New JCAHO Safety Goal: Identify Suicide Risks

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TUCSON, ARIZ. — As of this month, the Joint Commission on Accreditation of Healthcare Organizations has made the identification of patients who are at risk for suicide one of its patient safety goals for behavioral health care.

Yet little is known about hospital-based suicide and how to prevent it, according to speakers at a workshop on inpatient suicide at the annual meeting of the Academy of Psychosomatic Medicine.

"So far, there is no guidance whatsoever on how to do that, who should do that, what instruments you should use, and how frequently you should assess people," Dr. Donald L. Rosenstein said of the new patient safety goal.

Despite its being rare, inpatient suicide is the most common sentinel event reported to JCAHO, according to Dr. Rosenstein, clinical director of the National Institute of Mental Health in Bethesda, Md. He said JCAHO is informed of about 50 inpatient suicides each year, most of them occurring on psychiatric units or within 72 hours of discharge.

The new JCAHO mandate applies to psychiatric hospitals and to patients who are being treated for emotional or behavioral disorders in general hospitals. Suicides also occur on medical and surgical wards—albeit less frequently—and speakers focused on all patients for whom consultation-liaison psychiatrists may be called to assess suicide risk.

Most standard risk assessments do not predict inpatient suicides, according to Dr. J. Michael Bostwick. These are often acute events brought on by anxiety, pain, and delirium, said Dr. Bostwick, a psychiatrist at the Mayo Medical School in Rochester, Minn. Accordingly, the reduction of these risk factors can be more important than psychiatric interventions when an inpatient is at risk.

"The key is, suicidality is not really the point. The agitation and anxiety [are]," he said.

Dr. Bostwick cited seminal work by Dr. Jan A. Fawcett, a psychiatrist at the University of New Mexico, Albuquerque, who found that many—but not all—inpatient suicides do not exhibit chronic risk factors, such as hopelessness, suicide ideation, and prior attempts. Suicidal inpatients are more likely to present with acute risk factors, such as psychic anxiety or panic; severe anhedonia; and recent alcohol abuse, according to research by Dr. Fawcett and his colleagues in the 1980s. More recently, Dr. Fawcett reported that 79% of inpatient suicides followed severe anxiety and agitation (J. Clin. Psychiatry. 2003;64:14-9).

Although a medical illness, such as cancer, is a risk factor for suicide, Dr. Bostwick said it is not a useful predictor because most seriously ill patients are not suicidal.

Several reports cited by Dr. Bostwick found that older male patients are more likely to commit suicide. In a Finnish study that compared 26 general hospital suicides to 1,397 suicides outside of hospitals, the hospital patients were significantly older (mean age 58.7 vs. 44.3 years); they were also more likely to use a violent method (96% vs. 62%) or to jump (35% vs. 2%), to have a major depression (62% vs. 30%), and to be delirious (12% vs. 1%).

Conversely, the hospital patients who committed suicide were significantly less likely to depend on alcohol (12% vs. 33%), to have an Axis II disorder (8% vs. 31%), or to present with a borderline personality disorder (0% vs. 14%) (Gen. Hosp. Psychiatry 2002;24:412-6).

"Jumping is a big deal," Dr. Bostwick said. Although many hospitals have been redesigned to eliminate opportunities for suicidal patients to jump from high places or throw themselves down stairs, he said, such events still happen.

Dr. Bostwick concluded with an unpublished review of 25 cases evaluated as suicide risks at the Mayo Clinic. The patients came from a wide range of medical and surgical units. Of these, 12 had simply said the "S word" (suicide); 5 had been drunk, 4 had engaged in self-injurious behavior, 2 were delirious, and 2 were end-of-life patients.

Consultation-liaison psychiatrists must recognize the limits of their own ability both to predict suicide and to protect patients who are suicidal, said Dr. James L. Levenson. Among the factors he cited for consideration were countertransference by psychiatrists and nonpsychiatric staff; the complexity of depression and decision making; and the legal and medical implications when a patient with an advanced or terminal illness wants to stop treatment.

Assessment can be difficult even when patients are severely depressed, openly suicidal, and/or have already attempted suicide, advised Dr. Levenson, chairman of consultation-liaison psychiatry at Virginia Commonwealth University Medical Center, Richmond.

For example, one patient may be hospitalized after a near-lethal attempt that was not meant to be lethal, such as an unintended overdose of an over-the-counter painkiller. Another person in less serious condition might have expected an overdose of a prescription drug, such as Valium, to be deadly.

"It is important to look not just at what the person took, but what the person was thinking to do," Dr. Levenson said.

He recommended considering one-to-one care for suicidal patients and assessing environmental safety, which refers not only to exits and stairwells, but also to "all kinds of dangerous things coming in and out of the room." Before moving patients to psychiatric units, he said, psychiatrists should do their own "medical clearance" to be sure patients are medically stable.

Finally, he said that a suicidal patient who is being discharged should always be asked, "Do you have a gun at home?" ■

A Lexicon for Suicidality

Consultation-liaison psychiatrists need more than one word for suicidality, according to Dr. James L. Levenson, who offered a brief lexicon at the meeting.

Dr. Levenson defined the following terms in a talk on the varieties of suicidality that are encountered in the general hospital. All are difficult situations, he warned, "and they require judgment calls at the end of the day."

► **Occult suicidality.** (This is also referred to as the "shot-in-the-dark" patient.) Dr. Levenson described a 74-year-old, widowed, white man who was weak, losing weight, and suffering from nausea. The man was diagnosed with "failure to thrive." Nonmedical staff should be educated in how and when to ask patients about suicide, said Dr. Levenson.

► **Suicide in perpetuity.** The patient has made one attempt after another, and psychiatric hospitalizations did not help. The medical/surgical staff wants the patient transferred to the psychiatric service, but Dr. Levenson wonders whether that would make the patient worse.

► **"Boy who cried wolf."** Dr. Levenson told of a chronically ill woman who had threatened suicide for years, and then jumped off a roof while hospitalized for transverse myelitis. "Why was this threat different from all other threats?" he asked, warning against becoming inured.

► **Pseudosuicidality.** The patient who threatens suicide is about to be discharged and/or be cut off from opiates. Is the patient trying to manipulate hospital staff? Again, Dr. Levenson emphasized the need to document the reason for not taking a threat seriously.

► **Suicidality in the future conditional tense.** The patient "reserves the right to kill myself someday." Don't overreact, advised Dr. Levenson. "Explore what this means to the patient."

► **Suicidal figures of speech.** The patient says he feels like jumping out the window. He means it as a figure of speech, but family members and staff take him seriously. Dr. Levenson said to be sure to thank everyone for calling. Otherwise, nurses will think they wasted the psychiatric staff's time, and may not call the next time when a patient really means it.

► **Unintentional suicidality.** The patient is delirious and tries to jump out a window or poke himself with needles. "Delirious patients who are suicidal are impossible to predict. Nonpsychiatric personnel need to know the delirious patient is the one you need to be most concerned about," said Dr. Levenson.

► **Quasisuicidality.** The patient wishes to end dialysis. Does the patient want to die, or is his quality of life too poor? Recognize that this is not a simple decision to make, and that the assessment of the patient's capacity is not simple either.

► **De facto suicidality.** The patient is a nonstop drinker or an asthmatic who continues to smoke. Dr. Levenson said psychiatrists need to accept their limits when attempting to treat such patients, but also to guard against nihilism.

► **Medical Russian roulette.** The patient will not permit replacement of the battery in her pacemaker. Don't underreact or overreact, advised Dr. Levenson. "Explore what this means to the patient."