VIEWPOINT

Focusing Suicide Prevention on Periods of High Risk

Mark Olfson, MD, MPH
Department of Psychiatry, College of Physicians and Surgeons, Columbia University and New York State Psychiatric Institute, New York.

Steven C. Marcus, PhD
Center for Health Equity Research and Promotion, Philadelphia Veterans Affairs Medical Center, Philadelphia, Pennsylvania, and School of Social Policy and Practice, University of Pennsylvania, Philadelphia.

Jeffrey A. Bridge, PhD
The Research Institute at Nationwide Children's Hospital, Center for Innovation in Pediatric Practice, Columbus, Ohio, and The Ohio State University, Columbus.

Corresponding Author: Mark Olfson, MD, MPH, Department of Psychiatry, College of Physicians and Surgeons, Columbia University, New York State Psychiatric Institute, 1051 Riverside Dr, New York, NY 10032 (mo49@columbia.edu).

Although antismoking campaigns, cancer screening programs, and AIDS prevention initiatives can point to lives saved to measure their success, the overall annual suicide rate in the United States from 2000 through 2010 has increased from 10.4 per 100 000 persons to 12.1 per 100 000 persons, resulting in approximately 38 000 deaths.[1] Progress in the prevention of suicide has been limited by the large number, high prevalence, and wide distribution of suicide risk factors and the inherent challenges associated with financing and mounting large-scale, coordinated suicide prevention programs. Whether efforts focus on societal targets (such as limiting access to lethal methods) or aim at clinical targets (such as improving the community detection and treatment of mood, anxiety, or substance use disorders), achieving a reduction in the rate of suicide has proven to be an elusive public health goal.

Insights from the epidemiology of suicide can provide clues to promising suicide prevention strategies. For example, the period immediately following discharge from a psychiatric hospital poses an extraordinarily high risk of suicide. In a nested case-control study from Denmark, based on data from 1981 to 1997, the risk of suicide was significantly increased during the first week following psychiatric hospital discharge, although these risks sharply decline over the following weeks and months.[2] Roughly one-third (39%) of all suicides in the first year following hospital discharge have been found to occur in the first 28 days.[3] From a societal perspective, approximately one-quarter (24%) of all suicides occur among patients who are within 3 months of discharge from a psychiatric hospital.[4] This concentration of suicide risk should motivate research on developing and evaluating clinical interventions, programs, and policies that protect patients from suicide during the period immediately following psychiatric hospital discharge. In support of this strategy, an observational study from the United Kingdom reported that implementation of a 7-day follow-up after psychiatric hospital discharge was associated with a significant decline in suicide rates from 24.8 to 19.5 per 100 000 persons annually during the 3-month period following hospital discharge.[5]

In US community practice, there is room for improvement in patient transitions from inpatient to outpatient psychiatric care. Nationally, only about half of psychiatric inpatients receive any outpatient mental health care during the first week following hospital discharge and only about two-thirds receive mental health care during the first month.[6] A focus on improving linkages from inpatient to outpatient psychiatric care could lower suicide risk during this critical period. Yet much remains to be learned concerning which clinical interventions protect these high-risk patients. It is not known, for example, the extent to which clinicians should focus on traditional social work functions (such as case management and outreach) or more specific self-harm reduction strategies (such as motivational interviewing or individualized safety plans). In a variety of contexts, effective approaches to suicide risk reduction involve strengthening patient connectedness and reducing social isolation through engaging outpatient mental health professionals, community organizations, and supportive family members. These lessons may help guide the search for successful care management approaches during the high-risk period immediately following psychiatric hospital discharge.

Adults and adolescents who present for emergency care following a deliberate self-harm event represent a second key patient group at extraordinarily high short-term risk of suicide. An estimated 0.9% of these patients will die by suicide within 3 months of the self-harm event,[7] and approximately 15% of all people who die by suicide have had an emergency department visit for deliberate self-harm in the preceding year. Yet despite their high risk, deliberate self-harm patients are often discharged from emergency departments without mental health evaluations. In a recent analysis of 10 580 patients with deliberate self-harm who made emergency department visits, 62.7% of Medicaid-insured and 46.9% of privately insured patients who were diagnosed with deliberate self-harm were discharged directly to the community. Approximately 52.2% of the discharged Medicaid patients and 42.7% of the discharged patients with private insurance did not receive a mental health assessment in the emergency department.[8] For these patients, there is a risk that their treatment will be narrowly focused on their presenting medical injury without carefully considering the social triggers of their self-injurious behavior and the underlying psychological factors that may pose an enduring risk of suicide.

A weakness in the emergency management of high-risk patients involves the shortage of mental health specialists in general hospital emergency departments. Although most emergency departments of teaching hospitals have psychiatrists or other mental health professionals available on-site or on call, only a minority of emergency departments in nonteaching hospitals have access to any mental health specialists. As a result, potentially large numbers of patients who present to emergency departments following deliberate self-harm events may receive their emergency care entirely from emergency physicians and other health care professionals who are not mental health specialists.

In view of shortages of mental health specialists in emergency medical settings, enhanced training of emergency physicians in the management of suicidal patients and patients with deliberate self-harm may be

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helpful. A recent survey of physicians working in emergency departments (n = 325) revealed that only around one-quarter felt confident in their ability to create personalized safety plans for patients who were suicidal, and only about half indicated that they knew how to find these patients appropriate specialized care.[9] Providing specific training for emergency physicians in the evaluation and management of patients who are suicidal and increasing patient access to mental health care represent potential opportunities to improve short-term patient safety. The 30-day risk of repeated deliberate self-harm is significantly lower among deliberate self-harm patients who are discharged from emergency departments with a mental disorder diagnosis (7.8%) than among corresponding patients who are discharged without such a diagnosis (11.4%).[10]

Implementation of advances in clinical medicine into routine practice is often a slow process. The current era of health care reform, however, offers opportunities to accelerate cycles of improvement in quality of care. The consolidation of health care delivery into larger organizational entities, the proliferation of contractual mechanisms that embed quality-of-care metrics, growth of specialized care management protocols, increased use of medical informatics, and experimentation with performance-based financial incentives offer new, although largely unproven, levers that may speed improvements in the quality of care. Within the delivery of mental health care, policy makers should give priority to the promotion of continuity of mental health care in settings that serve patients at high risk of suicide.

It would be unreasonable to expect that addressing critical weak links in the broader mental health care system will replace the need for suicide-specific interventions (such as hotlines, screening programs, crisis counseling services, and public education campaigns). Suicide has proven to be a stubbornly difficult health problem, and sustained progress toward reducing suicide rates in the United States will likely require development of a range of complementary suicide prevention strategies. Within this set, concerted efforts should be made to improve the quality of mental health services that are available for patients who are at high short-term risk of suicide. Similar "critical time intervention" approaches have been applied to the prevention of recurrent homelessness and reduction of hospital readmission. There is good reason to believe that extending these principles to suicide prevention could help to promote lifesaving care.

ARTICLE INFORMATION

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