Suicide

Prevention is better than death

28 April 2022

It could happen to you too

Event 1

POOR ASSESSMENT OF THE SUICIDE RISK LEADING TO DEATH

A male patient known to the psychiatric department for a long time, suffering from poorly tolerated negatively progressing schizophrenia, is granted weekend leave and allowed to leave the day before, with an appointment at the part-time therapeutic reception centre (CATTP) scheduled the following Monday. He was to go to his parents. The mobile psychiatry team visited the patient on the Wednesday as they were worried he hadn't returned from his leave as he was supposed to on the Tuesday evening. They found the door closed, called the family, who found the patient dead.

What happened? *Immediate cause*

The patient hung himself at home.

Why did it happen? *Root causes, barriers absent or deficient*

- The family had not been informed of the patient's authorisation for leave.
- The suicide risk at the time of the authorisation for leave was not assessed.
- The patient did not attend his appointment on the Monday and the admissions department was not informed.
- No emergency number was provided to the patient before he was authorised to leave.

Event 2

LACK OF SURVEILLANCE OF A SUICIDAL PATIENT LEADING TO HIS DEATH

A male patient in his thirties with known history of suicide risk is brought in drowsy to the emergency department further to a suicide attempt by drug intoxication. He is transferred from the vital emergency room to a conventional bed in the emergency department when his condition stabilises. When the next nurse came round, the patient pulled out his infusion and became agitated. The doctor is informed and prescribes a sedative. A few minutes later, the patient forced the window and escaped. He was found dead sometime later at the bottom of a staircase.

What happened? *Immediate cause*

The patient threw himself down a staircase.

Why did it happen? *Root causes, barriers absent or deficient*

- The patient was left unattended when the medicinal product and room were being prepared.
- The patient did not receive the sedative prescribed.
- The windows were not securely locked.
- The medico-psychological unit was only contacted several hours after the patient's admission.

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Event 3

LACK OF HOSPITALISATION LEADING TO A SUICIDE ATTEMPT

A 15-19 year-old teenage girl is admitted in consultation at the paediatric emergency department for a psychiatric opinion due to a depressive state. After a medical examination, it was decided to send her home pending hospitalisation. The patient rejected this decision and became agitated and violent, and made two attempts to run away. Hospitalisation was then discussed between the care supervisors and the medical team while the patient was kept in a calming room to which the door was guarded. When it came to transfer her for hospitalisation, she is found huddled up behind her bed. She is immediately taken to the vital emergency department reception.

What happened? *Immediate cause*

The patient strangled herself with her shoe laces.

Why did it happen? *Root causes, barriers absent or deficient*

- The suicide risk was not assessed.
- A suicide risk assessment protocol had not been established in the department.
- The hospital staff was not trained in the identification and monitoring of patients at suicide risk, especially adolescent patients.
- Her personal effects had not been inventoried.
- A psychiatric assessment was not carried out in the paediatric emergency department as there was no child psychiatrist available.
- The patient could not be hospitalised in child psychiatry, as there were no places available in the region.

Event 4

LACK OF PATIENT MANAGEMENT LEADING TO SUICIDE

A 95-year-old female patient in a residential care institution for independent adults for some months, regularly says how she wishes to end her life. She is followed by her regular doctor. As her daughter is worried, she asked for her mother's room to be made secure. One day, as the patient was uttering more worrying words than usual and attempted to kill herself with a knife from the canteen (with no sequelae), the home staff called the French emergency medical aid services with the daughter's agreement. The emergency service doctor prescribed sedatives over the phone without examining the patient. The patient was found dead on the ground floor the next day.

What happened? *Immediate cause*

The patient jumped out of the dining room window on the second floor.

Why did it happen? *Root causes, barriers absent or deficient*

- Despite her repeated suicidal tendencies, the patient was unable to see a psychiatrist.
- The patient's environment could not be properly secured within the home.
- No medical visit was arranged by the emergency services.

Key words: ***suicide, prevention, suicide risk, postvention, defenestration***

So it doesn't happen again

Analysis of the serious adverse events in the REX-EIGS database showed 795 trSAEs related to suicide attempts (63.8% of which led to death), with and without death, recorded by HAS from March 2017 to June 2021. The deaths mainly concern elderly males and patients with mood disorders. Overall, the three main recurrent root causes in suicide attempts are the lack of secure areas, absence of suicide risk assessment and organisational failings. Inappropriate management also appears to be a root cause in the events described in this focus.

Existing guidelines recommend taking action from the outset, before suicidal thoughts even appear, by:

- **detecting and treating** depression (main diagnosis associated with suicide attempts in the trSAE database):
  - several questionnaires are available as a potential aid in the clinical approach and diagnosis, especially the PHQ-2 or the PHQ-9, the BDI-II, the HADS, the HDRS, and the GDS-15[1];
- **providing medical support for** the patient, once the diagnosis made. This is often essential.

Concerning suicidal thoughts, it is necessary to:

- **organise wide scale detection** in care units, to estimate the level of urgency and vulnerability to suicide:
  - with simple protocol-based questions on patient arrival.

It is useful to recall that asking questions about suicidal thoughts does not make any appear. It is therefore important to always ask questions on admission and if there is the slightest doubt at any point during the care pathway.

- Rapid recourse to a psychiatric assessment is necessary where there are suicidal thoughts: assessment always leaning towards a clinical approach, possibly along with tools to assess the suicidal crisis. It is used to arrange urgent care and hospitalisation, or if there is a lower risk, to arrange close monitoring in outpatient care.

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In France, the post-hospital monitoring programme for suicide patients, VigilanS, reduces the risk of suicide by providing closer rmonitoring of suicide patients. In effect, the risk of relapse in the year following the suicide attempt is estimated at between 10 and 20% and varies from 30 to 50% among adolescents.

A routine suicide prevention policy in health care organisations was set up successfully in Ontario from 2015. It is based on three main areas: a zero suicide model based on numerous prevention tools (universal or selective), ensuring hospitals have the support needed to review and improve the physical environment, and to improve data collection on adverse events (to allow for positive feedback for preventing similar events occurring). With the zero adverse event goal, the Children's National Medical Center in the USA has reduced the number of serious safety events by 70% in 5 years.

As for all treatment, the patients' life plan must always be considered, especially for the elderly in homes.

Finally, it is also necessary to improve treatment to support carers, teams and families in these traumatic situations.

Key messages

- **Always remember to screen for suicide risk.**
- **Remember to detect mood disorders.**
- **Remember to inform about existing support schemes (examples: VigilanS[2], SOS Amitié France[3] etc.).**
- **Do not forget postvention[4].**

Focus on patient safety collection

The "Focus on patient safety" collection aims to draw the attention of and raise awareness among healthcare professionals as to risk management. Each focus covers a specific and recurrent risk based on care-related adverse events, identified and selected from national care-related serious adverse event reporting databases or doctors' accreditation. This focus looks at suicide attempts with and without death, reported in the trSAE feedback database. The large majority of events reported are reported by healthcare and medico-social establishments, but some occur during standard private care, especially during times of vulnerability like leave. This guide relates events with which healthcare professionals have been confronted and which are always associated with a series of dysfunctions.

Find out more:

- Understanding treatment-related serious adverse events (trSAEs)
  www.has-sante.fr/jcms/c_2787338/fr/comprendre-les evenements-indesirables-graves-eigs
- Focus on patient safety
  www.has-sante.fr/jcms/p_3240311/fr/flash-securitepatient
- Feedback on treatment-related serious adverse events (TRSAEs)
  www.has-sante.fr/jcms/p_3309996/fr/rapport-annuel-d-activite-2020-sur-les-evenements-indesirables-graves-associes-a-des-soins-eigs
- French National Authority for Health. Suicidal thoughts and behaviour in children and adolescents: prevention, detection, assessment, management
  www.has-sante.fr/jcms/p_3288864/fr/idees-et-conduites-suicidaires-chez-l-enfant-et-l-adolescent-prevention-reperage-evaluation-et-prise-en-charge
- French National Authority for Health. Depression in adults – Screening and initial treatment
  www.has-sante.fr/jcms/pprd_2974237/fr/depression-de-l-adulte-reperage-et-prise-en-charge-initiale
- Ontario Hospital Association. Strengthening Suicide Prevention in Ontario Hospitals. Toronto: OHA; 2017.
- Szanto K, Whitman K. Improving Social Connections to Reduce Suicide Risk: A Promising Intervention Target? Am J Geriatr Psychiatry 2021;29(8):801-3.
- Report by the Standards Council of Canada. Suicide prevention. People-centred care; 2020.
- VigilanS alert programme - French Ministry of Solidarity and Health
  solidarites-sante.gouv.fr/prevention-en-sante/sante-mentale/la-prevention-du-suicide/article/le-dispositif-de-recontact-vigilans

1. *www.has-sante.fr/upload/docs/application/pdf/2017-10/depression_adulte_argumentaire_diagnostic.pdf*
2. National suicide prevention number: 31 14.
3. SOS Amitié France number: +33 (0)1 40 09 15 22.
4. Postvention includes actions developed by, with or for suicide survivors, in the aim of facilitating their recovery, and to prevent negative outcomes, including suicide attempts – *www.infosuicide.org/guide/postvention/*

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