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CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

How Should Suicide Prevention and Healing Be Expressed as Goals of Inpatient Psychiatric Unit Design?

Jennifer T. McIntosh, PhD, RN, CNE, PMH-BC, NEA-BC and Mona Shattell, PhD, RN

Abstract
Inpatient psychiatric units' policies and restrictions for suicide prevention can exacerbate harm rather than promote wellness. This commentary on a case examines ethics concerns about prevention policies that overly rely on liberty restriction, as expressed in the design of inpatient psychiatric unit structures and spaces. Person-centered approaches to design are key to promoting healing and preserving dignity.

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Case

KA is a 44-year-old patient with a history of major depressive disorder who is hospitalized for suicidal ideation. On day 3 of hospitalization, KA would like to spend time writing letters and journaling and asks Dr B for pens. Dr B is aware of the hospital policy that restricts access to pens for patients with active suicidal ideation due to the risk of self-harm. He also knows that writing would likely be therapeutic for KA. Dr B wonders how to respond.

Commentary

Mental illness is associated with an increased risk of suicide.[1,2] When individuals are admitted to an inpatient psychiatric unit, they become even more vulnerable, given the burden of their disease and the clinical environment. Hospitalization can highlight their experiences of trauma and stigma, and their presenting symptoms may also contribute to the loss of autonomy, social role, and overall control that are associated with inpatient admission to a psychiatric unit.

The case of KA and Dr B illustrates a common dilemma: to provide a safe environment that also facilitates healing. As experienced acute care psychiatric mental health nurses who have worked on these units and had to grapple with these issues firsthand, we understand well the delicate balance between safety and healing. In the case presented here, Dr B realizes that KA's request for a pen to write letters and to journal can be therapeutic. However, Dr B faces the dilemma of whether to transgress the boundaries

established by a hospital policy that prevents persons with active suicidal ideation from using writing utensils, such as pens. Whether Dr B chooses to explore this dilemma with the care team and advocate for KA's use of a writing utensil or chooses to comply with the restrictive policy will significantly impact KA—for better or for worse. Or perhaps Dr B is contemplating a compromise: collaborating with KA and the team to design an individualized plan of care with interventions that are intended to convey compassion and facilitate KA's healing while ensuring KA's safety.

Balancing Safety With Autonomy

In recent years, the need to reduce harm risks, such as suicide, in inpatient psychiatric units has emerged.[3,4] Despite interventions to reduce harm—such as multidisciplinary approaches to care, the use of standardized suicide risk assessment tools, psychopharmacology, and therapy— inpatient admission to a psychiatric unit is a significant risk factor for suicide.[3] Some posit that the circumstances leading to a patient's admission, such as suicidality, mental illness, and social factors, may increase their risk for suicide while an inpatient in the hospital.[3] Organizational-related factors, such as the built environment, the therapeutic effects of the milieu, and staffing may also impact inpatient suicidality. One meta-analysis estimated the number of admissions per inpatient suicide to be 676,[5] or the proportion of inpatient suicides to be 0.15% of all psychiatric admissions, and other studies have put the estimate at 0.1% to 0.4%.[6] While these incidence estimates might seem small, inpatient suicides account for approximately 5% of all suicides.[7]

There is no consensus on measures for preventing the occurrence of inpatient suicides.[8] Although the restriction of personal items, such as writing utensils, in inpatient psychiatric units is common, it is unclear whether these personal items pose a safety risk for individuals with active suicidal ideation or whether they have been used for suicide. In fact, published studies on inpatient suicide identify *hanging* as the most common method of suicide in inpatient psychiatric units,[9,10,11,12] with bathrooms and bedrooms being the most common locations for suicide.[12]

By its nature, admission to an inpatient psychiatric unit limits an individual's right to self-determination and self-governance. Physicians and nurses have an obligation to protect patients from harm. Yet the practice of exercising excessive caution that restricts patients in inpatient psychiatric units from accessing basic objects, such as writing utensils, may be more harmful than protective. Dr B thus may be concerned about violating the principle of nonmaleficence, or the obligation to abstain from causing harm to others,[13] if he does not (and the psychiatric nurses and administrators do not) protect and defend KA's right to receive respectful and dignified care.

Reconciling Safety and Healing

It is important for organizational leaders to critically examine their policies to ensure that those that are meant to protect patient safety do not result in the unintended consequence of causing harm and impeding healing, since the ultimate goal is to prevent harm and to remove conditions that may be harmful.[13] The assumption that a choice must be made between safety and healing can be detrimental. Moreover, the lack of consensus on reliable risk assessment tools results in health care professionals either underestimating or overestimating risk of self-harm.[8] The overestimation of patients' risk of suicide is often associated with excessive caution on the part of staff, which, as mentioned above, deprives patients of their fundamental rights and access to therapeutic interventions.[8]

In KA's case, the excessive caution resulting from the overestimation of risks likely led to the policy of restricting use of writing utensils for individuals with acute suicidal ideation. While one may argue that restricting the use of writing utensils is in accordance with the principle of beneficence, its implications for a person's healing are worth considering. In the case of KA, an assessment of the possible therapeutic benefit of writing vs the increased risk of suicide from the writing utensil should be explored. Therefore, the approach to KA's care should be individualized and not "one size fits all."

Taking an individualized approach to care can augment safety while promoting healing. An example of a general approach that emphasizes safety is the US Department of Veterans Affairs hospitals, which reduced inpatient suicides by 82% over a 7-year period by managing environmental risks associated with inpatient suicide with the implementation of a Mental Health Environment of Care Checklist.[14] This 114-item checklist includes questions (items) such as counting flatware before and after meals, eliminating possible anchor points for hanging, and examining potential hazards on the unit.[14] However, taking an individualized approach, it can be argued that even when deemed to be risky for use, some restricted items, such as eating utensils (and pens?) can be made available to patients under certain circumstances and with caution and possible modifications (rather than being completely excluded or restricted).

Integrating Safety Into Healing to Inform Policy

In the United States, it is estimated that 1500 suicides are completed in inpatient psychiatric units annually.[11] According to the National Violent Death Reporting System (NVDRS), 76.7% of hospital suicides were associated with a psychiatric admission in 2015, amounting to an estimated rate of 3.2 inpatient suicides per 100 000 hospital admissions.[12] Although one death by suicide is too many, it is important to evaluate the reported methods by which deaths by suicide occur in the inpatient psychiatric units globally in order to inform policies and procedures for suicide prevention in inpatient psychiatric units.

Let's look at the data. In the United Kingdom, hanging was identified as the most common method of suicide between 1999 and 2007.[9] In Switzerland, the most frequently used methods of suicide in inpatient units between 2000 and 2010 were hanging, self-defenestration, and voluntary drug overdose.[10] An analysis of US Department of Veterans Affairs hospital data found that hanging was the method used in 43.6% of suicides and suicide attempts.[11] Other methods reported were cutting (22.6%); strangulation (15.6%), and drug overdose (7.8%).[11] More recently, Williams et al reported that hanging was the most common method of inpatient suicide in the United States based on data in the NVDRS (33 of 46 suicides, or 71.7%) and the Joint Commission Sentinel Event Database (137 of 195 suicides, or 70.3%).[12] Common inpatient hospital locations were patient bathrooms (50.8%), bedrooms (33.8%), closets (4.1), and showers (3.6%). It is important to note that an older report estimated that one-third of deaths by suicide in US inpatient units occur while patients are on either one-to-one observation or every-15-minute checks.[15] While these data are significant, it should be highlighted that the availability of more current data on inpatient psychiatric unit suicides is limited. Furthermore, the coding of inpatient suicides often lack details that could support contextual factors, such as the observation status of the individual at the time of the suicide.[12]

Based on the above reports, it is critical that policies aimed at reducing patient harm do not unintentionally cause harm by impeding healing. While policies should be informed by research and practice, they must also incorporate provisions for an individualized or person-centered approach that engages the patient (and caregivers), as well as the treatment team, in decision making about treatment planning. This approach needs to focus not only on physical safety, such as ligature risks in private spaces, but also on the emotional safety and well-being of individuals.

Conclusion

It is the responsibility of health care systems, physicians, nurses, and others who work within inpatient psychiatric units to maintain the safety of individuals in their care while also promoting patients' healing in a respectful, compassionate, and dignified milieu. Patients should not be faced with the burden of sacrificing their basic needs to ensure their own safety, and physicians and nurses should have and use better tools to assess risks and to design care and treatment that does not follow a one-size-fits-all approach.

To support new interventions for promoting safety on inpatient psychiatric units, we suggest that organizations take a multidimensional approach to promoting safety while also supporting healing. In addition to providing ethically sound, recovery-oriented care, such as trauma-informed care, organizations should instantiate a just culture to empower their employees to deliver individualized care informed by the patient's individuality, characteristics, clinical presentation and diagnosis, identified risk factors, lived experiences, and personal preferences. Dr B should not have to choose between safety and healing. What are some alternatives to the yes or no question of whether or not to allow writing utensils? Can KA use a pen or pencil while being monitored? The issue needs to be discussed among members of the care team with consideration of both practical issues—can it, or how can it, be done—and ethical issues—patient autonomy, nonmaleficence, beneficence, and justice.

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Jennifer T. McIntosh, PhD, RN, CNE, PMH-BC, NEA-BC is a lecturer at the Yale School of Nursing in Orange, Connecticut. She was formerly the director of patient care at a large facility in New York that provides inpatient and outpatient psychiatric and substance use disorder treatments. Her published work and research interests focus on the care of individuals with mental illness.

Mona Shattell, PhD, RN is the chair of the Department of Nursing Systems, the Hugh F. and Jeannette G. McKean Endowed Chair, and a professor at the University of Central Florida in Orlando. She is also the editor of the *Journal of Psychosocial Nursing and Mental Health Services* and the author of more than 150 journal articles and book chapters. Her published work focuses on patient-clinician relationships and various environments of care.

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