the first place, and were denied by the patient in the context of the safe inpatient setting. Patients who pretend to show quick recovery may also bias physicians' judgment and lead to early discharge and insufficient treatment.

Suicide theory resulting from the research of Dr. Thomas Joiner suggests how suicidality may worsen in an inpatient setting. A sense of profound burdensomeness – a feeling of liability and not fulfilling expectations or obligations – may be deepened in those who have received inpatient psychiatric care. Similarly, failed belongingness may be amplified by hospitalization and may persist when the patient is discharged to the outside world. These two variables in Joiner's Interpersonal Psychological Theory of Suicide, together with the fact that the third variable – the capacity or sense of fearlessness about lethal self-violence – may not be affected by hospitalization, and may actually escalate the risk for suicide in the discharged patient.

Criteria for discharge from an acute care facility must be sound, reflect sufficient understanding of the risks and benefits of transition to a lower level of care, and establish clearly that the patient has the sufficient skills to manage his safety at this level of care. The discharge planning process must take into account that, as part of the recovery process, absolute suicide risk may remain at a high level after discharge from an acute setting and for months to come. Therefore, these criteria are meant to guide the decision to discharge from an acute setting to continue treatment and recovery from the acute suicidal crisis.

RECOMMENDATIONS

1. A collaborative discharge plan should be developed to allow a suicidal patient to be discharged from inpatient psychiatric care or the Emergency Department in order to mitigate the increased risk of suicide post discharge.
2. Patients who are discharged from acute care (hospitalization, Emergency Department) remain at high risk for suicide and should be followed up within seven days of discharge.
3. Discharge planning should include the following:
    a. Re-assessment of the Suicide Risk
    b. Education to patient and support system about the risks of suicide in the post-discharge timeframe
    c. Providing suicide prevention information (such as a crisis hotline) to the patient and family/unit members.
    d. Post-discharge treatment plans for psychiatric conditions and for suicide-specific therapies
    e. Safety plan with validation of available support systems
    f. Coordination of the transition to appropriate of care setting with warm hand-offs
    g. Identifying the responsible provider during the transition
    h. Monitoring of adherence to the discharge plan for 12 weeks

(For further recommendations and discussion see Module D: Follow-up and Monitoring)

DISCUSSION

Many recommendations for addressing suicide risk after hospitalization have been offered to "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" (Knesper, 2011).

A summary publication -- *The Continuity of Care for Suicide Prevention and Research (*Knesper, 2011) was developed to promote effective clinical and professional practices, and, in particular, guidelines for aftercare treatment programs for individuals exhibiting suicidal behavior, including those discharged from inpatient facilities. (The document may be found in the online library of the Suicide Prevention Resource Center: www.sprc.org)

The National Patient Safety Goals (NPSG 15.0101 – TJC) indicates a requirement that applies to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals:

- Identification of individuals at risk for suicide while under the care of or following discharge from a health care organization is an important requirement for protecting at-risk individuals.
- Conduct a risk assessment that identifies specific characteristics of the individual served and environmental features that may increase or decrease the risk for suicide.
- Address the immediate safety needs and most appropriate setting for treatment of the individual served.
- When an individual at risk for suicide leaves the care of the organization, provide suicide prevention information (such as a crisis hotline) to the individual and his or her family.

The National Committee on Quality Assurance (NCQA) calls for at least one outpatient visit in the first 7 or in the first 30 days following psychiatric inpatient discharge to improve patient outcomes during this period (2006).

Risk of Suicide After Discharge

Admission to a psychiatry inpatient unit is one of the strongest predictors of subsequent suicide death. Therefore, it is crucial that discharged patients receive prompt follow-up care (Crawford, 2004). Since persons at high risk for suicide are hospitalized often and this risk cannot be eliminated altogether prior to discharge, the suicide risk at the time of discharge may be considerable.

Indeed, the immediate period after discharge is when suicide death is most likely to occur (Qin et al., 2006) and discharged patients remain at high risk for at least the next year.

The risk of suicide in the four weeks after psychiatric inpatient care is around 100 times greater than that for the general population (Goldacre et al., 1993; Geddes et al., 1995; Qin et al., 2005). The weeks after discharge from psychiatric care represent a critical period for suicide risk (Hunt et al., 2009). This risk declines rapidly over subsequent weeks (Meehan 2006). A study of 954 patients discharged from an adult psychiatric unit in the United States found that over 20% self harmed in the 12 months after discharge but that the risk remained constant throughout the follow-up period (Skeem et al., 2006).

The following reviews and observational studies looked at the magnitude of risk and rates of suicide after discharge from acute care. All leading to the conclusion that prevention of suicide after discharge requires early outpatient follow-up and closer supervision of high-risk patients.

Desai et al. (2005) explored suicide rates based on data from a prospective mortality study of psychiatric inpatients from 128 U.S. Department of Veterans Affairs hospitals throughout the United States. Data collected on all patients discharged with a diagnosis of schizophrenia, major depression, posttraumatic stress disorder, or bipolar disorder (N=121,933) between 1994 and 1998. Of 121,933 unique patients included in the sample, 3,588 (2.9%) died within 1 year of discharge. Of those, 481 (0.4% of the total sample, 13.4% of deaths) died of suicide. Suicide deaths were concentrated in the first 6 months after discharge, with 46% in the first 3 months, 18.3% in months 4–6, 20.4% in months 6–9, and 15.4% in months 9–12.

Valenstein et al. (2009) evaluated suicide rates among 887,859 Veterans with depression (NARDEP merged with NDI data) and found that suicide events were highest in the first 12 weeks following psychiatric hospitalizations compared to the subsequent 12 weeks period (RR 1.9; 95% CI, 1.5 to 2.4).