# Office of the Ombudsman for Mental Health and Mental Retardation

# Suicide Prevention Alert

This Medical Alert is based on the work of the Medical Review Subcommittee and should be posted prominently. The Office of the Ombudsman for Mental Health and Mental Retardation works to improve the services provided to people with disabilities by communicating important information found in the Medical Review Subcommittee's reviews of deaths and serious injuries. Thank you for promptly reporting deaths and serious injuries. You are helping us to meet our mission.

The Surgeon General of the United States and many public health organizations have called suicide a serious public health problem. Most people are shocked to learn that, in the United States, more people die from suicide than homicide - 1.7 times more in 1998. In Minnesota, according to the Minnesota Department of Health, "Approximately three times the number of Minnesotans die from suicide than from homicide (approximately 500 deaths per year)."

This Medical Alert is not intended to be a comprehensive review of suicide prevention initiatives. Instead it is designed to share information learned during the death review function of the Medical Review subcommittee and to alert facilities, agencies, and health care providers to the unique vulnerability and increased suicide risk of the clients of the Office of the Ombudsman for Mental Health and Mental Retardation.



## Overview

Suicidal behavior typically occurs in the presence of mental or substance abuse disorders – treatable illnesses. Several studies have found that more than 90% of suicide completers had a major psychiatric illness and that half were clinically depressed at the time of the act. A recent study found drug abuse in 45% and alcoholism in 54% of suicide completers. Clients with schizophrenia have an annual suicide rate between five to 50 times higher than that of the general population.

The strongest risk factor for suicide is being a psychiatric patient, especially with a diagnosis of depression, alcoholism, or schizophrenia. *Regardless of diagnosis, the greatest risk is during the hospital admission and in the first week following discharge.* Other risk factors include male gender, being an older male, having a personal or family history of suicide attempt, recent interpersonal loss, feelings of hopelessness and low self-esteem, alcohol and other chemical use and abuse, social adjustment problems, serious medical illness, family history of suicide completion, divorce, separation, unemployment, and poverty.

In the United States, guns are used in about 57% of all suicides. Studies have found that the risk of suicide is almost five times higher for people who live in a household where at least one gun is kept. After suicides by guns, the second most common method of suicide among men is hanging. Among women the second most common method is poisoning (drug overdose). Alcohol intoxication is associated with at least 25-50% of all suicides.

Of the 64 completed suicides reported to the Office of the Ombudsman for Mental Health and Mental Retardation in a recent 33-month period, all of the clients had at least one psychiatric diagnosis. Twenty-seven percent of the clients hanged themselves, 19% overdosed on medications, and 12% shot themselves. The remaining clients used a variety of methods (self-asphyxia with plastic bag, stabbing/cutting, carbon monoxide poisoning, jumping from a height, stepping in front of train, and drowning). Thirty percent of the suicides occurred in a facility or treatment program (hospital, crisis center, Rule 36, jail, nursing home, foster care home, etc.) and 15% occurred while the client was on pass from a facility or program. The rest of the clients were living independently and receiving case management and other services.

Fifty-six suicide attempts were reported as Serious Injuries to the Office of the Ombudsman for Mental Health and Mental Retardation over the same time period. Fifty-two percent of the attempts were medication overdoses, and 23% were attempts to hang or strangle oneself. Eighty-two percent of the attempts occurred in a facility or treatment program as defined above.

In 1998, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) issued a "Sentinel Event Alert - Inpatient Suicides: Recommendations for Prevention." Their review of 65 inpatient suicides found that 61 occurred in a psychiatric or general hospital. Of the 27 that occurred in a general hospital, 14 occurred in a psychiatric unit, 12 in medical/surgical units, and one in the emergency room. In 75% of the cases, the method of suicide was a hanging in a bathroom, bedroom, or closet. Twenty percent of the suicides resulted from patients jumping from a roof or window.

After each completed suicide, each facility conducted a Root Cause Analysis, a quality assurance procedure, which identified opportunities for facilities to reduce the risk of future, similar suicides. (Many of these are listed below with other "Recommendations for Facilities.")

While the JCAHO's "Sentinel Event Alert" was prompted by deaths that occurred in hospitals and residential facilities, many of the factors identified are found in other settings and systems of care. One method of suicide not addressed in the JCAHO's "Sentinel Event Alert" but that was used in five suicides (two of them in facilities) reported to the Office of the Ombudsman was suffocation (self-asphyxia) in which the client placed or tied a plastic bag around his or her head. After reviewing the inpatient suicides, the Minnesota facilities responded by providing inpatient clients with plastic garbage cans without plastic (bag) liners.

## It is Possible to Prevent Suicide.

In 1995, the United States Air Force implemented a comprehensive, community wide suicide prevention strategy. Their program emphasized early interventions and strengthening protective factors (a sense of belonging and caring, effective coping skills, and policies that promoted help-seeking behavior). Estimates after the first eight months of 1999 were that the program had reduced the suicide rate from 16.4 per 100,000 members to 2.2 suicides per 100,000 members.

For comparison in 1999 in the United States, the overall suicide rate was 10.7 suicides per 100,000 people, the 11th leading cause of death.

There is still much to be learned about suicide prevention including effective screening, prediction of suicide risk, and effective interventions. While it may not be possible to prevent every suicide, it is possible to prevent many suicides. The Office of the Ombudsman offers the following recommendations from the JCAHO and suicide prevention literature.



## Recommendations for Facilities

- Institute practice guidelines and procedures that work to assure that people with conditions that contribute to the risk of suicide receive appropriate treatment in the appropriate location.

- Review/revise suicide risk assessment/reassessment procedures. For clients in facilities or programs, special attention should be paid to approaching discharges and passes. Be aware that times of vulnerability also include times when medication changes are taking place.

- Understand that suicide can occur at any time when a client is depressed. The suicidal urge can become stronger and weaker during the course of treatment for depression, not only when the client begins to recover and have more energy.

- Incorporate into polices and procedures the education of families and friends about the risk and prevention of suicide.

- Provide education about suicide risk and prevention to the client, client's family, friends, and significant other before the client takes passes and is discharged.

- Assure adequate staffing.

- Review/revise policies and procedures for client observation. "For patients with high suicide risk, make sure there is adequate around-the-clock observation," John Oldham, MD.

- Monitor consistency of the implementation of observation procedures.

- Enhance staff orientation/education regarding suicide risk factors.

- Identify and remove or replace non-breakaway hardware.

- Weight test all breakaway hardware, so that it works as designed for the lightest weight client.

- Avoid reliance on "no harm contracts" with patients. Having a "contract" or "pact" with the client, who promises not to act on suicidal impulses, is no substitute for staff observation and assessment. *In the experience of this Office, a "no harm contract" was in place in almost every completed suicide that occurred in an inpatient acute care facility.*

- Develop aftercare programs/planning that include: telephone contact, transportation arrangements to ensure that clients come to appointments, appropriate and safe housing arrangements, resources to guarantee purchasing of medications, and on-going client/family support and education.

- For outpatients, write frequent prescriptions for small numbers of pills and **consider using newer antidepressants that have a lower risk of death by overdose**. *Of the suicides by overdose reported to the Office, most of the clients had taken an overdose of their tricyclic antidepressant (i.e. Elavil/amitriptyline, Sinequan/doxepin, or Tofranil/imipramine) often combined with alcohol.*

## Recommendations for Client/Family Education Prior to Discharge or Pass

- Make sure the client is returning to a safe environment where access to lethal methods of suicide (guns, medicine, and poison) is eliminated or reduced. Many suicides are impulsive, so if one removes easy access to a method, a suicide may be prevented.

    - Remove all firearms from the client's place of residence. If the client/family is unwilling to remove them, then secure firearms by keeping **unloaded** guns and ammunition in separate, locked cabinets. Securing or removing guns, at least for the period of time the client is in the home, is a minimal safety precaution. *Use common sense: Do not send a client home on pass alone to remove guns from the home.*
    - Remove or place in a locked cabinet all unneeded medicines or household poisons.
    - Request that the physician, whenever possible, only prescribe medicine in small, non-lethal quantities.
    - *Use common sense. If the client thinks about suicide by jumping off a balcony, then the client shouldn't live in an upper floor apartment with a balcony.*

- Take all suicide threats seriously. Be sure that the client and family know what to do if they are concerned about a risk of suicide. Have in place an individualized crisis plan with the local Crisis Line phone number. Inform clients and families of the National Hope Line Network: 1-800-SUICIDE (1-800-784-2433. Toll-free in the US, 24 hours per day, 7 days per week).

- Teach clients and family about the increased risk of suicide in the weeks following a hospitalization, during times when medications are being adjusted, and during holidays. Be aware that suicide rates tend to peak during the spring and have a smaller secondary peak in the fall.

- Encourage continuing contact with providers. It does make a difference in prevention of suicide.

- Teach the client and family about the course of treatment: how long it will take to have effect, what side effects there might be, and when and who to call for help.

- Emphasize the need for support – provide information about community support opportunities, natural supports, and organizations.

- Do not be afraid to talk directly about suicide. It is a myth that talking about suicide will plant an idea that wasn't already there. People who are suicidal already have the idea.

- Tell the family and client that a suicidal person may not always appear particularly unhappy or upset. The risk of suicide may increase when people begin to recover from depression, when they have regained enough energy to take action to harm themselves.

- Know who or where to call for help. In Minnesota, the Suicide and Crisis Hotlines are a good place to start. More information is available at the following website: http://suicidehotlines.com/minnesota.html .

- Teach the symptoms of depression and the danger signs of suicide:

## The Symptoms of Depression Include:

- Persistent sad or empty mood.
- Feelings of hopelessness, helplessness, guilt, pessimism, or worthlessness.
- Substance abuse.
- Fatigue or loss of interest in ordinary activities, including sex.
- Disturbances in eating or sleeping patterns.
- Irritability, increased crying, anxiety and panic attacks.
- Difficulty concentrating, remembering, or making decisions.
- Thoughts of suicide, suicide attempts, or plans.
- Persistent physical symptoms or pains that do not respond to treatment such as headaches, stomach problems, neck/back pain, joint pain, or mouth pain.
- Help the client and family understand the client's individual symptoms of a relapse and teach the skills to manage them.

## The Danger Signs of Suicide Include:

- Talking or joking about suicide; making statements about being reunited with a deceased loved one; making statements like "It will all be better soon," or "You'll be better off without me."
- Statements about hopelessness, helplessness, worthlessness.
- Preoccupation with death.
- Suddenly happier or calmer.
- Unusual visiting or calling people one cares about – saying their good-byes.
- Giving away possessions.
- Making arrangements, setting one's affairs in order.
- Self-destructive behaviors like alcohol/drug abuse, self-cutting, promiscuity.
- Risk-taking behaviors like reckless driving/excessive speeding, carelessness around bridges, cliffs, or balconies, or walking in front of traffic.
- Having several "accidents" resulting in injury.
- Obsession with guns or knives; stockpiling pills or acquiring a weapon.



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# CASE STUDIES

## Could This Happen to one of your Clients?

### Case Study #1

A 37-year-old woman, with major depression and alcohol abuse, was committed to an RTC about 10 months before her death. She received a provisional discharge after 4 months, but her mental health quickly worsened, and she was re-hospitalized for an overdose of prescription and over-the-counter medications. Three months later she was provisionally discharged again to her own apartment. The client received weekly phone calls from her case manager and other community supports. She seemed to be doing well for 2 months. Then 3 weeks before her death, the case manager became concerned that the client was feeling more hopeless. The client then signed a "no harm contract" with the case manager. Four days later, the client went on a trip with her family. She went for a walk in the woods and didn't return. Despite an extensive search, her body was not found until 10 days later. She had bled to death after cutting her throat with a knife.

**Risk factors for suicide:** psychiatric diagnoses, recent expressions of hopelessness, history of alcohol abuse, recent hospitalizations.

### Case Study #2

A 30-year-old man, with bipolar disorder, had been hospitalized for four months after a serious suicide attempt during which he had cut his throat with a saw. He was considered high risk for suicide and assessed as impulsive. At the time of his death, he had lived at home and had been receiving case management and community mental health services with daily phone contact and weekly face-to-face contact. Before the onset of his illness, he had worked successfully and owned his own home. Records indicated the client was making steady progress but may have begun drinking over a holiday weekend. The client was found, sitting in his truck in his garage, dead from carbon monoxide poisoning. After the client's death, the client's father told his son's care providers that he had spoken to his son one week before his death. According to his father, the client had been upset about losing his health insurance and about his overall financial situation.

**Risk factors for suicide**: psychiatric diagnosis, recent and serious suicide attempt, male gender, impulsiveness, alcohol use, financial problems.



### Case Study #3

A 27-year-old woman, with bipolar disorder and mixed chemical dependence, hanged herself 6 months after being placed under a stay of commitment as mentally ill and chemically dependent. Two months after the stay of commitment was initiated, an attempt to revoke it was not supported by the county court even though the client had been found by police to be "wandering and confused" in winter in a neighboring community. At that time, the client was placed in a Rule 36 residential program. For the next few months she appeared to be doing better. She was taking her medications and staying sober. The day before her death, the client saw her doctor and reported depression. Medication changes were made and planned. The next night the police found her body hanging from a bridge in a public park.

**Risk factors for suicide:** psychiatric diagnosis with worsening depression, chemical dependence, recent medication change, stress of living with psychiatric illness, and stress associated with housing change.

## Resources and for Additional Information:

American Association of Suicidology
www.suicidology.org

American Foundation for Suicide Prevention
www.afsp.org

JCAHO, Recommendations for Prevention of Inpatient Suicides
www.jointcommission.org/SentinelEvents/SentinelEventAlert/sea7.html

Minnesota Department of Health
www.health.state.mn.us

Minnesota Suicide and Crisis Hotlines
http://suicidehotlines.com/minnesota.html

National Center for Injury Prevention and Control
www.cdc.gov

Suicide Awareness Voices of Education (in Minnesota)
www.save.org

Suicide Information and Education Centre (SIEC)
www.siec.ca

Suicide Prevention Advocacy Network (SPAN)
http://www.spanusa.org/

Surgeon General's National Strategy
www.mentalhealth.org/suicideprevention

Wisconsin Department of Health and Family Services "Clarification: Environmental Suicide Prevention"
www.dhfs.state.wi.us

World Health Organization
www.WHO.INT