Preventing Suicide

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About 35,000 people commit suicide every year in the United States. Almost all are seriously, but treatably, mentally ill. Most come to the attention of a physician, in an emergency room, primary practice setting, or psychiatric hospital or office, during the days, weeks or months before they die. Since 1995, suicide has been the second most commonly reported of all Joint Commission hospital sentinel events (not just psychiatric events). Suicide is involved in the majority of psychiatric malpractice lawsuits. It takes life from patients, parents from children, children from families, and valuable people from society. Suicide is a terrible way to lose a relative or friend, leaving much greater damage than most natural or accidental death. This paper discusses four points to be considered by those who want to improve this situation: 1) Suicide is rarely "voluntary" in any clinical sense of the term; 2) A great many suicides are preventable once a clinician becomes involved; 3) Suicide is worth preventing; 4) There are practical approaches to prevention that work. *(Journal of Psychiatric Practice* **2010;16:120–124**)

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Given the common estimate of 11–12 suicides/year per 100,000 individuals in the general population, about 35,000 people commit suicide every year in the United States.[1] Most of them are seriously mentally ill; only a handful of suicides can be considered "rational" (e.g., involving rational altruism or terminal illness). Almost all of the mental disorders associated with suicide are treatable, most with a substantial rate of success, and severe suicidality is usually a temporary condition.

Most people who have committed suicide came to the attention of a physician, in an emergency room, primary practice setting, and/or a psychiatric hospital or office, within weeks of their death. Some level of suicide risk was likely to have been recognized at those meetings, given appropriately trained clinicians and adequate evaluations. Negligently or not, errors in risk recognition, particularly in assessing the level of risk, were involved in an unknown but substantial number of these deaths. Management of risk that was or should have been recognized—that is, protection of the patient coupled with acceptable treatment—fell short in many of the cases of those who eventually died.

The Joint Commission encourages accredited hospitals to report "sentinel events," defined as "an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof…."[2] Since 1995, suicide has been the second most commonly reported of all sentinel events (not just psychiatric ones).[3] (Note that sentinel events do not necessarily imply medical errors or negligence.)

Suicide is involved in the majority of psychiatric malpractice lawsuits, but that's not the point of this paper. It takes parents from children, children from families, and valuable people from society, all prematurely and often in (or before) what should be the prime of their lives.

Suicide is the worst way of all, in my view, to lose a relative or friend. The families wrestling with that loss have deep questions of "What could I have done?" "What did I do?" and "Will it happen to me?" Those questions and doubts persist for years, often whole lives, even when the family member barely knew the deceased person (as when very small children lose a parent). Those who commit suicide believing the family will "think it was an accident" are almost always wrong.

This paper will discuss four points that should be considered by anyone who wants to ameliorate this tragedy. First, in spite of angry, frustrated comments

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from some of those whose lives are affected by suicide, it is almost never "voluntary." Second, a great deal of suicide is preventable; do not be misled by common rationalizations such as "if someone wants to do it, he'll find a way." Third, suicide is worth preventing; victims of suicide are not simply people who were too ill ever to be productive, or families that would somehow be "better off" once the suicidal person is gone. Finally, I'll provide what I believe are some specific avenues of action, clinical and societal, for substantially decreasing this terrible loss.

Suicide Is Rarely "Voluntary"

It is important to realize that although most people who die by suicide "know," in some rote fashion, that their behaviors will probably lead to death, only a small minority competently appreciate their suicidal acts and related situations. Their psychiatric symptoms overwhelm the parts of them that are rational and/or that want to live. In many, the capacity to resist suicidal impulses is simply not enough to protect them from dying. Some suffer from psychotic thinking that prevents them from realizing they are committing suicide, or that the death will be permanent. Many people who commit suicide and "know" their act is likely to be lethal wish not for death but for relief of intolerable, unimaginable pain, without realizing that they are viewing that pain through tragically unrealistic lenses.

Some of these behaviors can create the erroneous concept that suicide is somehow the patient's choice, that it is a result of the person's competent intent and under his or her control. That defense is occasionally raised in malpractice cases, or to protect clinicians from the thought that their care was inadequate. While "voluntary" and even "altruistic" suicides do occur, the great majority of suicides involve important things that are outside the patient's reasonable control, including certain feelings, perceptions, and impulses. Suicide may seem "reasonable" to the impaired patient because he or she is viewing the situation through "black glasses" (in contrast to rose-colored ones).

I am not shocked when lawyers try to defend insurance companies, hospitals, and doctors by alleging that a particular suicide was a voluntary act. Life insurance and workers-compensation policies, even those that allow claims for suicide-related death, often cite clauses that say the claim is not payable if the death was "voluntary." It is logical to assert that a malpractice claim should be diminished if the patient's damage was, in part at least, *voluntarily* self-induced. It is the lawyer's job to explore such defenses. On the other hand, I *am* often shocked when psychiatrists and psychologists, who should know better, exaggerate the role—if any—that the patient played in his or her own death.

Most Suicide Is Preventable

Psychiatrists and acute care nonpsychiatric clinicians, especially those in hospitals and emergency settings, should know how to prevent most suicides in the patients they encounter. Unfortunately, my clinical, peer review, and forensic experience indicates that many fail to adequately assess, recognize, and mitigate substantial suicide risk when it presents to them. The basic principles are well-known and the general standards of care have been established for years—we simply need to pay more attention.

First, ***protect the patient***.

Second, ***wait for significant, stable, and reliable change before relaxing patient protections***. This caveat should come as no surprise, nor is it unique to psychiatry; it is a routine attitude among our nonpsychiatric colleagues, for example, when they are treating acute trauma, severe cardiac symptoms, or delirium. We know that some psychiatric presentations and conditions (including significant suicide risk) are also life-threatening conditions, and we must treat them with the same care and caution that we expect of trauma specialists and cardiologists.

Third, understand that ***treatment works***. It must be real treatment, however, which is logically and individually planned, not a blind following of protocols and routines that are often designed more for the efficiency of the care system than for addressing the broad needs of a complex mental illness.

For example, antidepressant, mood-stabilizing, and antipsychotic drugs help a great many patients, but they must be properly prescribed and their interactions balanced. Even more important, when suicide risk is substantial, the clinician must observe the patient long enough to see whether or not the particular medication(s), dosage(s), and bal-

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ance of medications are working. Virtually all psychiatrists, and many primary care and emergency clinicians, know that the medications with which these patients are treated often take weeks to show their full effect (assuming an effect is destined to be shown), yet patients with serious symptoms for which they are prescribed are routinely discharged from hospitals after a few days (or not admitted at all), and then they receive only delayed or sporadic follow-up.

Psychotherapeutic treatment for acute and subacute conditions related to suicide risk is one of the success stories of modern psychology and psychiatry. Cognitive, cognitive-behavioral, and interpersonal psychotherapies often work well, but patients rarely get them, particularly in hospitals (where patients are relatively protected, often able to be motivated, and in a great place to begin therapy). Instead, many spend time in generic "group therapy" that has little chance of addressing suicide risk.

Fourth, ***get rid of harmful stereotypes and misconceptions about suicide and suicidal patients***. Most of these stereotypes are old news to those who read this column, but doctors, other clinicians, hospitals, and hospital staff keep relying on them, and patients keep dying unnecessarily. Here are a few harmful misconceptions (there are others):

- *"Suicide 'gestures' are relatively unimportant to risk assessment, and quite different from suicide attempts."* **The probability of death may be low, but the stakes are very high.** Further, the word "gesture" trivializes often-important signs and contributes to misunderstanding of risk.

- *"Asking the patient is a good way to assess suicide risk."* This may be true if the patient says he or she is suicidal, but **it is patently false, and dangerous, if the patient denies suicidality**. Suicidal patients often lie about their risk (many, perhaps most, want to keep the deadly option open). And clinicians usually can't tell when they are lying.

  Imagine for a moment that you are sitting with a man who has a loaded gun, pointing it in your general direction and putting his finger on the trigger. You ask, "Are you planning to shoot me?" If the person answers "Yes," you believe him. The danger is obvious. But if the person says "No," it would be foolish to believe him. The danger remains obvious regardless of the answer.

  Even patients who respond honestly often misunderstand their own symptoms, condition, and risk. They can't predict their future condition, impulses, and behaviors. Their judgment and depth of insight are routinely poor (as frequently is their impulse control). More broadly, information from patients with conditions such as severe depression, serious suicide potential, major borderline traits, or psychosis, is often simply unreliable. All of those factors impede risk assessment and increase the need for caution and collateral information.

- *"No-suicide 'contracts' ('contracts for safety') save lives."* Why are we still talking about this idea, after years of debunking in studies, textbooks, and practice guidelines? Because many hospitals still train their nursing staffs to use "contracts for safety" and many staff members still rely on them. We're not talking here about forming therapeutic alliances, but the persistent belief that is still common, usually among nursing staff and nonpsychiatric clinicians, that "contracts for safety" mitigate risk. They do not.

- *"Intensive outpatient treatment or partial hospitalization is a good alternative to hospitalization for suicidal patients."* A few hours per week, or even per day, in a clinic or partial hospitalization program leaves a great deal of time in unmonitored, potentially risk-increasing environments. Don't discharge the patient until you are confident about his or her level of outpatient risk, no matter what follow-up modality is planned.

- *"Protective factors can balance risk factors."* Patients who are serious about suicide (such as those who are admitted to hospitals) are relatively unaffected by so-called "protective factors." Suicide occurs in all demographics, among the employed and the unemployed, the married and the divorced, those with loving families and those without, and the devout and the less devout of all religions. The substantial risk implied by factors such as (but not limited to) a recent attempt, suicide plans and obsessions, hopeless pessimism and depression, significant anxiety, substance abuse, or psychosis cannot be balanced by demo-

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graphic differences or "protective factors." Do not allow caution to lapse because you think the patient has "a lot to live for."

Suicide Is *Worth* Preventing

Most patients who are prevented from committing suicide recover sufficiently from their acute symptoms to experience productive and rewarding lives. Some eventually die by their own hands, but most do not. Many of the mental disorders that give rise to suicide risk are chronic, with relapsing and remitting courses; however, patients who experience no reward from life at all are indeed rare. When one considers the variety of good treatments now available for mood disorders, severe depression and anxiety, affective instability, psychosis, and substance abuse disorders, it becomes clear that their lives are not saved merely to provide another chance to commit suicide, but to offer an opportunity for lasting relief of unnecessary emotional pain and dysfunction. In addition, when we save patients, and treat their disorders, we do a great service to their families, particularly the children of suicidal parents, and the parents of suicidal children.

Practical Approaches to Preventing Suicide

Several keys to what we can do to decrease death and promote life, both as practicing clinicians and as advocates for our patients and their families, lie in fairly simple acts which are too often ignored.

- ***Practice well***. Understand suicide risk assessment, risk recognition, patient protection, and quality treatment.

- ***Raise the awareness of emergency room and primary care physicians and other acute care clinicians (including triage nurses) about suicide risk and managing that risk***. Severely suicidal people who are seen by a health care professional are more often seen by an emergency room or primary care clinician than by a psychiatrist (or at least must pass through an emergency or primary care gateway before seeing one). Psychologists and other nonphysician mental health professionals outside hospitals play an important role in providing care to suicidal patients, but they are not usually the first clinicians contacted (by patients, families, or the police) when suicide risk is acute.

- ***Improve risk assessment, recognition, and management in psychiatric hospitals and units.***

An April, 2010, suicide prevention press event with Congressman Patrick Kennedy at the U.S. House of Representatives will recommend some or all of the following:

- State medical licensing board continuing medical education (CME) requirements that address suicide risk awareness, assessment, and management as a condition of license renewal. This requirement should apply to all physicians, not just psychiatrists (cf., common requirements for ethics CME and California's pain management education mandate).

- Enhanced, well-marketed programs in suicide risk awareness, assessment, and management from organizations that provide continuing clinical education (such as professional societies and commercial purveyors of continuing education).

- Enhanced offerings in suicide risk awareness, assessment, and management from malpractice insurance carriers, perhaps as part of premium-reduction programs.

- Consideration of rules by the Centers for Medicare and Medicaid Services (CMS), The Joint Commission, and state regulatory bodies requiring approved facility procedures for training and monitoring facility staff and medical staff members on suicide risk awareness, assessment, and management, as well as requirements for facility reporting of suicide-related outcomes and events.

- Reporting and publishing of suicide and suicide-related outcomes, for use in shaping future procedures related to the above. In particular,
  a) Collect in-hospital and post-hospital suicide events for facility and medical staff review.
  b) Collect follow-up information on patients seen in emergency rooms but not hospitalized.
  c) Report in-hospital suicides in a specific, comparable format statewide and nationwide, for public, professional, and facility dissemination.

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The groups sponsoring the Washington press event are cautious about prescribing specific assessment and management behaviors, since regulation often stifles important creativity; nevertheless, several problems keep coming up in sentinel event reports, clinical and peer reviews, and malpractice litigation:

- *Inadequate monitoring and protection of new patients with moderate or high suicide risk, or with unknown risk.* Unknown or unpredictable risk must be assumed to be "high" until clarified by a qualified clinician. Since it is clear that monitoring "every 15 minutes" does not prevent suicide, all patients who are at substantial risk should be continuously monitored by a qualified person, and new patients and those at unknown risk should be continuously monitored until evaluated by a well qualified clinician.

- *Premature discharge* (for example, of patients admitted with substantial suicide risk who have not yet exhibited significant, stable, and reliable change in their risk).

- *Reliance on inadequate outpatient monitoring, either after or in lieu of hospitalization* (for example, but not limited to, inappropriately relying on family members).

- *Inadequate transition to outpatient or partial hospitalization care.* When patients known to have been at high risk are discharged, they should be seen by well qualified outpatient clinicians very soon, and the transition to outpatient care begun smoothly, while the patient is still in the hospital.

- *Provider organizations, facilities, and payers that discourage clinicians from acting on the side of caution when suicide risk is suspected* (e.g., discouraging admission, continuous monitoring, or delaying of discharge, often by citing costs or staffing pressures).

Psychiatry, the acute care professions generally, and hospitals should keep the promise that has been implied for decades: that we are the helpful, knowledgeable, safe place for patients to go when they are in psychiatric crisis.

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