

The American Association of Suicidology (AAS) has prepared “Recommendations for Inpatient and Residential Patients Known to be at Elevated Risk for Suicide”. These recommendations were developed in an effort to enhance the provision of care in inpatient and residential facilities and in particular to promote, when possible, the incorporation of families as meaningful members of the treatment team. This effort was inspired in particular by Objective 7.8 of the National Strategy for Suicide Prevention;

Objective 7.8: By 2005, develop guidelines for providing education to family members and significant others of persons receiving care for treatment of mental health and substance use disorders with risk of suicide. Implement the guidelines in facilities (including general and mental hospitals, mental health clinics, and substance abuse treatment centers).

AAS has incorporated into these recommendations suggestions from a number of organizations invited to make public comment on earlier drafts. The AAS does not regard these recommendations as invariant standards of care but rather as evolving best practices. They are subject to change as additional research is published and new knowledge is gained.

AAS Recommendations for Inpatient and Residential Patients Known to be at Elevated Risk for Suicide

These recommendations are for consideration prior to pass, trial leave or discharge and are appropriate for inpatient psychiatric units in general hospitals, psychiatric hospitals, and residential treatment centers.

These recommendations are not comprehensive treatment guidelines regarding suicidal persons and are not a substitute for the clinical decisions that arise from the treatment relationship. Research to support these recommendations is not conclusive. However, based on the literature that does exist, and in the collective clinical experience of the authors and the American Association of Suicidology, these recommendations represent current best practices. They are subject to change as additional research is published and new knowledge gained. For a review of the evidence, and for more comprehensive recommendations, the reader is invited to consult the American Psychiatric Association’s *Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behavior* (American Psychiatric Association, 2003).

Background:

Trial leaves, passes and discharges are transitions that necessarily result in a reduction in the level of monitoring of patients known to be at elevated risk for suicidal behaviors. Frequently, some or many clinical or environmental risk factors remain to at least some degree. Vulnerability to suicide may persist, and may be exacerbated while the individual is on pass or leave, or after discharge from an inpatient or residential setting. While the use of trial leaves and passes have declined significantly because of changes in the system of financing for inpatient care, they still warrant selective use but with an understanding that they require a careful balancing of risks and benefits. For patients at significant risk of suicide, risk may also be exacerbated during the period following discharge from an inpatient setting. That risk is most elevated in the month following discharge with about half of all post discharge suicides occurring in the week following discharge (Appleby et al., 1999; Ho, 2003). It is also clear that patients do not always accurately self-report suicidal ideation to mental

health professionals, increasing the importance of communication and coordination between families and the treatment team (Busch et al., 2003). To minimize suicide risk during these periods of transition, the American Association of Suicidology issues the following recommendations.

Recommendations:

- 1) Treatment providers should reevaluate suicide risk prior to approving a pass or discharge.
- 2) The decision to grant a pass or discharge should include a risk-benefit analysis to support the clinical decision. This decision should be based, at minimum, on a consideration of the following: response to treatment, external support(s), current mental status, presence of current suicidal ideation, availability of means to suicide (including firearms), patient's adherence to treatment, and history of impulsivity and of past suicide attempts. The assessment should also include a review of the crisis that precipitated the admission, and whether or not the precipitating crisis has abated or been resolved, and whether or not any new potential precipitants have arisen during hospitalization. The crisis precipitating admission may have been resolved but profound distress may be arising for additional reasons.
- 3) The simple denial of suicidal ideation is insufficient evidence to determine an absence of suicide risk. One recent study of 76 suicides that occurred during inpatient hospitalization or immediately after discharge reported that 78% of the patients had denied suicidal ideation when last assessed (Busch et al., 2003).
- 4) Reliance on so-called "no-suicide" contracts should not be considered, by itself, to be a sufficient intervention upon which to make a pass or discharge recommendation. According to the Minnesota Office of the Ombudsman (2002), such contracts were in place for almost every suicide that occurred in an inpatient, acute care facility. Other studies have also found that significant number of those who made suicide attempts or died by suicide had such contracts in place at the time of their suicidal act (APA, 2003).
- 5) The availability of the family and other sources of support should be assessed, as well as their willingness and ability to provide such support.
- 6) A family session should routinely be recommended.
- 7) Both the patient and the family or significant others should be given instruction regarding suicide and its associated risk, including, but not limited to the following: warning signs of suicide, the increased risk for suicide during pass or following discharge; the need for medication and other treatment adherence; explanation of how psychiatric symptoms may impair judgment; explanation of the need for the patient to avoid use of intoxicants and how intoxicants increase risk; the need for the removal of the means for suicide, and the particular risk associated with firearms.
- 8) The patient and family or significant others should be given explicit instructions on how to access the treating physician or therapist regarding questions, observations or concerns, and should be given information regarding how to access treating clinicians after office hours and any limitations on their availability. Emergency phone numbers that are available 24 hours a day, 7 days a week, such as psychiatric emergency services, and crisis lines should also be given.
- 9) If family members or significant others are asked to assist in the outpatient monitoring of risk, specific instructions should be given, including action steps to be taken in the event of felt concern or the development of a crisis. Consideration should be given to providing these in writing, as oral instructions

may be difficult to recall accurately in the midst of a crisis.

- 10) Where permitted by law, and with the patient's written permission, the patient's family members or significant others should be alerted to the patient's history of suicidal thinking, feeling, behavior, and non-fatal suicide attempts.
- 11) Every effort should be made to assure that the clinicians with responsibility for treating the patient following discharge receive a copy of the patient's discharge summary.
- 12) The patient should have an outpatient follow up appointment scheduled before discharge.
- 13) Prescription of psychiatric medications at pass and discharge transitions should be undertaken with consideration of the potential for overdose.
- 14) All clinical and residential staff should have training in the assessment and management of suicidal risk, and the identification and promotion of protective factors.

The American Association of Suicidology does not regard the previous recommendations as invariant standards of care, but rather as evolving best practices. They may not be feasible for every patient in every setting.

References

- American Psychiatric Association, *Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behavior*, 2003.
- Appleby, L., Shaw, J., Amos, T., McDonnell, R., Harris, C., McCann, K., et al. (1999). Suicide within 12 months of contact with mental health services: national clinical survey. *British Medical Journal*, 318, 1235-1239.
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- Ho, T.P. (2003) The suicide risk of discharged psychiatric patients. *Journal of Clinical Psychiatry*, 64 (6), 702-707.
- Office of the Ombudsman for Mental Health and Mental Retardation, State of Minnesota, *Suicide Prevention Alert*, February, 2002.