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Could an allied health care approach reduce the unacceptable incidence of suicide after psychiatric hospital discharge?

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Could an allied health care approach reduce the unacceptable incidence of suicide after psychiatric hospital discharge?

Abstract
We propose that an allied care model could assist to reduce the unacceptably high incidence of suicide after psychiatric hospital discharge. A designated care coordinator is needed to provide holistic discharge planning that incorporates medical, functional and social support for the patient. At a minimum, this approach must include assessment of suicide means access and modifications to the home environment to reduce risk of injury as a standard management procedure.

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Title: Could an allied health care approach reduce the unacceptable incidence of suicide after psychiatric hospital discharge?

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Clinical Care:

Key message: We propose that an allied care model could assist to reduce the unacceptably high incidence of suicide after psychiatric hospital discharge. A designated care coordinator is needed to provide holistic discharge planning that incorporates medical, functional and social support for the patient. At a minimum, this approach must include assessment of suicide means access and modifications to the home environment to reduce risk of injury as a standard management procedure.

Discussion: Suicide is a leading cause of death in people with bipolar disorder, with specific patient groups (mixed states bipolar disorder, women and adolescent girls) identified as particularly high risk populations (1). Furthermore, there is an increased incidence of suicide after discharge from psychiatric facilities in people diagnosed with affective and psychiatric disorders, such as bipolar disorders, depression and schizophrenia, compared to those without. Based on half a century of evidence, Chung and colleagues (2) identified an alarming post-discharge suicide rate that was 44 times higher than the global suicide rate; a statistic that had not declined over the past 50 years despite development of psychosocial and pharmacological treatments. Nordentoft et al (3) fittingly described the issue of post-discharge suicide as ‘a nightmare and a disgrace’, suggesting that psychiatric patients should not be considered cured at the time of discharge - on the contrary, some can represent a particularly vulnerable population. Chung et al (2) identified that the greatest post-discharge suicide risk was associated with patients originally admitted to hospital with suicidal ideation, and the highest risk time period was the first three months after psychiatric hospital discharge. Other research has identified the common methods of suicide in post-discharge mental health patients (including hanging and opiate overdose) (4). Therefore, we are now in a position where we have identified the high risk populations, critical time points, and

common methods of post-discharge suicide. The pivotal question is: what are we going to do to reduce the unacceptably high incidence of suicide after psychiatric hospital discharge?

Recommendations for management of suicidal patients with bipolar disorder include risk reduction through community support, hospital admission, means restriction and pharmacological approaches (1). However, although adverse patient outcomes can be lowered through timely post-discharge follow-up, this is not standard practice. Furthermore, assessment of home access to lethal means is not routinely conducted, even when suicide patients admit to owning means, such as firearms (5). Overall, the combined evidence paints a clear clinical message, that post-discharge suicide preventions are lacking but interventions are critically needed within the first few months after psychiatric hospital release, with some calling for patient follow-up within the first 2-days (4).

For other in-patient groups (such as frail and ill elderly patients, ambulatory surgical patients and stoke victims), allied health professionals are involved in discharge planning and post-discharge care. For example, an occupational therapist can assess and recommend modifications to the built environment to ensure safety at home, reducing the risk of injury and rehospitalisation. Therefore, care models do exist that can involve modifying the home environment to improve an at-risk individual's safety following hospitalisation. Why aren't psychiatric patients supported in the same manner? The complexities of suicide pose challenges for prevention and strategies must undoubtedly be multi-factorial; however, restricting common means of suicide can reduce death rates. Could an allied care model assist high post-discharge suicide risk individuals, whereby a designated care coordinator provided holistic discharge planning that incorporated medical, functional and social support for the patient? (Figure 1). At a minimum, this approach should include assessment of suicide means

access and modifications to the home environment to reduce risk of injury as a standard management procedure during the known critical risk time period post-psychiatric facility discharge.

Learning Points:

- Research has identified key data on suicide: (1) the suicide rate in patients post-discharge from a psychiatric facility is 44 times higher than the global suicide rate, (2) the highest risk period is within the first 3-months post-discharge, (3) the most common methods of suicide include hanging and opiate overdose.
- A medical and allied health care model that considers the medical, functional and social support needs of the patient, led by a designated Care Coordinator, could lower this risk.
- Patients should be supported by medical and allied health clinicians immediately after and throughout the 3 month critical suicide risk time period post psychiatric hospital discharge.

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Figure Legend:

Figure 1. Schematic of a potential medical and allied health care model for managing suicidal patients post-discharge from a psychiatric facility.

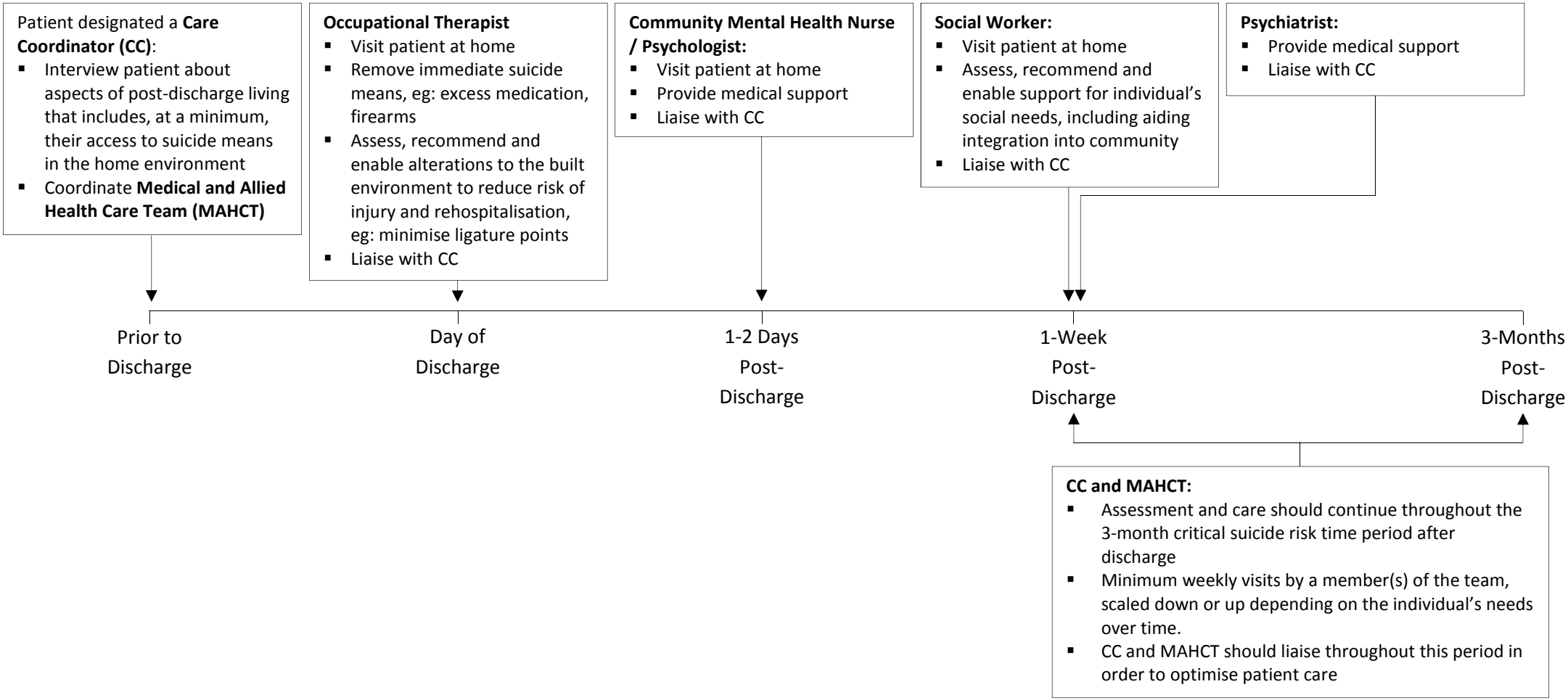
Patient designated a **Care Coordinator (CC)**:
Interview patient about aspects of post-discharge living that includes, at a minimum, their access to suicide means in the home environment
Coordinate **Medical and Allied Health Care Team (MAHCT)**
Occupational Therapist
Visit patient at home
Remove immediate suicide means, eg: excess medication, firearms
Assess, recommend and enable alterations to the built environment to reduce risk of injury and rehospitalisation, eg: minimise ligature points
Liaise with CC
Community Mental Health Nurse / Psychologist:
Visit patient at home
Provide medical support
Liaise with CC
Social Worker:
Visit patient at home
Assess, recommend and enable support for individual's social needs, including aiding integration into community
Liaise with CC
Psychiatrist:
Provide medical support
Liaise with CC
Prior to Discharge
Day of Discharge
1-2 Days Post-Discharge
1-Week Post-Discharge
3-Months Post-Discharge
CC and MAHCT:
Assessment and care should continue throughout the 3-month critical suicide risk time period after discharge
Minimum weekly visits by a member(s) of the team, scaled down or up depending on the individual's needs over time.
CC and MAHCT should liaise throughout this period in order to optimise patient care

Figure 1