

Preventing Suicide

EXECUTIVE SUMMARY

About 36,000 people commit suicide every year in the United States. Almost all are seriously, but treatably, mentally ill. Most come to the attention of a clinician in an emergency room, primary practice setting, or psychiatric setting within days or weeks of their deaths. Since 1995, suicide has been the second most commonly reported of all hospital "sentinel events" (not just psychiatric ones). Suicide takes life from patients, parents from children, children from families, and valuable people from society. Suicide is a terrible way to lose a close relative or friend, leaving much greater damage than natural or accidental death. This paper discusses four points for those who want to improve much of this situation: (1) Suicide is rarely "voluntary" in any meaningful sense. (2) A great many suicides are preventable once a clinician becomes involved, but lack of simple recognition or procedures is often an obstacle to survival. (3) Suicide is worth preventing. Its personal, family, and social costs are enormous. (4) We recommend several practical ways to decrease suicide and the human costs that accompany it.

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INTRODUCTION

- **Suicide Is Rarely "Voluntary."**
- **Most Suicide Is Preventable.**
- **Suicide Is Worth Preventing.**
- **This Paper Suggests Several Ways to Prevent Suicide.**

Some 36,000 people, about 12 per 100,000 in the U.S. general population, commit suicide every year. Most 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 high rate of success; severe suicidality is usually a temporary condition.

Suicide 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 hurts families terribly. It is the worst possible way lose a relative or close friend, far more damaging than natural or accidental death. Family members 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 entire lives, even when the family member barely knew the deceased person (such as when very small children lose a parent).

The Joint Commission, which surveys and accredits general and psychiatric hospitals, encourages hospitals to report "sentinel events," defined as "an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof" Since 1995, suicide has been the second most commonly reported of all sentinel events (not just psychiatric ones). Most people who commit suicide come to the attention of a physician – in an emergency room, primary practice setting, and/or a psychiatric hospital or office – within weeks of death. Some level of suicide risk is likely to be recognizable at those meetings, given appropriately trained clinicians and adequate evaluation. Errors in risk recognition, particularly in assessing level of

risk, were involved in a 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 those who eventually died.

This brief informational paper will discuss four points that should be considered by anyone who wants to change this tragic situation. First, in spite of the angry, frustrated comments one hears from those whose lives are affected by suicide, it is almost never "voluntary." Second, a great many suicides are preventable; do not be misled by the common rationalization, "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. Fourth, there are several specific, easily implemented actions that will substantially decrease this terrible loss.

Suicide Is Rarely "Voluntary."

While "voluntary" and even "altruistic" suicides do occur, the great majority are outside the patient's reasonable control. Suicide may seem "logical" to the patient because he or she is viewing his situation through "black glasses" (in contrast to rose-colored ones).

Although every case is unique, the general causes of suicide are obvious to those who work in the field. In almost all suicides, powerful psychiatric symptoms overwhelm the part of the patient that wants to live; the ability to resist suicidal impulses is not enough to protect the patient from dying. In many patients, extreme anxiety or morbid depression prevents the patient from seeing hope when it is there. In some, "psychotic" thinking prevents him or her from realizing that he/she is actually committing suicide, or that the death will be permanent. Most patients know in some rote way that the suicidal act is lethal; their wish is often not simply for death, but for escape from intolerable, unimaginable emotional pain.

Most Suicide Is Preventable.

Hospitals and clinicians already have access to the knowledge that can prevent most suicides by patients seen in clinical settings, but its implementation is often inadequate.

- **Protect the patient.**
- **Wait for significant, stable, and reliable change before relaxing patient protections** (just as other specialists do when treating acute trauma or severe cardiac symptoms).
- Understand that **modern treatment usually works when safely and properly applied.** But it must be *real* treatment, logically and individually planned, not a blind following of protocols and routines designed more for system efficiency than for addressing each patient's need.
- **Get rid of harmful stereotypes and misconceptions about suicide and suicidal patients.**

It's not rocket science. The general standards of care in suicide risk assessment, recognition, and management have been established for years; Clinicians, hospitals, and care provider systems simply need to pay better attention.

Suicide Is Worth Preventing.

Patients who are prevented from committing suicide usually recover and experience productive and rewarding lives. Some commit suicide eventually, but most do not. Their lives are not saved merely to offer another chance at suicide, but to provide an opportunity for lasting relief of 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.

Here's How To Do It.

Several keys to decreasing suicide lie in three fairly simple goals.

- **Give clinicians an opportunity to practice well, then expect them to do so.** Provide the training they need, time to adequately evaluate and understand their patients, the resources to protect and treat suicidal patients, encouragement to overcome bureaucratic limitations, and a public expectation of safe and high-quality care. **Don't settle for less from your health plan and those who administer it.**
- **Raise the awareness of emergency room and primary care physicians,** and other clinicians (including triage nurses), about suicide risk assessment, recognition, and management. Severely suicidal people are more often seen by emergency room or primary care clinicians than by psychiatrists (or must pass through emergency or primary care gateways before seeing psychiatrists).
- **Improve risk assessment, recognition, and management in psychiatric hospitals and care units.**

These goals can be brought closer by pursuing four practical objectives.

- **Press for state and federal agency and legislative hearings** to educate decision makers about the importance of the above goals, and about easy-to-implement actions (such as those listed below) **that will save lives.**
- **Press state professional licensing boards to implement rules requiring all clinicians to participate in approved continuing education addressing suicide risk awareness, assessment, and management.** The requirement should apply to all clinicians who may come into contact with suicidal patients/clients, and be a condition of license renewal.

- **Press the Centers for Medicare and Medicaid Services (CMS), The Joint Commission, and state hospital licensing & regulatory agencies for rules** requiring
 - approved facility procedures for training facility staff on suicide risk awareness, assessment and management;
 - follow-up performance monitoring, and
 - facility reporting of suicide-related outcomes and events.
- **Press for establishment of a better system of reporting and publishing suicide and suicide-related outcomes**, perhaps through the CMS or state regulatory agencies, for use in shaping future procedures related to the above.
 - Collect inpatient and post-hospital suicide events for facility & clinician review;
 - Collect follow-up information for emergency room patients evaluated for suicide risk but but not hospitalized, and
 - Report in-hospital suicides in a specific, comparable format statewide and/or nationwide, for public, professional, and facility dissemination.

Advocates should be cautious about prescribing very specific assessment and management behaviors, since regulation often stifles important creativity; nevertheless, several problems keep coming up in sentinel reports, clinical and peer reviews, and malpractice litigation:

- **Inadequate monitoring & protection of new patients with moderate or high suicide risk, or with unknown risk.** Since it is clear that "every 15 minutes" monitoring 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).
- **Relying on inadequate outpatient monitoring after, or in lieu of, hospitalization** (for example, but not limited to, inappropriately relying on family members).
- **Inadequate transition to outpatient care.** Previously suicidal patients should be seen by well-qualified outpatient clinicians very soon, and the transition to outpatient care begun smoothly, usually while the patient is still in the hospital.
- **Provider organizations, facilities, and payers discouraging clinicians from meeting the standard of care when suicide risk is suspected** (e.g., discouraging hospital admission, proper monitoring, or later discharge, often citing cost or insufficient staff).

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Clinicians, hospitals, and health care systems must remember their public promise to be knowledgeable and safe resources for high-risk patients. Continuing, preventable tragedies raise serious questions about whether or not that promise is being kept.