Suicide among psychiatric in-patients in a changing clinical scene

Suicidal ideation as a paramount index of short-term risk

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Background Rapid changes in styles of clinical practice mean that we should carefully monitor the way suicides occur among psychiatric patients both in hospital and in the wider community.

Method Patients who had died through suicide either while receiving in-patient care or within 2 months of discharge from hospital were compared with a similar series reported 10 years previously. Clinicians' perceptions of patients' behaviour were compared with concurrent controls.

Results Patients in the more recent study were younger, more often male, and a greater proportion had been discharged from in-patient status. Hazards which complicated risk assessment included short-lasting misleading clinical improvements, variability in degree of distress, and a reluctance to discuss suicidal ideas. Over a range of perceived behaviours it was not possible to distinguish suicides from controls.

Conclusions In assessing suicide risk paramount importance should be attached to monitoring suicidal ideation and addressing the several hazards which might complicate this procedure.

In previous reports concerning suicides among psychiatric in-patients in Avon (Morgan, 1979; Morgan & Priest, 1991) several problems associated with the assessment and management of suicide risk in this patient group were identified. These included alienation, misleading symptomatic improvement, maintaining appropriate levels of supervision in hospital wards and absence without leave. In the 10 years since the second of these series was described many changes have occurred in the way mental health services are organised, particularly in terms of increased emphasis on community as opposed to hospital-based care. The present paper describes a more recent series of psychiatric in-patient suicides in Avon and attempts to evaluate further the particular hazards which may hinder effective suicide risk assessment and management in the present day clinical scene.

METHOD

The files of all sudden or unexpected deaths reported to the Avon coroner were inspected for probable suicides over a period of 30 months (from July 1991 to December 1994). Only those who subsequently received a coroner's verdict of 'open' or 'suicide' were included in the series. The data were cross-checked with the medical records of all hospitals in Avon in order to identify those persons who were psychiatric in-patients or who had been discharged from a psychiatric hospital ward in the 2 months preceding their deaths. Consultants or other clinical team members completed questionnaires concerning clinical details of these patients, including their perceived behaviour and the reaction of staff towards each patient during in-patient stay. In a small number of cases it was necessary for the research worker to complete the questionnaire directly from medical notes. Responses were less complete the greater the delay following in-patient stay. Identical methodology was applied to both series of suicides.

Attitudes to each patient were measured from responses to a series of specific items included in the postal questionnaire. Responses were of course retrospective and required recall by the respondents who were aware of the subsequent clinical course of each patient. Each item was self-rated along a four-point scale: not at all (0), sometimes (1), often (2), nearly always (3). The total score in each category was compared for suicides and controls as a percentage of the maximum possible score for the whole group. The latter consisted of those patients admitted to the same ward either next, previously, or subsequently, whichever was the closer. With regards to alienation three closely related categories are reported: alienation from patient, distance from patient, patient perceived as deliberately misusing symptoms. These were all concerned with critical attitude towards the patient's behaviour. Other categories which were evaluated included vulnerability, uncommunicativeness, variable mood, depression and aggression. (Details of the scales used are available from the authors.)

RESULTS

The relevant findings in the two series are illustrated in Table 1. Affective disorder was the most common diagnosis in both series. The more recent series contained a significantly greater proportion of younger patients (average age 38.0 years compared with 47.85 years, $t=2.12$, d.f.=43, $P<0.05$) and there was a trend towards a greater proportion of males in the later series. More of the patients in the recent series had been discharged by the time they died ($\chi^2=4.21$, d.f.=1, $P<0.05$). In both series a majority of patients had expressed suicidal ideas (74% and 83%), yet significant clinical improvement had occurred before their deaths (52% and 61%). In both series such clinical improvement in a considerable number of cases was not accompanied by resolution of relevant stress factors (44% and 50%). In view of the subsequent suicide, the amelioration of distress in such patients must be regarded as only temporary and potentially misleading in risk assessment. In the earlier series, absence without leave was a major problem which occurred in 13 out of 20 (65%) patients who still had in-patient status. In the more recent series it occurred in only one out of seven such patients. Other factors which may have hindered assessment of suicide risk included

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Table 1 Psychiatric in-patient suicides or open verdicts in Avon (in-patient status or within 2 months of discharge). Comparison of 1982–1984 and 1991–1993 series

	1982–1984 series (*n*=27)		1991–1993 series (*n*=18)	
Age[1]				
Average (years)	47.85		38.0	
Range	28–73		21–66	
s.d.	15.24		14.32	
Gender[2]				
Male	11		11	
Female	16		7	
Diagnosis				
Affective disorder	14		8	
Schizophrenia/other psychosis	6		7	
Personality disorder	3		1	
Other	4		2	
In-patient status at death[3]	20		7	
Discharged within 2 months	7 (26%)		11 (61%)	
Location of death	All(27)	In-patient(20)	All(18)	In-patient(7)
Hospital ward	3	3	3	3
Hospital grounds	4	4(4 AWOL)	2	2
Community	16	11(8 AWOL)	5	1 (AWOL)
At home	4	2(1 AWOL)	8	1
Suicidal ideas during admission	20 (74%)		15 (83%)	
Clinically improved	14 (52%)		11 (61%)	
Improved but stress factors unchanged	12 (44%)		9 (50%)	

AWOL, absent without leave.
1. t=2.12, d.f. 43, $P<0.05$, 95% CI 0.507–19.197.
2. χ^2 1.07, d.f. 1, NS, 95%CI–0.085 – 0.477.
3. χ^2 4.21, d.f. 1, $P<0.05$, 95% CI 0.072–0.631.

variability in degree of distress (four patients) and reluctance to talk specifically about suicidal ideas (five patients).

Measures of expressed attitude to the patient did not reveal any statistically significant difference at <0.05 probability between suicides and controls with regards to alienation, feeling distance from, and deliberate misuse of symptoms, total scores ranging from 16–27%. Scores for other variables also reveal no significant differences between suicides and controls along the themes vulnerable/anxious, withdrawn/uncommunicative. There was however a trend for controls to be seen as more aggressive and alienated, and for suicides as being more depressed and variable in mood.

DISCUSSION

Changes in age and proportion discharged from hospital

Psychiatric in-patient suicides have become younger, they tend more often to be male than previously, and are significantly more likely to have been discharged from hospital by the time death occurs. These changes are consistent with a move towards community care, and the national trend towards an increase in numbers of male suicides.

Hazards of risk assessment

In a recent series of in-patient suicides reported from Greater Manchester (Dennehey *et al*, 1996) retrospective analysis of case notes revealed that almost half were not recorded as being suicidal during their admission, which had occurred up to 5 years previously. In the present study direct enquiry of clinicians revealed that 83% of the suicides had been recognised as having suicidal ideas (compared with 74% of the earlier series). Even then practical difficulties in management still occurred. Absence without leave was a problem in both series, but less so in the more recent one. As found in the earlier series a considerable number of in-patients who proceeded to suicide became symptomatically much improved. That this can be a misleading sign, possibly due to temporary removal from relevant life stresses is suggested by the fact that most of these individuals return to face unresolved problems in the community. It seems crucial, particularly at the present time when the high demand for beds means that patients may well be discharged after only a brief stay in hospital, that mere symptomatic improvement should not be regarded as a sufficient index in itself that suicide risk has necessarily fully resolved, especially when stress factors continue unresolved. Other hazards in recognising the true degree of suicide risk in the more recent series included variability of distress, and reluctance to talk specifically about suicidal ideas. The present study also attempted to explore further the theme of alienation which had emerged from the earlier Avon series as a terminal malignant clinical sign in some suicides, having potential causal implications (Watts & Morgan, 1994). The more recent Avon series of suicides has not demonstrated any statistically significant difference in the magnitude of alienation between suicides and controls although the degree of negativity in attitudes to both is noteworthy. It should also be noted that a considerable proportion of the recent series had been discharged from hospital before suicide occurred, and so the course of alienation more immediate to their deaths in the community remained unknown. Clarification of the concept of terminal malignant alienation requires a more precise operational definition, as well as data regarding its prevalence in psychiatric patients generally, before any possible differences in alienation between suicides and other psychiatric patients can be evaluated reliably.

The paramount importance of face to face skills in risk assessment

The assessment and management of short-term suicide risk remains a major clinical challenge. The limitations of traditional suicide risk factors have long been recognised (Pokorny, 1982; Nordentoft *et al*, 1993) and they have been highlighted again recently (Dennehey *et al*, 1996). The present paper further suggests that psychiatric patients who proceed to commit suicide exhibit, shortly before their death, a wide range of symptoms and behaviours which are shared with others who do not kill themselves, and this makes it difficult to distinguish one group from the other. To take one important example, it certainly

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does not seem appropriate to see risk of violence and suicide as being mutually exclusive. Relevant here is the finding of the recent Confidential Inquiry (Steering Committee, 1996) that 32% of suicides in psychiatric patients had a history of aggressive behaviour.

In the face of all these difficulties, what should be the essentials of suicide risk assessment? The unreliability of traditional risk correlates does not mean that they should be ignored, but rather that they are best applied in parallel with more direct face to face clinical procedures, the paramount importance of which is perhaps insufficiently recognised because they appear commonplace. They can be listed quite simply: establish and maintain an effective therapeutic alliance (ideally with key others as well as the patient), thus allowing regular monitoring of suicidal ideation; avoid where possible any distancing and alienation as a result of challenging behaviour or failure to respond to help; recognise that marked fluctuation in degree of distress does not rule out suicide risk; be cautious in interpreting symptomatic improvement, especially when stress factors remain unresolved; be vigilant concerning ward supervision and leave (Bannerjee *et al*, 1995) and try to ensure that discharge is not premature. Such basic face to face clinical procedures are surely the mainstay of our approach to the assessment and management of suicide risk.

CLINICAL IMPLICATIONS

- Suicides in psychiatric patients are increasingly likely to occur in a setting of community based care, to be male and younger than previously.
- Over a wide range of behaviours as perceived retrospectively by members of staff, psychiatric patients who proceed to commit suicide within the near future are difficult to distinguish from others who do not kill themselves.
- In assessing risk, paramount importance should be accorded to close monitoring of suicidal ideation, with full awareness of the several hazards which may complicate this difficult task.

LIMITATIONS

- The numbers of suicides in both series were small, making it difficult to compare them reliably in detail.
- Perceived behaviours and staff attitudes were evaluated using an unstandardised postal questionnaire. Responses were often delayed, incomplete and prone to the unreliability of retrospective reporting.
- Controls were identified solely as patients admitted immediately before or after those who later committed suicide, because shared environment was the crucial variable. It was not possible to control for other factors.

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