

Suicide Risk Management in Inpatient Psychiatric Settings

Jesse Jahrig, BA (Hon)

Background

The US Joint Commission on Accreditation of Healthcare Organizations [Joint Commission] (2010) reports that in settings with round-the-clock care (e.g., a hospital), suicide is consistently among the five most common sentinel events¹ reported. Managing suicide risk among inpatients in a psychiatric setting is a difficult yet important challenge to address. The loss of life and pain suffered by family, friends, and health professionals makes preventing inpatient suicide a priority. While there is no panacea that guarantees the prevention of suicide, a comprehensive approach can reduce the risk. Key elements of this approach should properly address environmental safeguards, suicide risk assessment, observation, training, and auditing.

Objectives

The purpose is to summarize key findings from a brief literature review that was produced to inform policies and procedures aimed at reducing the risk of suicide in the inpatient psychiatric setting.

Method

A search of the relevant literature was conducted using the electronic databases: Academic Search Premier, Medline, PsycInfo and the Cochrane Library from January, 2006 to April, 2010. The search terms used were: suicide, suicide risk assessment, inpatient, policy, practice, protocol, treatment, model, training, best practice, and suicide potential. Additional articles were retrieved by exploring the relevant references in the selected articles. Articles were reviewed for information on policies, procedures, and practices used in the inpatient setting to manage suicide risk. The resulting literature that was selected varied in topic, focus, and robustness.

Efforts were made to focus on the most robust studies; however, due to a paucity of literature in some areas this was not always possible. While articles were evaluated in terms of language, relevancy, robustness of findings, they were not systematically reviewed (e.g., methodological criteria were not set for the selection of studies). Moreover, the search of the literature was not exhaustive due to time constraints.

¹ The Joint Commission defines a sentinel event as “an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase ‘or the risk thereof’ includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.” A few examples of sentinel events include medication errors or operative/post-operative errors.

Results

Environmental Safeguards

Creating a safe environment or “suicide proofing” is perhaps the most effective measure that can be undertaken to improve inpatient safety. Several research studies describe the methods inpatients employ to perform a suicide or suicide attempt. Hanging and jumping from windows are the most common methods in the inpatient setting (Joint Commission, as cited in Tishler & Reiss, 2009; Yeager et al., 2005; Wint & Akil, as cited in Tishler & Reiss, 2009; Bostwick, & Rackley, as cited in Tishler & Reiss, 2009; Tishler & Reiss, 2009).

Ensuring a safe environment requires thorough and regular examination of the inpatient setting for safety hazards. This includes removing anchor points that can support a person, using breakaway items (e.g., breakaway shower rods), having unbreakable windows to prevent jumping, and removing ligatures to prevent hanging, strangulation and suffocation (Yeager et al., 2005; Cardell, Bratcher & Quinnett, 2009; Lieberman, Resnik & Holder-Perkins, 2004; Tishler & Reiss, 2009; Mills et al., as cited in Mills et al., 2010). There are guidelines that can be used by health professionals to help ensure a safe environment such as the Mental Health Environment of Care Checklist (U.S. Department of Veteran Affairs, 2009).

Suicide Risk Assessment

Suicide risk assessments are an important part of a comprehensive suicide prevention strategy (American Psychiatric Association, as cited in Lynch, Howard, Mallakh & Mathews, 2008) but there are many uncertainties regarding the predictive value of assessments. Suicide risk assessments are challenged by a lack of effective and reliable methods and instruments. They are further complicated if patients are reluctant to reveal information about their suicide intent and behaviour (Busch, Fawcett & Jacobs, as cited in Lynch et al., 2008; Simon, as cited in Simon 2008; Isometa, as cited in Simon 2008; Fawcett, as cited in Simon 2008). Therefore, suicide risk assessments are recommended as an aid to a health professional who must ultimately judge the suicide risk based on information and clinical expertise (APA, as cited in Lynch et al., 2008).

A suicide risk assessment can be composed of several components and it is important to consider each of these when conducting an assessment. These components include:

- *Assessment of risk factors* may be useful but there is an array of risk factors that vary in predictive value (Combs & Romm, 2007; Tishler & Reiss, 2009; Lieberman et al., 2004).
- *Suicide risk assessment instruments* can vary in type and in predictive value (Combs & Romme., 2007; Lynch et al., 2009; Malone, Szanto, Corbitt & Mann, as cited in Yeager et al., 2005; Jacobs, as cited in Sullivan, Barron, Bezman, Rivera & Zapata-Vega, 2005; Sullivan et al., 2005). Despite inconsistencies, these instruments are valuable because they provide a systematic method for staff to use when assessing suicide (Yeager et al., 2005).

- In addition to an initial assessment, assessments should be conducted at various stages throughout inpatient care (Tishler & Reiss, 2009; Joint Commission, as cited in Tishler & Reiss 2009; Lynch et al., 2008).
- *Proper documentation of assessments and standardized language* can improve staffs' ability to understand and care for suicidal inpatients (Sun, Long, Boore & Tsao, 2005 as cited in Lynch et al., 2008).
- *Developing a therapeutic relationship* with patients can aid caregivers in terms of management and identification of suicidal behaviour (Lynch et al., 2008).

Observation

Observation involves vigilant monitoring of inpatient behaviour and actions that could be considered suicidal. Even under constant supervision, inpatient suicide can occur (Martin, as cited in Janofsky, 2009; Gournay & Bowers, as cited in Janofsky, 2009; Busch, Fawcett & Jacobs, as cited in Janofsky, 2009; Dong, Ho & Kan, as cited in Janofsky, 2009; Meehan et al., as cited in Janofsky, 2009). When practices are followed, observation can be an effective technique and a key element of a suicide prevention strategy (Janofsky, 2009). Using standardized terminology for communicating observation orders (e.g., intermittent observation, differing levels of constant observation) is recommended (Janofsky, 2009). Additionally, designing a process for staff to follow when observing (e.g., an observation workflow) can minimize potential for miscommunication and help ensure observation practices are followed (Janofsky, 2009). Lastly, and importantly, providing adequate staff resources allows observers to focus on the task at hand and not be distracted with other duties (Janofsky, 2009).

Training & Auditing

Training and auditing are essential when introducing new policies, procedures and practices. Inadequate training and orientation have been identified as factors contributing to inpatient suicide (Joint Commission, as cited in Lynch et al., 2009; Joint Commission, as cited in Cardell et al., 2009). It is important that leadership ensure commitment to training, create an atmosphere that promotes education, and regularly audit procedures and practices to ensure policy adherence (Cardell et al., 2009; McAuliffe & Perry 2007; Tishler & Reiss, 2009). It is suggested that training and auditing accompany new policies such as those related to environmental safety, suicide assessments and observation (Joint Commission, as cited in Cardell et al., 2009; National Health Service, 2009). Also, training and auditing should be ongoing as required (National Health Service, 2009).

Conclusions

The reviewed literature identifies several core elements of a suicide management strategy. When developing a strategy, the strengths and weaknesses of these elements (environmental safeguards, suicide risk assessments, and observation) should be considered carefully. In order to ensure these are understood and adhered to, it is essential that they are accompanied by training and auditing.

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