

Prognosis After Suicide Attempt: Standard of Care and the Consequences of Not Meeting It

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A significant number of people who attempt suicide and survive eventually die by their own hands, many within a year of the index attempt. A history of multiple past attempts further increases risk of eventual suicide. That most attempters do not later die by suicide is a statistical fact that should not distract psychiatrists and other mental health professionals from the substantial increase in risk associated with a suicide attempt. Short-term intensive treatment, often with psychiatric hospitalization, reduces immediate risk, but the standard of care often requires more than just a few days of generic inpatient care. Before discharging patients, the psychiatrist should be reasonably certain that the conditions associated with the attempt and initial suicide risk have improved in some significant and lasting way. Although for many patients, severe suicide risk is a relatively transient condition, patients should not be discharged just because they feel better or show superficial signs of lessened risk. Before sending the patient into the community, the psychiatrist should have good reason to believe that the dangerous condition(s) that precipitated the attempt and hospital admission have been ameliorated, and that the important improvements in the patient and his or her environment, on which the patient's safety relies, are both real and stable. (*Journal of Psychiatric Practice* 2009;15:141–144)

KEY WORDS: suicide, suicide attempt, risk assessment

I am sometimes asked what a patient's prognosis would have been if he or she had not committed suicide (for example, when a patient has been treated for a suicide attempt, then commits suicide either in the hospital or soon after discharge). That's the "forensic" part of this month's article. More important, how should clinicians use available clinical and statistical findings that describe prognosis for patients who have attempted suicide? No one has a

crystal ball. In forensic work, we routinely examine extensive patient records (usually more than were available to the treating clinicians) but have not actually seen the patient, much less seen him or her around the time of the attempt (which adds a disclaimer to these comments).

The recent psychiatric literature addresses some of these questions, at least in a statistical way. A quick search of reputable articles and studies at the National Library of Medicine website¹ produces much information. However, it is important to be cautious when trying to apply group or statistical findings to specific patients and situations, because each individual is different and "statistics" are not the same as individual patients.

Before we get to the meat of this month's article, I want to review a few key issues I've discussed in previous columns. First, dealing with suicidality is about working with patient risk. Second, there may be more or less risk, but it is never zero. Third, although the likelihood of tragedy may be lower than, say, the chances of a coin coming up heads or tails, poorly managed clinical risk, even of improbable events, is unacceptable. Fourth, the interpretation of risk factors is not a dichotomous exercise. That is, the presence of major risk factors is more important than the mere fact of their absence. Fifth, traditionally "protective" factors per se (such as having children or a job) should never be relied upon as if they outweighed indicators of severe risk. Sixth, not all risk factors are created equal. For example, the absence of demographic conditions associated with a small increase or decrease in group risk (such as age, gender, or religion) is easily outweighed by individual conditions and behaviors (such as severe symptoms, recent ominous behavior, or instability).

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Finally, in this article, I am discussing suicide attempts. "Attempt" is defined differently in different studies and contexts. Some of the sources for the information discussed here refer simply to any level of behavior that might have resulted in death, or that the patient believed might result in death. Other reports limit their definition of an "attempt" to behavior that led to critical treatment, such as life-saving medical care. As with all group data, the differences are not always clear. The only broad exception to "attempt" that applies to the discussion here is superficial cutting that is clearly associated with some characterologic purpose—readers can assume that such behavior has been omitted from the studies reviewed here unless otherwise stated.

It sometimes seems that circumstances conspire to prevent adequate treatment of psychiatric patients, even those with obviously unacceptable suicide risk. As you read the discussion below, think about your own practice environment and whether or not it offers patients access to good care. Don't leap to the conclusion that it does, or that you are meeting the standard of care for treating suicidal patients just because you follow common local practice with regard to things like length of stay or patient monitoring (local practice rarely defines the "standard of care" that civil courts require). Think about what's really necessary—there are guidelines in many good textbooks—and what is available if you choose to order it. Then think about what care you would expect if the patient were a member of your own family. Is that different from what you're willing to accept for a member of someone else's family?

Likelihood of suicide after a first known attempt

A study recently published in the *British Medical Journal*² supports the common finding that once a person has attempted suicide, his or her statistical (i.e., group) probability of eventually dying by suicide increases substantially, particularly if the person has a serious mental illness such as schizophrenia, bipolar disorder, or major depressive disorder. In this large Scandinavian population of persons with mental illness, up to 25% of women and almost 40% of men killed themselves within 21–31 years of the initial attempt (the period varies because initial cohort sampling covered a decade). Members of a control group who attempted suicide but had no apparent

psychiatric diagnosis at the time also had significantly increased risk, although it was measurably lower (7% of women and 11% of men). Schizophrenia was the most ominous diagnosis, followed closely by bipolar and unipolar mood disorders. Substance abuse and several other diagnoses also increased relative risk. (Note that people with one disorder often have others as well.)

Most other studies have not examined such a long period after the index suicide attempt, but have found significant increases in suicide rate (e.g., Jenkins et al. 2002³). Most large studies that explore similar population statistics do not differentiate patients who receive good follow-up from those who refuse follow-up, drift away from treatment, or lack good access to care.

Of course, some completed suicides take place on the first known attempt (up to 20%, depending largely on patient characteristics), very often with noticeable warning signs (but sometimes not). The suicide rate in the general population in the Western world is about 12–20/100,000/year, or about 0.02% per year, far lower than the rate among patients with serious mental illness who have attempted to kill themselves.

Likelihood of suicide soon after a first known attempt

The statistics for early suicide are similar to, but in some ways more dramatic than, the longitudinal cohort results. In the Tidemalm study,² more than half of those who were destined to commit suicide did so within the first year. That means that, as a group, about 12%–13% of Scandinavian women and 18%–20% of men with severe mental illness who attempted suicide for the first time, and were hospitalized or seen in an emergency department, died as a result of suicide within the following year.

Increase in risk associated with multiple attempts

The effect of chronic self-injury or multiple suicide attempts on current risk is often underestimated. Patients with multiple past attempts are associated with significantly elevated risk of future lethal attempts.^{4,5} Clinicians should be cautious about exempting chronic self-injurers (such as patients who engage in frequent superficial cutting) from

those at increased risk. Similarly, the concept of suicide “gesture” is rarely useful, overlaps greatly with “attempt,” and can easily distract clinicians from the seriousness of associated psychopathology and risk. Do not be misled by the folk adage, “those who try rarely die.”

Effect of diagnosis

“Diagnosis” is not the most prominent prognostic factor. It is clinically and statistically important, but more because of highly correlated symptoms, instability, and behavior than the label in itself. Seriousness of the attempt (e.g., potential lethality or the patient’s expectation of dying) is a very important factor in risk of future suicide, as are overall symptom severity, time since last attempt, instability of symptoms or remissions, and some other characteristics that most readers probably already consider.

Effectiveness of adequate post-attempt treatment

Good evaluation, protection from self-harm, treatment of risk-related mental disorders, and adequate follow-up help patients and save lives.^{6–10} Decreasing patient monitoring, protection, or treatment before lasting and reliable positive change have taken place is associated with increased risk. Suicide is very often the result of an impulsive act; in many cases, severe suicidality lasts for only days or weeks (often associated with periodic symptom increases or triggers that come and go). Adequately assessing internal and external precipitants, protecting patients while such precipitants are prominent, ameliorating them in lasting ways, and monitoring patients for their return all mitigate short-term risk and can reduce longer term risk.

Among the many important principles of working with suicidal patients, two aspects of treatment particularly stand out. First, when suicidal thoughts and impulses arise as a result of conditions such as severe depression, psychosis, confusion, anxiety, and/or intoxication, it simply makes sense that decreasing those conditions in some significant and lasting way decreases the patient’s likelihood of suicide. Addressing the mental illness or disorder is important—which means focusing on aspects of care such as accurate diagnosis, good treatment choices,

enhancing treatment adherence, and evaluating treatment response (or observing reliable change) before reducing protective measures.

Second, as already mentioned, many patients’ severe suicide risk is relatively transient. That doesn’t mean that most patients can be discharged from the hospital as soon as they say they feel better or show signs of lessened risk. It means that when psychiatrists, other clinicians, and/or treatment teams can help such patients survive the days or weeks of acute suicidal danger and have good reason to believe that the improvement is stable, those patients are more likely than inadequately treated and protected patients to return to safe and effective functioning once discharged and not to relapse (given adequate follow-up treatment and monitoring).

“He’ll kill himself no matter what we do.”

The professional literature is occasionally misconstrued—sometimes by those who are rationalizing inadequate clinical efforts—as suggesting that it doesn’t really matter how suicidal patients are treated. It is hard to test a hypothesis for which the endpoint is something as uncommon as suicide and for which a truly matched “no-treatment” control group cannot ethically be created. Some researchers try to extrapolate inferences about suicide from studies of parasuicidal thoughts, behaviors, or attempts. Others examine common clinical covariates of suicide, such as depressive symptoms, and treat them as markers of suicide risk. We know, however, that behaviors and situations that actually end in suicide are often different, quantitatively and qualitatively, from those that do not. The best data are usually found in very large, lengthy, prospective studies, even though one should be cautious about blindly applying large group data to individual patients.

I am sometimes asked (e.g., in malpractice consultations) whether psychiatric hospitalization after a serious suicide attempt, or hospitalization longer than a few days, is really associated with decreased risk. In most cases, the answer is clearly “yes,” although valid studies are difficult to perform or find. I think of it this way: First, the patient must stay alive long enough for the suicidal crisis to pass, and I assume reasonable psychiatric hospitals are better at keeping suicidal patients alive than are day programs, outpatient clinics, or families at home. Second, the patient must stay alive long enough for treatment

to take effect. Treatment response (especially response to biological treatments) is usually better and more safely assessed in a hospital than in the community. Meaningful treatment response—especially response to psychotropic medications—almost always takes more than a few days. The list goes on.

Must we keep suicidal patients in the hospital forever?

That's a trick question. For most patients who try to kill themselves, the "suicidal" part of that question diminishes greatly at some point. The patient may respond well to a treatment and seem likely to continue the treatment after discharge. The acute exacerbation of depression, psychosis, or morbid hopelessness that precipitated the attempt may pass and not be expected to return soon. The patient's illness itself may become less severe, as happens when parts of a broken psyche are reconstructed or the patient builds new, stronger emotional resources with which to deal with the world.

Clinicians who have become accustomed to hospitalizations that last only a few days may view longer admissions as "forever" (as may many payers for hospitalization and other intensive treatment services). That is a foolish and dangerous attitude. If the patient continues to be truly suicidal, then hospitalization and other closely-monitored care is likely to be necessary, just as it is for some patients in other medical specialties, and in some other realms of psychiatry. Remember that you, the psychiatrist, are the gatekeeper; you're the person who writes admission, discharge, and treatment orders. Pressures to discharge the patient prematurely are usually related to resources rather than clinical issues. Lots of people may push for discharge (including the patient, who may do so because of poor judgment or as a surreptitious pathway to suicide), but the physician is the one responsible for knowing the clinical issues

and acting on them according to the standard of care. The patient ultimately relies on the physician to put clinical and protective issues first, and to use clinical judgment rather than bending to administrative voices or relying on patient statements or promises that often hide poor judgment, limited insight, and suicidal plans.

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