

Preventing Inpatient Suicide

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The goal of preventing actual suicide was never achieved by the traditional suicide prevention programs (typified by “hotlines”), in spite of decades of national support from the National Institute of Mental Health (NIMH). By their very design, these programs dealt primarily with people experiencing suicidal thoughts. But we now know that a great majority of completed suicides occur in the context of a major psychiatric disorder, whereas suicide ideation and even suicide attempts are, on the whole, nonspecific with respect to diagnosis. Thus, the focus of suicide prevention began to shift toward an emphasis on the diagnosis and treatment of the underlying disorders, principally major depression and bipolar illness.

But efforts to demonstrate reduced suicide among patients on antidepressant treatment have produced inconsistent results at best. It was not until Jan Fawcett and colleagues published the landmark NIMH prospective study of actual suicides¹—the first of its kind—that psychiatry finally had valid predictors that were free of retrospective recall bias. And there were surprises. Neither of the classical predictors—suicide ideation or even prior attempt—was associated with “acute” risk of suicide (that is, within the first year).

Obviously, for a risk factor to be useful clinically, it should be able to affect how we manage an individual patient. That is, it should shed some light on the relatively imminent risk of suicide, and it should be amenable to treatment. On the other hand, even a relatively robust chronic risk factor, such as being male, does not help. One can hardly maintain a high level of suicide precautions over years simply because a male patient has other chronic risk factors such as prior attempt, suicidal thoughts, or even helplessness.

But the good news is that Fawcett and colleagues, in the NIMH collaborative study, did uncover robust acute predictors of suicide, namely, severe anxiety and panic, global insomnia, severe anhedonia, and recent alcohol abuse. It was not clear, though, just how useful these predictors of events within a year would turn out to be in situations in which one needs to assess the here and now, such as deciding when to discharge a potentially suicidal patient from the hospital.

Now we have even more good news. With their new study,² Fawcett and colleagues have gone a long way toward narrowing that 1-year window by providing near-term predictors that should prove to be both practical and effective; that is, properly applied, they should save lives. I fully expect the findings of this article to change clinical practice, especially given the fact that suicide is the number one reason that psychiatrists are sued.

What the authors have come up with are clear warning signs for the inpatient management of at-risk patients—not only what predicts their risk, but what misleads. Especially misleading is the absence of suicidal ideation. Indeed, acknowledged suicidal thoughts were more common in those who did *not* kill themselves. One is almost tempted to say that it might be a little reassuring when the patient is willing to acknowledge suicidal thoughts! Certainly it is quite unlikely that a patient who has decided to do it is going to confess and let the clinician thwart his or

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her plans. Even prior attempts can be quite misleading—in fully half of the suicides, the first attempt was the last.

What about preventive interventions? Again, some rather shocking surprises here. A time-honored routine inpatient procedure—15-minute checks—fell tragically short; half of those who committed suicide did it while under this heightened surveillance. No-harm contracts were not much better.

But again, good news. What this study tells us is that the aggressive pharmacologic management of anxiety, panic, and insomnia should work. One can hardly overestimate the importance of restating this. Why do I say that? Because something else that the authors uncovered was

that effective anxiolytic medications were used sparingly, if at all.

In summary, this study moves the field of psychiatry to a new level in what should be expected of suicide risk assessment. It will have wide impact, not only among clinicians, but also among lawyers.

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