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## Introduction

Death by suicide exists on a continuum that takes on board other behaviours which involve risk taking, cognitions that are intrusive and distressing, self harm and gestures of hopelessness and helplessness (Nicholas and Golden 2001). The majority of suicides among users of mental health services involve those categorised as 'in contact within the preceding year' (National Confidential Inquiry 2006). However some 155 completed suicides per year in England (National Confidential Inquiry 2006) and 25 per year in Scotland (Mental Welfare Commission For Scotland 2005) involve 'in-patients'. The bulk of such suicides occur though 'off ward' (National Confidential Inquiry 2006) However, these include suicides completed in those whose absence from the ward has been approved or in those who have absconded.

The work of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness has served to draw attention to the issue of suicide amongst users of mental health services including in-patient and provided the basis for a series of recommendations aimed at improving practice (Appleby et al. 2001, National Institute for Mental Health England 2003). Some of the recommendations such as those regarding the elimination of ligature points reflect the high frequency of completed suicide by hanging in in-patients and are perhaps notable only for being seen as necessary rather than already a *fait accompli* in the relevant settings. It has been argued however, that underlying many of the recommendations produced by the National Confidential Inquiry is an implicit view on the causes of suicide. Holloway (2002) suggests that such events '*represent a failure in the management of risk by practitioners*' and consequently that, further and/or improved training in risk management is desirable.

In attempting to prevent suicide by in-patients many services in response to perceived pressure to deliver the undeliverable i.e. a service free from suicides and in fear of the consequences of such events in terms of public approbation and potential litigation appear to have adopted a peculiarly inappropriate interpretation of the concept of risk in relation to suicide (Harrison 1997). The result, in some services, has been the increased use of 'mechanical' strategies to manage suicide risk by increasing the numbers of patients placed on higher levels of observation and the use of locked doors (or staff monitored exits which amounts to the same thing!) to prevent absconding resulting in suicide (Cutcliffe and Barker 2002).

The nature of this response can actually be argued to stem in part from the misuse of the term risk in this context which when considering the likelihood of an *individual* imminently attempting to take their own life is actually fundamentally misleading. The use of the term risk is historically restricted to 'conditions in which the probability estimates of an event' are known or knowable (Lupton 1999). In contrast, '*uncertainty*', applied '*when probabilities were inestimable*' (Lupton 1999). It was only during the latter part of the 19<sup>th</sup> century that risk became increasingly used to '*refer to undesirable events or outcomes*' (Stalker, 2003). The reality is however, that in working with service users in in-patient settings who are experiencing often acute crisis we are dealing not with outcomes estimable with any degree of known probability but instead with uncertainty and ambiguity. We are 'uncertain' precisely because the probability of a given individual patient committing suicide over a given time frame cannot be reliably estimated unless we ensue via intrusive and/or restrictive measures that they cannot attempt suicide during the period in question. Even then such strategies may be all too fallible (Gournay and Bowers 2000).

## **AIMS**

In the light of such concerns it seems timely to review what we know about the prediction and management of suicidal behaviour by in-patients and to reflect upon the implications of that literature for prevention. This paper will therefore firstly, review what have been described as the static predictors of suicide in acute in-patient care and will then consider alternative dynamic phenomenological perspectives on risk assessment and management with service users who may be considering using suicidal behaviour as a coping strategy.

### **Traditional approaches to suicide prediction and prevention**

It has been suggested that 'risk assessment' for suicide in an in-patient context requires the systematic collection of objective data particularly in relation to long term risk factors (Mental Health Reference Group, 2000). A number of risk factors are included in traditional risk profiles for suicide. These include suicidal behaviour, suicidal thoughts, hopelessness, patient diagnosis, gender and previous admission history. These factors function as predictors of suicide over the long term, i.e. years or months as opposed to days or even hours (short term). The following section discusses each of these traditional factors briefly, outlining the rationale for their inclusion in traditional risk profiles

### **Cultural Dimensions of Suicide**

Suicide rates can indicate wide variation both internationally and locally between different religious and ethnic groups mediated by issues of poverty, age, social class, gender and sexuality. Such cultural influences may have a significant influence on the immediate phenomena of inpatient suicide locally and on the individuals understanding of the reasons for their current distress.

### **Previous Suicidal Behaviour**

The most significant risk factor for predicting future suicide is generally considered to be a history of suicidal behaviour. A history of 1 or more suicide attempts is frequently cited as the most significant risk factor for future suicide and has been shown to be a strong discriminatory factor between suicide cases and controls (Roy and Draper, 1995; Sharma *et al*, 1998; Modestin *et al*, 1992). Judging the degree of actual suicidal intent is however not always easy and Hawton (1987) has suggested that when attempting to assess future risk a key theme to explore is the individuals reactions to failed suicide attempts.

### **Suicidal Behaviour during current admission**

Suicidal behaviours occurring throughout admission are strongly related to completed suicide and the strongest predictors of future in-patient attempts (Modestin *et al* 1992). Such behaviours will however, commonly reflect suicidal thoughts whether overt or covert. The extent to which the presentation of suicidal thoughts is a reliable indicator of immediate (i.e. short term risk) is always questionable because such thoughts do not exist in a vacuum but may co-exist with beliefs about the potential harm or distress that suicide might cause to a family member. The result may be fluctuating ambiguity regarding the desirability or otherwise of suicide (Runeson, 2002).

### **The role of hopelessness in suicide**

The importance of hopelessness as a long term predictor of suicide is now widely acknowledged (Beck *et al* 1985). Its predictive validity is however better in the long term, i.e. during follow up years 2-10, than in the short term, i.e. within 1 year of follow up Fawcett *et al* (1990). In practice, scales measuring the degree of hopelessness and other symptom scales such as the Beck's Depression Inventory (BDI), when used with in-patients, typically identify excessive numbers of 'false positives'. This means they identify many more service users as at high risk of committing suicide than will actually do so and are thus insufficiently specific to be used to inform any individual risk management strategy (Caldwell and Gottesman, 1990). However, as a construct hopelessness is clearly useful for developing an awareness of *psychological* factors in suicide and has been shown to have a stronger association with suicide than diagnostic factors such as depression (Beck *et al*, 1985; Minkoff *et al*, 1973; Wetzel *et al*, 1976)

## **Diagnostic factors**

The diagnostic categories most commonly associated with inpatient suicides include Affective Disorders (42%), Schizophrenia (20%) and Personality disorders (11%) (DoH, 2001). Because of the relatively high risk of suicide associated with affective disorders and schizophrenia, much of the literature draws our attention to these 2 categories. The risk associated with depression is particularly emphasised with many authors highlighting the risk associated with both the unipolar and bipolar subtype (Guze and Robins, 1970; Goldney, 1985). Positive symptoms of schizophrenia (command hallucinations and delusions) have been found to precipitate suicide in some service users (Levy and Southcombe 1953; Roose et al 1983). However, it has been suggested that the high rates of suicide observed in association with schizophrenia are more a function of co-morbid depression than the symptoms of schizophrenia. (Roy et al, 1986).

## **Gender**

Male inpatient suicides represent 64% of inpatient deaths in the National Confidential Inquiry study (DoH, 2001). However, like other diagnostic factors, patient sex may be best regarded as part of a necessary framework for establishing the overall likelihood of suicidal behaviour, rather than an effective predictor of individual suicides (Hawton, 1987).

The factors discussed so far can be appropriately described as 'patient-specific' factors (Pirkis *et al*, 2002) in that they are characteristics of service users, albeit at a group rather than individual level. In contrast, 'treatment based' factors related to the nature and duration of treatment including the course of hospitalisation while less well documented, also seem to be strongly associated with suicide risk (Rossau and Mortensen, 1997).

## **Previous Admission Histories**

Previous admissions to psychiatric care may increase the risk of completing suicide. Suicide risk clearly increases statistically as the number of previous admissions rise (Goh *et al*, 1989, DoH, 2001; De Hert *et al*, 2001). Multiple admissions are of course related to the individual previous response to treatment and in part a reflection of their social networks and life circumstances.

## **Time after admission**

Suicides during admission have been suggested to peak twice. Firstly during early admission, particularly in the first week which is perhaps reflective of an acute presentation when 24-44% of deaths may occur. (DoH, 2001). A second peak is suggested to occur after 1 year of admission accounting for between 19-42% of suicides in some studies (Roy and Draper, 1995). Such differences in distribution will reflect differences in causation. Both social isolation (Crammer, 1984) and discharge planning (Roy and Draper, 1995) may function as causal factors in 'later' suicide.

## **Practical Implications of Risk Factors**

The factors discussed thus far are predominantly 'group-level' characteristics, shared by many service users and largely static i.e. they may change either not at all or only slightly during admission (Crammer, 1984). These factors can be used to construct a model for risk assessment. However, despite the fact that the idea of such a tool may appear intuitively attractive, its ability to reliably estimate the potential for imminent suicide in any individual patient is very limited (Caldwell and Gottesman, 1990). The problem of how to assess in order to generate reliable, stable and valid predictions of risk is, it appears, actually wholly incapable of being resolved by current models of risk assessment. Ironically the relative infrequency of suicide among in-patient populations hinders the identification of statistically robust risk factors for completed suicide among in-patients which might have clinical utility in risk assessment (Powell et al., 2000).

Suicidal crisis can and fortunately often do, involve ambiguity in service users as to their desire to suicide. Such ambiguity is indeed the crucial protective factor. The extent and nature of motivation both for and against suicide are however, not static but rather fluid and dynamic sometimes varying rapidly. This suggests that we may need to consider risk in a more fluid and dynamic way. A clinically useful 'tool' in such circumstances becomes thus not one which attempts to predict imminent risk but rather one that assists in mapping the service users reasons for choosing suicide versus continuing to live as a precursor for active, structured, collaborative engagement. Suicidal tendencies (such as intent and ideation) can fluctuate rapidly during the course of hospitalisation, meaning an examination of a history of previous attempts might tell us very little about the immediate risk of suicide, particularly if the attempts occurred some time prior to hospitalisation (Cullberg *et al*, 1988).

### **A phenomenological approach to risk**

However a number of more dynamic factors potentially predictive of suicide have been identified in the literature and their utility will now be discussed.

### **Clinical Improvement**

Data from the National Confidential Inquiry showed that 80% of service users who committed suicide were considered to be at low or no immediate risk of suicide (DoH, 2001). Symptomatic improvement is manifestly therefore not a sufficiently robust indicator of a resolved suicidal crisis (Morgan and Stanton, 1997). The emergence of clinical improvement has been reported in service users with particular diagnoses, notably during the mixed state of bipolar disorder (Winokur *et al*, 1969) and during early stages of remission from severe depression (Schweizer *et al*, 1988). As risk perceptions decrease, staff may cease to routinely ask about suicide and reduce vigilance. Discerning 'superficial' improvement in service users who may choose not to reveal their true thoughts, from genuine improvement, evidencing the resolution of a suicidal crisis, presents a critical challenge for clinicians.

### **Insight**

Conceptual ambiguities and the lack of a standardized measure have rendered the study of insight in psychiatric disorders particularly problematic (Amador, 1993). However its potential for helping to reduce the likelihood of suicide has been recently highlighted. Recent studies have suggested that increased suicidality is not associated with a general awareness of illness, but rather to specific aspects of increased insight, namely the awareness of need for treatment (Schwartz 1999), the social consequences of the disorder (Schwartz, 2000) and negative symptoms and delusions (Amador, 1996). In contrast, poor general awareness and attribution (Amador, 1993) and poor awareness of negative symptoms (Rossi *et al*. 2000) have been associated with poor outcomes, which may indirectly increase suicide risk.

### **Co-morbid Substance Misuse**

Comorbid substance misuse exacerbates the risk of suicide with histories of both drug and alcohol misuse reported in approximately 33% of inpatient suicide cases (DoH, 2001). Risk is also shown to be elevated for those with current misuse. The Mental Welfare Commission for Scotland (1998) reported that a quarter of inpatient suicides had *current* drug or alcohol misuse. Kamali *et al* (2000) reported that suicidal ideation and suicidal attempts were more prevalent among schizophrenic service users with current co-morbid substance misuse (20%) compared to 40% of those with lifetime substance misuse and non misusers. Changes in patterns of misuse may suggest increased risk in the short term, with 24% of all National Confidential Inquiry suicide cases demonstrating an *increase* in alcohol or drug intake in the 3 months prior to suicide (DoH, 2001).

An awareness of the role of dynamic factors is therefore clearly important in working with service users who are suicidal. However, even the incorporation of such factors into risk assessments in and of itself may offer little in terms of improving the validity of the process. Such difficulties have led to an interest in whether alternative approaches to risk management focused not on statistical models but rather the lived experiences of service users might offer scope for improved outcomes. Not in any improved accuracy in predicting the risk of suicide but rather in terms of decreasing the likelihood of suicide during the in-patient episode and perhaps even immediately post discharge where the risk of completed suicide peaks (National Confidential Inquiry 2006).

### **Not managing risk: Individualising assessment**

Such perspectives reflect a phenomenological perspective on suicide which suggests that assessing the potential for suicide crucially depends on understanding an individual's reason for suicide and not committing suicide at a particular point in time. Central to this perspective is the belief that suicide is an endpoint in a trajectory following high levels of societal, intra and interpersonal stress which result in unendurable psychological pain described, compellingly by Shneidman (1993a) as "psychache". In the context of such unbearable distress suicide becomes a compelling and even attractive means of escape. Risk factors such as suicidal attempts and suicidal thoughts are expressions of distress which can exist independently and /or co-exist with underlying pathology. An understanding of the sources of stress, particularly at an individual level is therefore necessary because it is the individual's idiosyncratically understood psychological anguish which is the driving force behind suicide (Shneidman, 1993b).

For some service users, addictions and/or substance dependency may serve as significant stressors. One prospective study found moderate alcohol misuse to be an acute correlate of suicide (occurring within 1 year of admission) (Fawcett *et al*, 1990). Another study reported that whilst hopelessness was the most significant predictor of lifetime suicidality, hopelessness and substance misuse were strongly related to current suicidality (Kim *et al*, 2002).

Interpersonal difficulties are commonly cited precipitants of suicide. Relationship difficulties occurred in 50% of all National Confidential Inquiry cases within 3 months prior to suicide (DoH, 2001). It is of course not the loss of the relationship per se which is a risk factor at an individual level but the level of distress such a loss evokes. Jobes (2000) has recently called for a radical shift in our approach to working with suicidal service users. He argues that current approaches to therapy implicitly address suicide as a function of the individual's mental illness. Jobes' (2000) premise is that suicide is essentially 'relational' in that it is the '*presence and/or absence of certain key relationships*' which mediate the risk of suicide. Such relationships can include those with staff working in in-patient services (Watts and Morgan 1994).

Phenomenology rejects prior assumptions about causation in favour of an investigation of the meanings that the person involved attaches to the internal and external events that constitute their life experience both consciously and unconsciously (Cutcliffe, 2003). A phenomenological, as opposed to a narrow bio-medical model of suicide, seeks therefore to ascertain in partnership with the service user their reasons for living and dying (Jobes 2000). These reasons, revisited regularly, form the basis of a care plan which focuses not on the treatment of the disorder but on addressing explicitly these issues which the patient gives for wishing to kill themselves as treatment priorities, whilst maintaining and expanding on the reasons for the patient's ambiguity about suicide (i.e. their reasons for not committing suicide). Practice is focused on changing the balance in favour of living with suicide seen not as a symptom of a mental illness which can be addressed via treatment of the supposedly underlying disorder but simply as a coping strategy '*albeit a limited and problematic one*' (Jobes 2000:11). Therapy aims to supplant the functional role of suicide with more adaptive means of coping.

Chiles and Strosahl (1995) suggest that the presence of three cognitive features can evoke serious consideration of suicide as a coping strategy.

- **Intolerable** i.e. unbearable pain whether physical or psychological
- **Interminable** i.e. the pain is experienced in the context of a life situation which is seen as inevitably likely to continue.
- **Inescapable** i.e. the situation is one in which the individual concerned believe themselves powerless to change, such that the situation cannot be changed and that no coping mechanism or strategy attempted or known will be sufficient to materially change it.

The challenge in such circumstances is to engage constructively with the service user in order to enable them to want, and be able, to say yes to life (Degan 1996) cited by Barker 2003). Williams and Pollok (2001) suggests that while a sense of loss, rejection and defeat is common in depression, it is only when such defeat is perceived as inescapable that the individual finds themselves 'entrapped' that suicidal ideation and behaviour occurs. At the point at which an individual is most hopeless, they would normally attempt to generate alternative ways of coping with their problems (Sidley et al 1997). However, research with suicidal service users suggests that they do significantly worse, in comparison to controls in simulated situations, when asked to generate appropriate problem solving strategies (Pollock and Williams, 1998). These differences are not a function of depression (Pollock and Williams, 1998). Instead it has been argued they may reflect an underlying problem in the nature of memory, that is, a general difficulty in recalling events from the past in a specific enough way to use as a guide to the present (Pollock and Williams 2001). This inability impairs their capacity to generate effective solutions to interpersonal problems and appears to persist even after recovery from depression indicating that it may function as a long-term risk factor for suicidal behaviour (Schotte and Clum, 1987, Evans et al., 1992).

Behavioural problem solving interventions have however, already clearly demonstrated their potential effectiveness with a range of client groups leading to suggestions that such interventions should be a core element of work with suicidal service users (Jobes 2000, Joiner et al. 2001). Structured problem solving assists with the development of choices and adaptive methods of solving problems (Salkovskis, et al 1990) addressing directly thereby the pathological cognitive scenario discussed by Chiles and Strosahl (1995). Problem solving approaches are based on the premise that 'Symptoms' can be seen as being caused by everyday situations/problems. If the problems can be resolved, symptoms can improve. Potentially helpful resolutions can be achieved through problem solving techniques. The intervention is structured and directed towards the achievement of specific goals. Behavioural problem solving skills despite offering an effective treatment strategy for many service users, perhaps complement rather than directly challenge the continuing dominance of the bio-medical model in many practice settings.

This is in marked contrast to the recent development of The Tidal Model which states that people can provide a mutually satisfying definition of the current situation they are experiencing without reference to the discourse of mental illness (Barker 2002). The model aims to ensure that the responsibility for the positive changes remain in the ownership of the person (Barker 2003). The special nature of **the** interpersonal relationship is central to any progress that is made and in this sense echoes Jobes' assertions of the central importance of relationships (Mynors-Wallis 2001). The Model postulates that people can recover a feeling of well being from a negative and overwhelming situation that has been impacted on by the likes of stress and illness (Clay 2003). It offers a consistent non medical model of distress based on the metaphor of a sea journey in place of the experience of '*conflicting and often disempowering methods, and inconsistent, confusing and judgemental explanatory systems*' (Bloom 1997:10) that can often characterise the service users experience of care. The model seeks to promote engagement with the service user and practitioner working together to discuss and negotiate the priorities of care, optimum methods of maintaining safety and strengthen feelings of well being (Barker and Buchanan-Barker 2004).

## **The Role of the Organisation**

Despite rapid developments in alternatives to admission such as intensive home support in-patient services are likely to continue to play an important role in the management of acute crisis. Arguments for a change of emphasis from observation to engagement are not new (Clinical Resource and Audit Group 2002). Case studies report that changing the emphasis from observation to engagement has in some settings been associated with no increases in suicides and reductions in behaviours such as absconding and violence towards staff (Dodds and Bowles 2001). However, where service cultures are defensive 'low skill' models of risk management, albeit intensive in staff costs when observation is used frequently with little regard for its therapeutic value' can be seen as the 'safe' if not the only option. There are however, now a range of alternative models of care and interventions. Such 'high skill' alternatives involve more co-ordinated and service user focussed care. Such approaches have though the potential to be overwhelming and threatening to the staff members involved if they do not feel they have the appropriate support and skills to cope to promote, implement and manage the significant consequences of the deep changes required. Collaborative working with service users in in-patient services, who may be contemplating using suicide as a coping strategy challenges services, managers, practitioners and also educationalists to deliver on an agenda of recovery and to strive to reject reductionist low skill models of risk management.

## **Conclusion**

Suicide prediction (as opposed to prevention) research has actually made little progress in the last decade (Goldney, 2000). As practitioners we should openly acknowledge that we remain unable to predict accurately the imminent suicide risk in individual persons (Simon, 2006). This is not an admission of failure but rather simply a reflection of the reality that suicide may not be feasibly predictable at the level of the individual particularly over the short terms i.e. the minutes, hours and days of the in-patient admission. With that perfect vision lent only by hindsight, we have perhaps been looking in the wrong direction for some considerable time in directing our efforts at trying to improve the prediction and management of risk using increasingly complex models as opposed to developing and promoting models and interventions that may hold more promise by aggressively addressing the individual's unique reasons for suicide. Initial evaluations of both Jobe's CAMs model and Barker's Tidal model (Stevenson et al. 2002) discussed in this paper, while limited methodologically and therefore far from conclusive, are distinctly encouraging. However, reframing the task of inpatient care in relation to suicide prevention does not require the adoption of a specific model but it does demand a change in our philosophy and our practice.

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