

Post-Discharge Suicidal Behavior Risk

Tony Salvatore, MA
Montgomery County Emergency Service
Norristown, PA

tsalvatore@mces.org

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Objectives:

1. Describe risk and the occurrence of post-discharge suicidal behavior
2. Discuss how hospitals can address risk prior to discharge
3. Recommend prevention measures for inpatient and community-based providers after discharge

“...Psychiatric units are increasingly populated by anti-social malingerers who have no pressing need for hospitalization – but...claim they’re contemplating suicide...”

***Jacob Appel, MD
NY Post 9/13/11***

Part I:

***What we know
About Suicide Risk
Before and After Discharge***

“There is no evidence that psychiatric hospitalization prevents suicide...in the immediate period after discharge.”

Knesper (2011)

Concern:

“The risk of suicide is higher during the period immediately following discharge from inpatient psychiatric care than at any other time in a service user’s life.”

Crawford (2004)

“Mental health clients are 100 times more at risk of suicide at the time of discharge from inpatient care.”

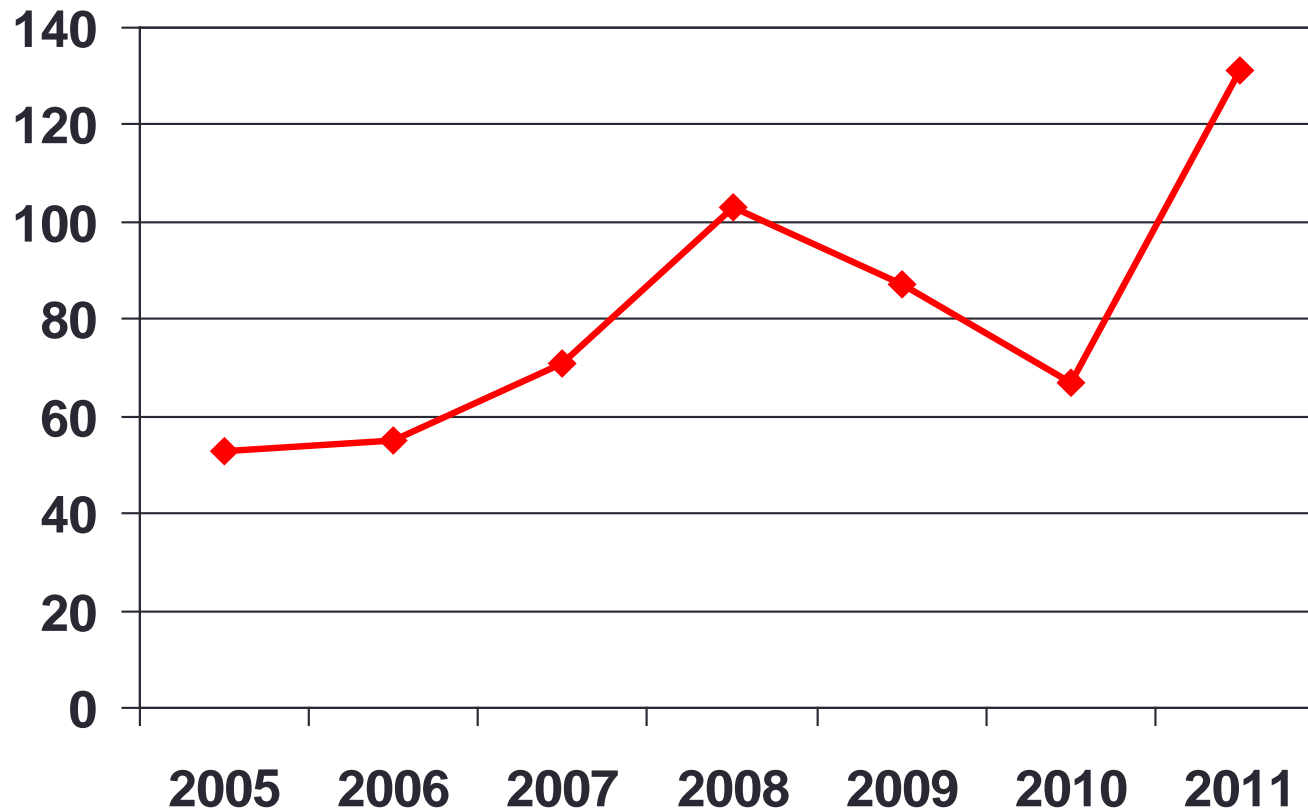
Centre for Mental Health, NSW Health Department (1999)

Hospitalization:

“Hospitalization, by itself, is not a treatment....Inpatient settings can implement approaches such as constant observation, seclusion, or physical or pharmacological restraint that may restrict an individual’s ability to act on suicidal impulses.”

*American Psychiatric Association
Practice Guidelines for the Assessment and
Treatment of Patients with Suicidal Behaviors (2003)*

TJC – Sentinel Events*:



*Suicides within 72 hours of inpatient D/C

Suicidal Behavior Post-D/C:

- 43% suicided < 1 month; 47% died before first appointment
- First day/week were high risk periods
- Hx of self-harm; primary Dx of affective disorder

Hunt et al. (2009)

- 23% engaged in suicidal behavior < 1 year; 18% made attempts
- Hx: Past suicidality, depression, impaired functioning

Skeem et al. (2006)

- Poor early post-D/C functioning and early signs of psychotic symptoms linked to later (2 yrs.; 7.5 yrs.) suicidal behavior in men

Kaplan et al. (2012)

Risk:

- High for 30 days after hospital D/C.
- Suicidality major reason for readmission in 30 days.

*Appleby (1992); Goldacre et al. (1993); Geddes et al. (1997);
Sohlman & Lehtinen (1997)*

- Post-D/C suicide most frequent in the first 2 weeks.
- Most suicides occur on the first day.

Meehan et al. (2006)

- 6% complete suicide within 10 years of first admission for attempted suicide.

Holley, Fick, & Love (1998)

Risk:

- Almost half of those who had committed suicide [after D/C] were not documented as suicidal.
- In almost half of those who had expressed suicidal ideas, treatment was not changed.

Dennehey et al. (1996)

- Of 21,000 suicides in Denmark in 1981-1997, 37% of males and 57% of females had histories of psychiatric hospitalization.
- Of those completing suicide after D/C, most died within 6 months of leaving the hospital.

Qin & Nordentoft (2005)

SMI-Specific Risk Factors:

- Young age and early stage of illness
- Good pre-illness functioning
- Good intellectual functioning
- Frequent exacerbations/remissions
- Post-relapse improvement periods
- Depressive episode/hopelessness

Bongar (1992)

Risk:

- Inpatient Suicide Risk Factors:
 - High LOS and multiple prior admissions
 - Prior attempt, self-harm; planned attempt
 - Suicidal behavior before/during admission
 - Depression
 - Family Hx of suicide, mental illness
 - Recent bereavement
 - Single, living alone

Combs & Romm (2007)

Risk:

- Finnish Study of Suicides in week of D/C:
 - More often female and unmarried
 - More education, employment, higher SES
 - Dx of schizophrenia spectrum or affective disorder
 - Less improvement during hospitalization (poorer global functioning)
 - Jumping from bridge, drowning most common means

Pirkola, Sohlman, Wahlbeck (2005)

Risk:

- Return to life stressors in the community
- Return of insight resulting in awareness of the consequences of the illness
- Reduced oversight
- Relapse
- Non-adherence and non-engagement

Meehan et al., (2006)

Risk:

“Patients returning to the community may find the reduced social support they experience distressing”

Simons et al. (2002)

“In the post-discharge period, risk may be declining only slowly whereas the protective influence of inpatient care is fairly abruptly removed.”

Meehan et al., (2006)

Problems:

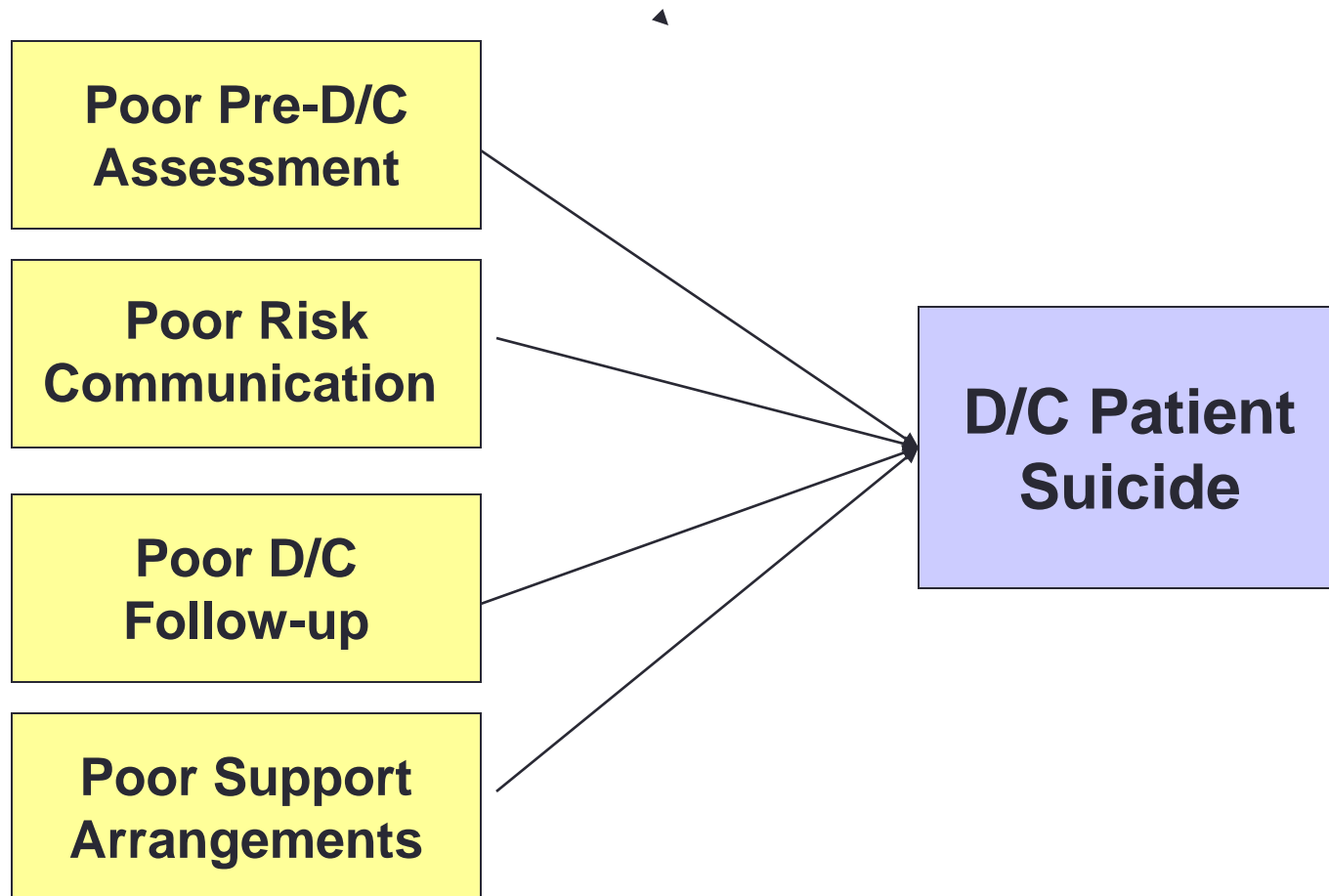
- D/C decision based on “stabilization” rather than resolution of pre-hospital destabilizing factors
- Depression may lift during stay; hopelessness may persist during stay

Davidson (2005)

- D/C plans focus on psychiatric Dx rather than suicidality.
- D/C plans that target a Dx fail to fully address the nature of suicidal risk (i.e., patient may move toward less depression, but remain suicidal).

USAF Guide for Managing Suicidal Behavior (2005)

Root Causes:



Part II:

What we Need to Know About Suicide Risk Before and After Discharge

“Every patient making a suicide attempt or having suicidal ideation needs to be managed as if the next attempt will result in death.”

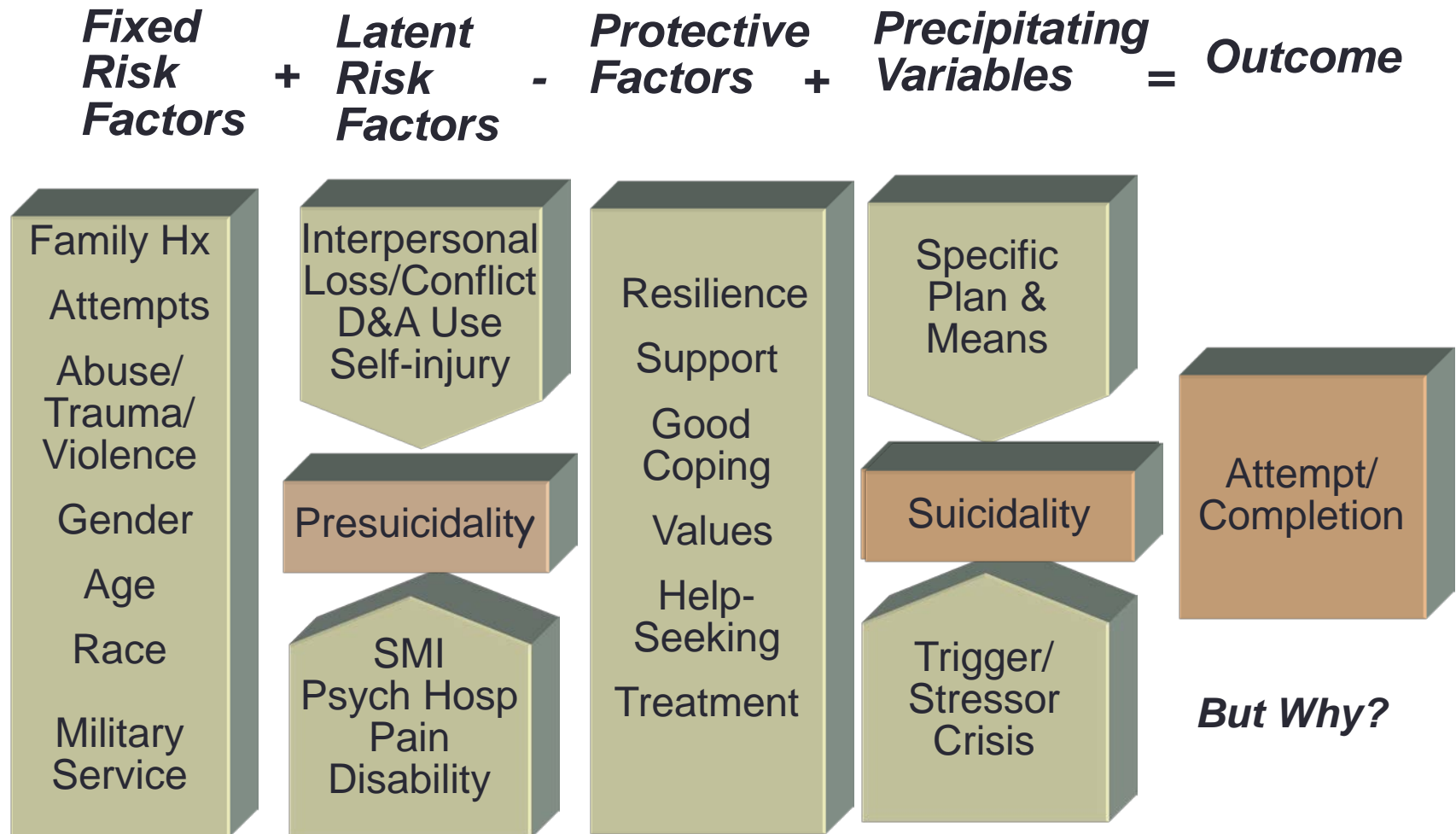
Knesper (2011)

What We Know About Suicide:

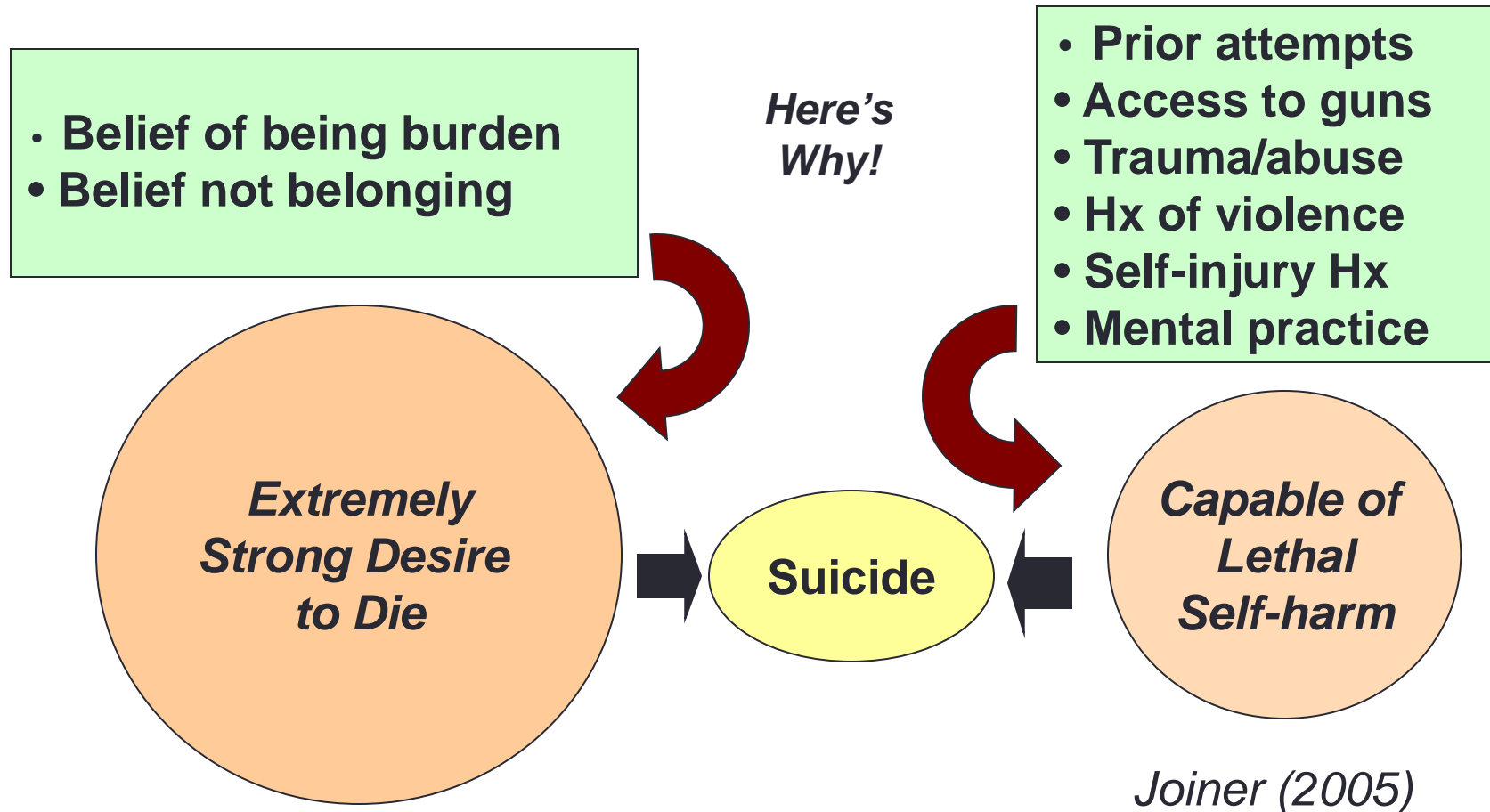
- A great deal about the underlying conditions
- *Who* completes suicide
- The *hows, wheres, and whens*
- The methods, places, and seasons
- But not why: “What we do not know kills.”

Kay Redfield Jamison
Night Falls Fast: Understanding Suicide (1999)

Prevailing Schema:



Interpersonal Psychological Theory:



Perceived Burdensomeness:

- The belief or feeling of being a unbearable burden on family, friends, or society
 - Sense of being a burden on those one cares about
 - Belief that one is a liability to these others
 - Belief of failing to contribute as expected
 - Belief that one's death would be worth more than one's life
 - Reversible

Failed Belongingness:

- A sense of failure regarding maintaining social relationships and connections
 - An strong unmet need to belong
 - Involves a lack of frequent, positive social interaction
 - Sense of not being cared about by others
 - Perceived inability to connect with others
 - Reversible

Acquired Capability:

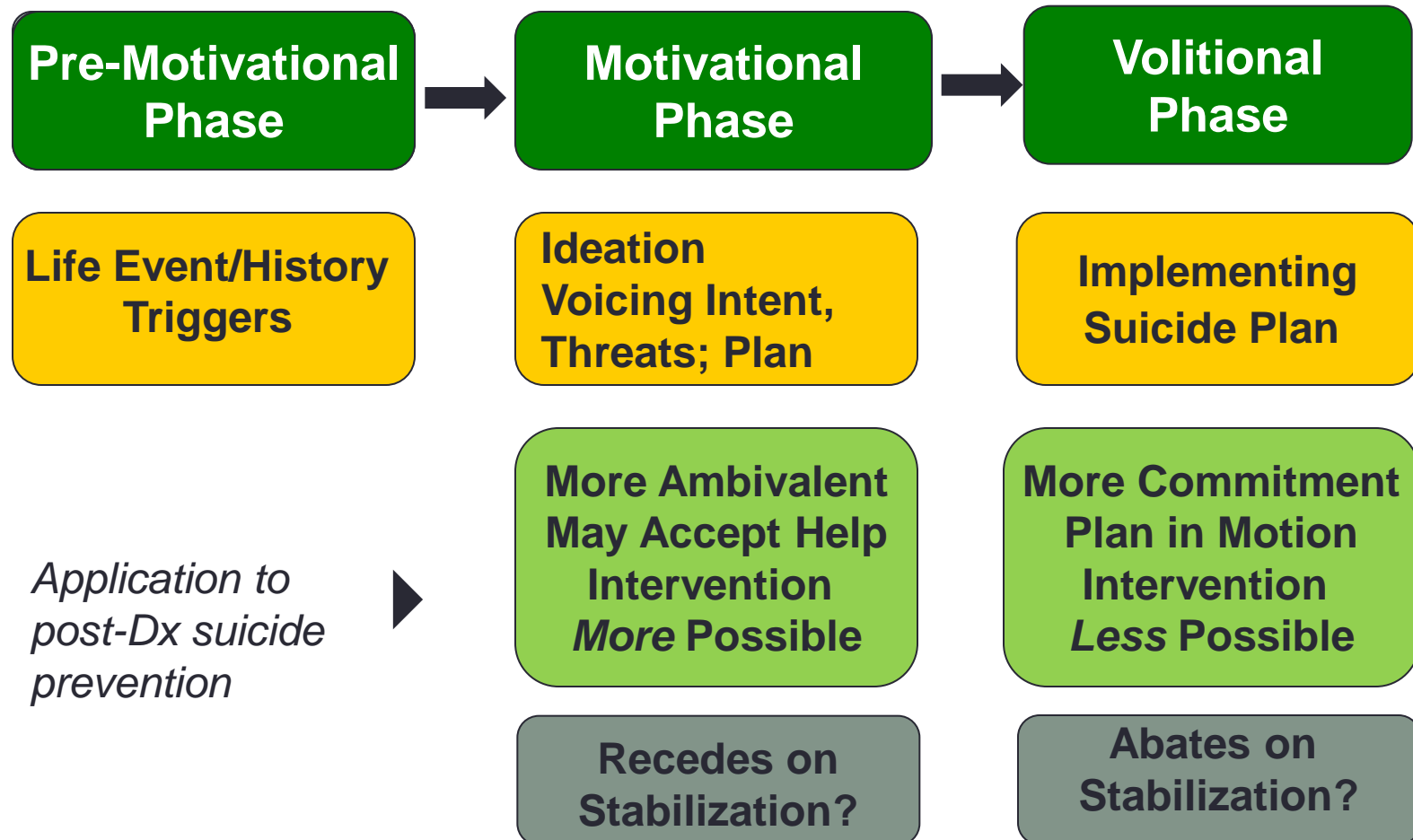
- The acquired ability to engage in or to withstand violence or painful behavior
 - The degree to which one overcomes fear of death and the instinct for self-preservation
 - The degree to which this capacity is developed overtime by exposure to fearful, provocative, and/or hurtful experiences
 - Irreversible

Capability Habituation:

- Pathways to lowered self-harm resistance:
 - Suicidal Ideation – Constant rumination on thoughts of suicide (*O'Connor, 2011*).
 - “Mental Practice” - Repeatedly running over specific suicide plan in one’s mind (*Joiner, 2005*)
 - “Aborted Attempt” – Plan/means present, but change of mind immediately before attempt (*Barber et al. (1998)*)
 - “Suicide Rehearsal” – Behavioral enactment of method often as part of plan (*Simon, 2012*)
 - Chronic Suicidality – Persistent contingent threats, pseudo-attempts without intent to die (*Paris, 2006*)

Suicide Risk Stages:

Integrated Motivational-Volitional Theory (O'Connor, 2011)



Part III:

What we can do to Prevent Suicide After Discharge

“The most glaring gap in the present system of treating suicide attempters seems to be a lack of follow-up and continuity of treatment.”

Welu (1977)

Recommendations:

- Pre-discharge assessment of risk at admission and risk acquired during stay
- Identify sources of supports and willingness and ability to provide support
- Give patient and family instruction on suicide and risk after D/C and thereafter
- Give clear instructions on how to access crisis intervention and other sources of help

American Association of Suicidology (2005)

Recommendations:

1. Treatment ASAP after D/C
2. Pre-D/C discussion of suicide risk and make a series of short, non-demanding follow-up contacts post-D/C
3. Anti-suicide therapies (e.g., CBT, DBT) available
4. Replace fragmented/disconnected services with a cohesive/coordinated provider arrangement
5. Upgrade D/C planning practices to support suicide prevention

Knesper (2011)

Recommendations:

- Immediate post D/C treatment of at-risk patients

Pirkola, Sohlman, Wahlbeck (2005)

- Early community follow-up of at-risk patients after D/C
- Closer supervision of at-risk patients after D/C

Meehan et al. (2006)

- Intensive and early post-D/C community follow-up
- Outreach after missed outpatient appointment

Hunt et al. (2009)

- Enhance support/follow-up for all patients leaving hospital

Crawford (2004)

Telephone Follow-up:

- N =991 patients D/C from ER after suicide attempt
- Calls after one week, at 1, 3, 6, 9, 12-month intervals
- Intervention delayed further attempts
- Intervention reduced rate of re-attempts

Cebria, Parra, Pamias et al. (2012)

What can be done?

- Suicide prevention training for peer specialists
- Family education on suicide risk, warning signs
- Personal safety plans/suicide prevention WRAPs
- Support group for attempters, and those who experienced an acute episode of suicidality
- Warm lines for help with suicidality, suicide loss
- Peer-led suicide bereavement support group

Personal safety plans:

1. Triggers – Feelings, occurrences that preceded past episodes of suicidality
2. Warning signs – Thoughts, feelings, moods, behaviors, etc. that are indicators of emerging suicidality
3. Coping strategies – Measures to avert suicidality.
4. Social supports – Friends and social settings
5. Family supports – Relatives to serve as supports
6. Providers – Physicians, therapists, crisis lines, etc.
7. Means restriction – Identification of possible means of self-harm and what can be done to block access

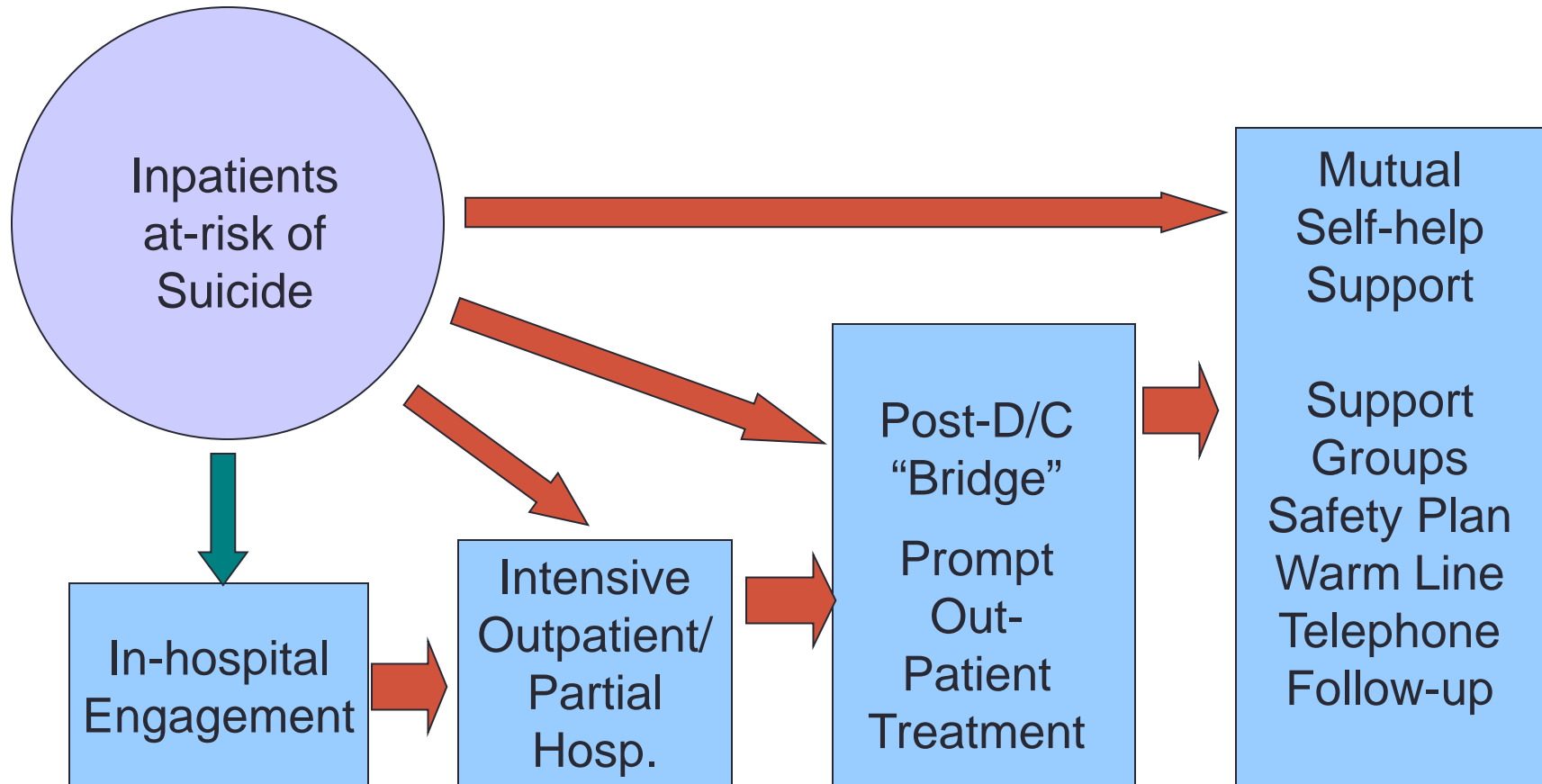
Some Best Practices:

- Special D/C Instructions to all patients
- Peer-led inpatient suicide prevention group
- Consumer/family information
- Pre-D/C Suicide Risk Assessment
 - Treatment Team
 - Self-assessment
- Telephone follow-up within 24 hours
- Follow-up in the community

Consumer Risk Reduction:

- Remove firearms and old/unused meds.
- Use only prescribed meds as directed;
- Reduce abuse of alcohol, drugs, and non-Rx meds
- Contact 3-5 relatives or friends to call.
- Follow through on D/C plan.
- Find a mutual self-help support group.

Aftercare Continuum:



Bottom Lines:

- I. Post-D/C suicide prevention starts at intake.
- II. Suicide risk assessment is a process not an event.
- III. Post-D/C suicide prevention is every provider's business.
- IV. Hospitals "own" short-term post-D/C suicide risk.
- V. Fewer admissions would put fewer people at risk.

Objective 8.4: Promote continuity of care and the safety and well-being of all patients treated for suicide risk in...hospital inpatient units."

2012 National Strategy for Suicide Prevention