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SUICIDE PREVENTION IN THE HOSPITAL

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Suicide is an unhappy and distressing event. It implies failure for the victim in that there was no other way out, and for the survivors in that their help was not enough. It is a special problem when it occurs among hospital patients, in a location where help is available and specifically directed toward relief of the most common causes of suicide: physical illness and emotional problems. The family members are truly the survivors, but the hospital staff members are also survivors in that they have been recently involved in an intimate way with the patient, providing direct care for him. Suicide in the hospital therefore merits special study directed toward the development of programs for its prevention. A recent report from the Central Research Unit of the VA Center at Wadsworth describes the status of suicide in the VA hospital system from 1950 through 1972. Highlights from this report will serve as a background and a framework within which the problem of suicide prevention in the VA hospital system can be viewed.

The annual rate of suicide deaths for all VA hospitals from 1966 through 1972 averaged 161 per 100,000 patients. This is an increase of about 20% in comparison with the rate of 121 per 100,000 patients for the previous 10 years, 1956 through 1965. It is important to note that the average daily patient census decreased from about 110,000 (from 1956 through 1965) to 87,000 (from 1966 through 1972) – a decrease of about 21%. This decrease alone could account for the rise in the rate for all hospitals.

Vietnam veterans make up 9% of the hospital population, but contribute 20% to the suicide population, an overrepresentation of 11%. Peacetime veterans overcontribute by the greatest percentage (15%), making up 8% of the hospital population and 23% of the suicides. The largest number of suicides, 43%, are by World War II veterans. However, they make up only 54% of the hospital population, thus undercontributing by 11%.

In neuropsychiatric (NP) hospitals, the suicide rate from 1967 through 1972 averaged 254 per 100,000 patients. In the decade preceding, the average rate was 158 per 100,000 patients. Again, the average daily patient census decreased markedly, over 50%, from 1967 to 1972. This is in part attributable to patients' decreasing lengths of stay, for example, 22 days median length of stay in 1960 and 14 days in 1972. The highest suicide rate, 1,114, is found among the youngest age group, patients below age 35. The method most often used by patients in the hospital is hanging (55%); for patients outside the hospital, it is guns (42%). Diagnostically, schizophrenics contribute 67% of the suicides, but compose only 31% of the NP population, thus overcontributing by about 36%. The diagnostic category which contributes least is that of alcoholics, which is responsible for 5% of the suicides, although composing only 27% of the hospital population.

Among patients on the general medical and surgical (GM&S) wards, the suicide rates are 124 per 100,000 patients for the period 1970 through 1972, almost double the rate of 65 per 100,000 for 1963 through 1969. Whereas GM&S suicides were previously a phenomenon of older patients, they have become a middle-age event, with the age group 35 to 54 now containing about one-half of the GM&S suicides. Since 1971, however, the highest age-specific rates are in the below-35 age group (239 per 100,000 patients). In the hospital, the most frequent method used is jumping; off-station, it is guns. Diseases of the nervous system, sensory organs, and respiratory system overcontribute most among the diagnostic distributions, by about 15%. The diagnostic categories most underrepresented are diseases of the circulatory system and of the digestive system. Cancer, which used to overcontribute by the greatest percentage in previous years, now is overrepresented by only 4%; patients with these two diseases make up 14% of the suicide population and 10% of the hospital population.

Suicide in the United States in general has also undergone marked changes over the past decade. Most of the suicide rates in previous decades have shown a marked rise in older patients, with the highest rates occurring in white males aged 70 and above. Recently, however, the rates in the younger age group (29 and below) have increased, and the rates in the older age group have decreased. The curve has therefore almost flattened out, reaching a high spot at about age 30, and continuing at the same level through the older ages. Young black females have

shown the greatest proportional rise, although there has been a general increase in the rate for younger blacks of both sexes. Guns continue to be used most often by males, and pills are increasingly the method of choice for females.

To meet the problem of suicide prevention in the hospital, each individual hospital should establish its own Suicide Prevention Committee. The Committee can serve as a nucleus for preventive efforts by providing guidelines, recommendations, and resources for evaluation of new procedures. In general, the guidelines should deal with the facilitation of 1) identification of high-risk patients, 2) lines of communication about the patients, and 3) assessment, management, and follow-up for patients that are high suicidal risks.

Identification of High-Risk Patients

On admission, the patient's psychiatric workup should include a history of depressive states, suicidal states, and suicide attempts, as well as current manifestations of suicidal ideas, impulses, and behavior. After the patient's admission, all hospital staff should be alert to evidence of any indication of self-destructive impulses, whether direct, indirect, verbal, or nonverbal. Evidence should be documented and called to the attention of the patient's therapist at the earliest moment. At the patient's discharge, all evidence of suicidal ideas, impulses, or behavior should be reevaluated and communicated to the person to be responsible for the patient's continuing care after discharge. Records of outpatients posing a suicidal risk should be reviewed regularly to ensure the staff's alertness to the risk.

Communication Regarding High-Risk Patients

It is essential that all observations and actions taken in the management of high-risk patients be carefully documented in the medical records. In most instances, the Nursing Service is a major center for communication, and personnel can channel pertinent observations to the nurse in charge of the patient. The nurse can then notify the patient's therapist or the therapist's supervisor, if necessary. If any suicidal behavior has actually taken place, the circumstances should be reported to the Nursing Office and documented in full in the patient's file. Communication must be both horizontal and vertical. Information should be given to members within the same echelon and above and below in the hierarchy. Reports should also be channeled to the Suicide Prevention Committee, so that formal consultation can be initiated if, in the Committee's judgment, such action is appropriate.

Assessment and Management of High-Risk Patients

Responsibility for the decisions concerning high-risk patients lies with the physician in charge, who should make these decisions with the aid of the rest of the staff. If the physician is in doubt as to what action to take, special consultation should be obtained with senior staff members or members of the Suicide Prevention Committee. Orders written to implement management must be unambiguous. The term "suicidal observation" should never be used in a written order unless the specific procedures desired are made explicit in writing as well. Precautionary measures should not be discontinued without a physician's order. Special precautions must be taken if the patient is removed from the ward, for example, to an x-ray or EEG laboratory. The person accompanying the patient must be informed of the risk, and indicated precautions taken. Precautionary measures should indicate the locations to which a patient is restricted, what objects are removed, who has special responsibilities to observe or accompany the patient, and why the procedure is ordered. It should be clear in the medical records that the risk of self-destructive behavior is recognized, that reasonable measures to minimize that risk have been ordered, and that those measures have been carried out.

In general, the philosophy of patient care in terms of suicide prevention should enable staff to: avoid an atmosphere of anxious preoccupation with suicide; accept the fact that human errors occur and honest mistakes in judgment are made; realize that one cannot eliminate all elements of risk; and be alert to suicidal risk in students and other staff members.

One kind of treatment program with suicidal patients, for some reason little pursued, is group therapy. It is understandable that a therapist would be reluctant to gather a group of suicidal people together for fear that they might support each other in suicidal acting-out; a related fear would be that the risk of such acting-out would be greater in patients in a group than in patients in individual care. Experience has shown the opposite to be true. Group therapy programs can and should be varied to fit the needs of the patients, depending upon the patients' suicidal status and their need for particular responses. In general, most suicidal persons support each other strongly when one of the group members runs into a stressful period and reacts with strong self-destructive impulses. Most of the members will offer both constructive advice and useful practical help. Therapy in such a situation cannot be reflective, and the therapist cannot be passive. What may be called for is active participation and direction by the therapist. In general, co-therapists are more desirable than a single group therapist because of the support that they can

obtain from each other, and because their presence allows the group members to respond to the feeling of family interest rather than individual concern. Some patients require directive, authoritative intervention. In such cases, the therapist's activity is designed to provide support, as well as to rally the support of other members. In other cases, the patients may be together because they have been suicidal but nevertheless are capable of insight-oriented therapy. In such instances, the therapists can afford to be less active and less directive, handling the group in the more traditional manner.

Hospitals are concerned with legal responsibility as well as medical treatment. It is helpful to review the liability of medical treatment facilities for patients' suicides. As precedents have developed over the years, the primary principle used has been foreseeability. Through the 1930's, courts seemed to expect rigid standards of care and held the hospital responsible when a previous history of suicidal behavior was known. In the 1940's, the courts adopted a concept of therapeutic goals that permitted looser supervision and more freedom for the patient. From the 1950's to the present, courts have not viewed patients' suicides in accordance with any one philosophy.

In general, the principle of foreseeability still appears to be the central issue in determining negligence. Conclusions that can be drawn from the most recent court decisions indicate that the level of patient behavior is not directly related to a necessary level of watchfulness. The amount of time that has passed since a patient's expression of suicidal feelings, impulses, or thoughts is also a factor. Hospital records must show greater improvement in the patient, in order for him to obtain more freedom. However, it must be clear from the records that supervision was lightened because of the patient's improved condition, and not for the hospital's expediency. The courts have also made it clear that the hospital has an inherent duty to maintain facilities and equipment so as not to create new hazards. The ratio of staff to patients is not a crucial factor in determining the question of negligence, and there does not seem to be any agreement in the courts on the amount of supervision required. The courts will accept an "honest error of judgment"; however, a legal dilemma still exists because of the hospitals' need to provide maximum opportunity for patients' therapeutic improvement while still offering patients adequate safeguards from the risk of suicide.