British Journal of Psychiatry (1992), **160**, 149–153

Annotation

Suicide Prevention
Hazards on the Fast Lane to Community Care

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In 1989 a crisis occurred in a West Country seaside town. Its psychiatric services had been regarded as a vanguard of community care, having been fully established some three years previously when the in-patient facilities which had been based in a mental hospital some 15 miles away were closed. The framework of the new-style service consisted of five mental health centres scattered throughout the residential area and a 60-bed in-patient unit, based in the grounds of the local district general hospital.

After the new service had been in action for three years, HM Coroner criticised it in a series of press releases and television interviews. He expressed alarm at the number of suicides committed by psychiatric patients, and at the fact that "mentally ill patients appear to be discharged into the community without sufficient care facilities being available to them". He cited the multiple readmissions of certain patients in support of his view. The implication was clearly that in-patient care had become inadequate for patients at risk of suicide, and that care in the community had not compensated for the radical change in style of service.

There developed a crisis of confidence between community and hospital. Both local and national newspapers, as well as television, featured the problem prominently, and tension within the community began to rise. In this setting, I was asked by the regional medical officer to conduct a personal inquiry into the situation, and to provide him with a confidential report. This article summarises my findings as a result of a five-day visit in order to produce an urgent appraisal of the difficulties which had occurred. My visit focused on the care of the suicidal, but, in conducting it, I was able to gain many other insights into the problems which may beset a psychiatric service as its emphasis moves from traditional hospital to community care. My impressions are set out here, together with more specific considerations of the care of the suicidal.

The new-style service

The population served by the psychiatric service consisted of 240 000 adults aged 15 years or over. Of the population, 34% were females aged 65 or over and 23% were males aged 65 or over. This was a seaside town with a very considerable summer influx of people with psychiatric problems, particularly those with drug addiction, many staying on after the holiday season had ended. The five community mental health centres had been set up first, and were distributed throughout the area in a well-judged strategic way in order to facilitate easy access for the people served: each of these centres was multidisciplinary in the way in which it worked; the concept of 'normalisation' was prominent and was supported very strongly by many members of staff, who discouraged the term 'patient' in favour of 'client'. The acute 60-bed in-patient psychiatric unit was added later, together with the provision of 20 beds for the elderly. The three hostels, which were staffed by nurses, later became an independent trust, and these gradually developed their own admission policies, setting rules such as limiting the stay of patients to a duration of one year. One long-stay facility offered a total of 34 rehabilitation beds for the chronically ill.

The personal inquiry

My inquiry had several separate components. First of all, I was able to review the inquest dossiers concerning all patients who had received a verdict of suicide, and about which HM Coroner had expressed concern. This allowed me to calculate suicide rates for the local population (allowing for the specific age groupings within it), and so compare the rates with those found nationally. The numbers involved were very small (Table 1) and there was considerable variation from one year to the next, so that to base conclusions on such statistics was particularly hazardous. In 1990 (the year following this inquiry),

Table 1
Suicide rates in a West Country town

Year	Males		Females	
	Nos	% national rate	Nos	% national rate
1986	16	113	16	214
1987	22	151	5	67
1988	24	165	10	133
1989	23	158	8	106
1990	15	103	6	80

Table 2
Suicides in contact with the service for mental health

Status	No.
In-patient at time of death	
drowned in bath	1
left ward, without permission, to commit suicide	3
In-patient previously	
1 month ago	1
2 months ago	2
8 months ago	1
12 months ago	1
15 months ago	1
Contact with community mental illness services only	4
No contact with mental illness services (seen by approved social worker in police station)	1
Total	15

the suicide rates in males and females were respectively 103% and 80% of the national average. Although male rates appeared to be consistently higher than female rates during the years which were examined, 10 of the 15 suicides committed by psychiatric patients during the previous 15 months had been by women. In parallel with this review of inquest dossiers, the psychiatrists collaborated in a clinical audit in which the management of all these cases was reviewed in detail. Diagnoses ranged widely over categories such as depression (most commonly), schizophrenic psychosis, and personality disorders. The kind of contact these patients had made with psychiatric services is illustrated in Table 2. Only four had been in-patients at the time of their death: the others had left in-patient care between one month and 15 months previously. Four had contact restricted to community mental illness services, and one had only been seen by an approved social worker in a police station.

Review of the difficulties in management which had been posed by these patients revealed that these had been challenging and frequently intractable. The clinical procedures for care of the suicidal were evaluated, and it was clear that no major areas of omission had occurred.

HM Coroner had expressed considerable anxiety concerning the proportion of suicides who had been in contact with psychiatric services. This is a complex point because, ideally, a service should be able to make contact with all persons at serious risk of suicide. In general, it is found that about half of all suicides have at some time in the past been in touch with psychiatric services, and a recent survey in Avon (Morgan & Priest, 1991) has suggested that about 25% have had contact within the previous two months. In the current study, 10 patients out of a total of 40 who committed suicide fell into this category, and there seemed, therefore, to be no major difference in the way psychiatric services there were reaching out to persons at risk, compared with elsewhere.

The inquiry also included discussions with various mental health professionals including nurses (both hospital and community-based), general practitioners, and representatives of voluntary agencies. All expressed satisfaction with the principles of the new-style service, although a great deal of stress had been engendered at times by difficulties in obtaining crisis admissions to hospital. It was clear that the emphasis on community care had allowed certain clinical problems to be contained in the community without the need for hospital admission, but the demands which this placed on staff were very considerable.

The available evidence did not make it possible to decide whether or not the numbers of suicides in this population had changed since adoption of a new-style psychiatric service. Clinical practice concerning the assessment and management of suicide risk had followed conventional lines. Several problems were identified, however, concerning the management of suicide risk in a service which emphasised community care, and which afforded only limited access to intensive in-patient care facilities. Before considering these, the principle of good care for suicidal individuals needs to be identified.

The assessment of management of suicide risk – some essential principles

Whatever the style of psychiatric service or the basic training of a mental health care professional, there are certain incontrovertible rules, and a clear discipline inherent in the clinical assessment and management of suicide risk. Assessment should encompass both personal and sociodemographic risk factors, and involve thorough collection of clinical data, categorisation of the problem, and then matching of the findings with well established risk factors. Such an approach should over-ride all theoretical models. Once risks rise above a certain degree, then the programme of care should be intensified to permit adequate supportive observation, usually by admission to hospital. The need for this will remain, however efficient crisis intervention in the community may be. The level of ongoing care needs to be matched with the degree of suicide risk, and agreed clinical policies are crucial while such risk remains. The aim should be to provide intensive personal support which is fully explained to the patient, rather than impersonal surveillance.

The uncertainties and hazards which complicate the care of the suicidal are many, and management

may involve taking calculated risks: not all suicides can be prevented, even within the best-run psychiatric wards, and the real challenge is to reduce the numbers to a minimum. All staff should accept that suicide prevention is intrinsically worthwhile; they should not adopt value judgements that in certain cases suicide can be allowed to happen, by withdrawing care or by avoiding more intensive involvement when this is otherwise indicated. At the same time, setting limits for persons who are judged to be able to take responsibility for their behaviour is an important clinical skill which needs to be invoked in certain instances. Recently reported research in Avon (Morgan & Priest, 1991) has illustrated how important it is to ensure that in-patients at risk of suicide are not discharged prematurely, merely because of symptomatic improvement. Unless adverse life events are resolved adequately, such improvement may well be spurious and misleading, heralding rapid relapse on discharge. Alienation of patients is another major factor which can hinder delivery of effective care. This, and/or misleading clinical improvement, was identified in more than 80% of the series of suicides which formed the basis of that same study.

Community care: hazards for those at risk of suicide

It may be that new styles of service which emphasise care in the community will produce new ways of caring for the suicidal. Whereas in the past it has been assumed that intensive in-patient care is required once the risk of suicide escalates beyond a certain point, perhaps we will soon question such an assumption, and find that some patients might even be harmed by admission to hospital under such circumstances. All this remains to be investigated further, but for the moment, certain essentials of service provision need to be safeguarded, if the care of the suicidal is to remain adequate as community services are developed progressively. The in-patient resource should not become an underfunded Cinderella of the service. It is the place where the most severe and urgent problems are cared for, and it should not be seen merely as an undesirable addition to a service, inferior in status and less interesting in which to work than the community. An in-patient unit needs a full range of staff to allow an intensive multidisciplinary clinical approach. If the numbers of beds are reduced excessively, then suicidal individuals will be denied admission or discharged prematurely, to face the possibility of rapid escalation of risk once they return to the community. It is crucial that an in-patient psychiatric unit should enjoy full and efficient integration with all other parts of the service: there should be no question of individual components breaking apart to establish their own rules for admission and discharge. Unless such coordination is satisfactory, a small in-patient unit may rapidly become inefficient in dealing with acute clinical crises because of increasing numbers of longer-stay patients with chronic clinical problems. Adequate provision of day care is invaluable in ensuring that a comprehensive and adequate spectrum of care is available, and in relieving the load on an in-patient unit. An effective service for rehabilitation, with adequate provision for the care of acute relapses which punctuate chronic illness, is perhaps the first part of the service that needs to be secured, if an in-patient unit is to maintain its ability to cope with acute illnesses, including suicide risk.

Community care: general themes and problems

Nobody would today question the principle of encouraging treatment in an environment as near as possible to a person's home, thereby possibly minimising secondary disability and any stigma of being apart as a psychiatric patient. Early intervention is of enormous potential value in preventing chronicity, and the history of psychiatric in-patient care, punctuated as it has been with disasters and scandals, demands that we should exploit new styles of care which avoid the well-known potential ills of hospital admission. To many individuals, the idea of becoming a psychiatric patient in hospital is frightening, indeed offensive, in terms of being patronised and controlled. Nevertheless, many hazards may complicate community care. The more obvious of these are now discussed.

Conflicting ideologies

Ideology is defined by the *Concise Oxford Dictionary* as 'visionary speculation', yet it may also have pejorative overtones, implying a set of ideas which ignores criticism and which tends to impose a particular solution to complex problems, regardless of evidence which demands caution. As psychiatric services undergo radical change, driven by professional groups which are committed both to the change itself and to the development of their own professional roles, it is not surprising that conflicting ideologies in this second sense may complicate and indeed undermine the process. The psychiatrist's ideology was, in the past, one which construes mental distress as illness which necessarily requires medical, often physical, treatment. Although this in no way does justice to the attitude of present-day psychiatrists,

regrettably they are often caricatured in this image, and fiercely challenged by those who assume psychiatric disorder to be an adverse reaction to social and interpersonal stress, amenable to the process of 'normalisation' in the community, and for which admission to hospital is highly undesirable. The end result of such difference of opinion can be a bitter polarisation between psychiatrists and other professionals, forced apart by their views of one another. Professionals other than psychiatrists often refer to sick persons as 'clients' or 'customers', and object to the term 'patient', expressing abhorrence for the 'medical model' which is regarded as being concerned merely with listing symptoms and signs in order to produce impersonal categorisations of sick persons in terms of diagnosed disease. In turn, hospitals are referred to as 'Victorian', with the implications that they are suspect: any collection of beds above a very small number is dismissed as an undesirable 'institution', the latter word again being heavily loaded with negative connotations. In the present-day situation of rapid change, healthy debate between professionals should be the rule, but when attitudes arise primarily from professional rivalries, the resulting controversy can have a most deleterious effect on a psychiatric service. Hostility to 'the medical model' leads to the situation in which in-patient resources are regarded as an undesirable, even expendable, power base for the psychiatrist. These facilities then risk being drastically reduced in size, and those which are allowed to remain may be denuded of resources, unable to provide adequate multidisciplinary care for the most severely ill patients – a true irony. The potential effectiveness of in-patient care is thereby grossly undermined. National norms, such as they are, can mean nothing in the face of severe managerial pressure to close as many beds as possible in an uncritical way.

Fragmentation of the service

Conflicting attitudes may also lead to a disorganised service; an unbridged Great Divide may open up between community and hospital, crossed by no one as part of day-to-day duties, and so it becomes difficult to ensure effective continuity of care between the two, whether in ensuring effective admission to hospital or continuity of care on discharge.

Difficulty in monitoring and evaluation

Whatever the deficiencies of traditional in-patient psychiatric care, it is easier than community care to monitor reliably. A community multidisciplinary approach is often cited as the ideal, and there is much to commend this. Yet what really is offered? Is this dependent upon the personal, possibly idiosyncratic, interest of an individual health worker? What supervision and guidance are provided by senior professionals? Such potential criticisms can, of course, be levelled at hospital care, but community services, in spite of their implementation with such vigour, have not yet been scrutinised thoroughly in terms of audit procedures. What guidelines are available to the referring general practitioner who wants to ensure that a patient to be seen in the community gets a full psychiatric assessment, when this is thought desirable? A letter addressed 'Dear Team' does little to ensure that such will occur. The question of team leadership and ultimate clinical responsibility can appear to be decided in a way which reflects the attitudes of the personalities involved. This is a remarkably arbitrary approach to a most important aspect of clinical care, yet one on which the hierarchy of authority in the National Health Service seems to have defaulted on giving firm guidance.

Compromise in caring for the severely ill

If planned ineptly, there is a real risk that community-style services will neglect the needs of the severely ill. If in-patient facilities are inadequate and shabby (and up to now, this is how they have tended to be), then suicidal patients will find it difficult to gain admission, they will be ejected prematurely because the beds are needed for other patients in crisis, and so will become at-risk in the community, where their problems had not been resolved. They will not be keen to return to sordid in-patient facilities at some future date, should some crisis recur. Unless in-patient facilities retain a critical mass, they become too small to deal with major behavioural disturbance, because adequate reserves of staff are then not available to provide urgent intensive care; this may be needed at any time, often unexpectedly. Difficult patients are then either not admitted or are discharged prematurely. Can anyone feel complacent about the inadequate provision of care for chronic mental illness in this country today? The advent of care plans is a step in the right direction, but will do little to safeguard the needs of the acutely ill if in-patient resources are dismantled indiscriminately.

Conclusion

The picture presented here may well not apply universally, and some may even regard it as a

caricature of reality. Evidence suggests, however, that it approximates to the fraught situation which applies in many psychiatric services today. It should in no way be taken to imply that psychiatrists have all the answers, such that they should attempt to monopolise mental health care. While other professionals clearly have their own distinctive contribution to make, mutual stigmatisation and polarisation of attitudes is disturbingly common, and adversely influences the way in which some services are planned. The provision of adequate intensive care facilities for persons in crisis seems to be caught up in this process of attitudinal conflict and mutual prejudice, yet all mental health care professions have a responsibility to consider this urgently and objectively. It would be tragic indeed if those who extol the virtues of community care so vigorously and at times uncritically merely encourage it into being discredited, as a result of an escalating number of clinical tragedies and inadequately treated disturbance. The end result would be loss of society's tolerance and a hasty reversion to institutional care of the worst kind; stigmatisation would then arise again, both in the community and hospital. The history of health care teaches us that such a cycle has in the past been the rule rather than the exception, and demands that we should strive to avoid such a sequence in the way that mental health care now evolves. Zeal for what is new and for that which we intuitively feel to be both desirable and enlightened does not excuse us from an obligation to evaluate all innovations as they are introduced.

To return to suicide prevention: has anyone initiated procedures for auditing unexpected deaths in persons cared for by community psychiatry? Can we be sure that these will not escalate rapidly, if in-patient resources become markedly reduced? Suicidal individuals, in common with others who become severely ill, will be the first to pay a heavy price if we ignore their clinical needs, and achieving the correct balance between hospital and community in this respect is of vital importance. The planning of new services should be informed far more by careful, step-by-step clinical evaluation, as opposed to hasty implementation which is akin to reckless driving in the fast lane. That West Country seaside town where my inquiry was based has set us a positive example of how to meet the many hazards faced by all new-style community-based services. Renewed attention has been given to relieving the demands placed on the in-patient unit by extending provision for the care of chronic relapsing illness, improving facilities within hospital itself, establishing audit procedures both for hospital- and community-based services, and ensuring that there is full debate and consultation between professionals, managers, and voluntary bodies. We should all be well advised to follow their example.

Reference

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