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Patient Safety Tip of the Week

April 15, 2025

Hospital Suicides

Suicide that occurs in a hospital is obviously devastating for the family and loved ones of the patient who commits suicide. But it is also devastating for hospital staff and the community in general. We've done many columns on suicide that occurs either in behavioral health facilities or in general hospitals. But we were surprised to see that we had not done one in almost 4 years. A recent Medscape article (Lavaud 2025) reminded us that this might be a good time to again discuss the subject.

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Stephanie Lavaud discussed a presentation by French psychiatrist Pierre-Emmanuel Michels at a psychiatry conference held recently in Paris (Lavaud 2025). (Interestingly, Lavaud used several editorial tools, including AI, to translate the article from the French edition of Medscape.) Michels noted that epidemiological studies from the United States and Sweden found that the suicide rate in psychiatric hospitals is 50-72 times higher than that in the general population. The studies also found a high suicide risk at the start of hospitalization (77%), and an extremely high suicide rate immediately after discharge, particularly within the first week post-discharge. 73% of suicides occurred in psychiatric units. Hanging was the most common method (70%) in all settings.

Nearly one-third of deaths by suicide occur while the patient is on 15-minute observations (Mills 2008). A study of suicide in patients admitted to psychiatric hospitals in Sweden (Lindberg 2024) found that 17% of patient who committed suicide were on 15-minute checks and one-third were on agreed leave at the time of the suicide.

Michels noted identified risk factors for suicide include a family history of suicide, previous suicide attempts or self-harm, despair, guilt, and depression. The risk is significantly higher among individuals who express suicidal thoughts and the odds are 2.35 times greater for those with mood disorders (Hubers 2018).

Michels analyzed almost 800 cases of hospital suicide and identified five main contributing factors:

1. Inadequate security — unsafe rooms or furniture

2. Communication failures — within and between hospitals and with families
3. Staff-related issues include insufficient training and excessive workload
4. Service organization — lack of clear suicide risk assessment protocols, limited psychiatric referral access, and staff shortages
5. Patient-related factors — refusal of care, social isolation

Risks in the emergency department are a little different. A study of 184 self-harm incidents involving 118 unique patients (Lawrence 2022) found suicidal intent was present in only a minority of incidents. Other contributing factors included psychosis, intoxication, aggression, managing distress, communication, and manipulation. A wide variety of self-harm methods were used. In the emergency department, patients often do not indicate suicidal ideation. Therefore, it is important to restrict access to lethal means in the ED.

We've discussed the VA's Mental Health Environment of Care Checklist (MHEOCC) in many columns (most recently in our January 29, 2019 "National Patient Safety Goal for Suicide Prevention"). We've also previously mentioned 2 publications (Watts 2016, Mills 2016) showing sustained results from implementation of the Mental Health Environment of Care Checklist (MHEOCC). The checklist and program became mandated at all VA hospitals in 2007. Inpatient suicide rates in VA hospitals dropped from 4.2 per 100,000 admissions to 0.74 per 100,000 admissions from 2000 to 2015. The reduction in suicides coincided with introduction of the MHEOCC and has been sustained since implementation in 2007. Those authors stress that the physical changes brought about by the MHEOCC likely have a bigger impact on inpatient suicide reduction than the numerous other interventions used.

Since hanging is typically the most common mode of suicide in hospitals, we need to make sure the environment does not contain structures or items to which ligatures might be attached. While behavioral health units focus on using ligature-resistant hardware, other parts of hospitals do not. We can almost always find a potential means for hanging oneself in bathrooms in radiology suites or emergency departments. Hence, we emphasize that "Ticket to Ride" checklists for intrahospital transport have a section for considering patients who might be at risk for suicide.

Suicides in general hospital units often occur because rooms do not meet the MHEOCC standards and because staff observing patients are often not adequately trained for that task. See our columns below on falls or jumps from hospital windows for more details.

Some of our prior columns on preventing hospital suicides:

- January 6, 2009 "Preventing Inpatient Suicides"
- February 9, 2010 "More on Preventing Inpatient Suicides"
- March 16, 2010 "A Patient Safety Scavenger Hunt"
- December 2010 "Joint Commission Sentinel Event Alert on Suicide Risk Outside Psych Units"
- September 27, 2011 "The Canadian Suicide Risk Assessment Guide"

- December 2011 “Columbia Suicide Severity Rating Scale”
- July 2012 “VA Checklist Reduces Suicide Risk”
- August 2013 “Suicide Attempts on Med/Surg Units”
- August 25, 2015 “Checklist for Intrahospital Transport”
- October 6, 2015 “Suicide and Other Violent Inpatient Deaths”
- March 2016 “TJC Sentinel Event Alert on Preventing Suicide”
- April 12, 2016 “Falls from Hospital Windows”
- February 14, 2017 “Yet More Jumps from Hospital Windows”
- August 29, 2017 “Suicide in the Bathroom”
- December 12, 2017 “Joint Commission on Suicide Prevention”
- July 10, 2018 “Another Jump from a Hospital Window”
- September 18, 2018 “More on Hospital Suicides”
- January 22, 2019 “Wandering Patients”
- January 29, 2019 “National Patient Safety Goal for Suicide Prevention”
- July 30, 2019 “Lessons from Hospital Suicide Attempts”
- September 3, 2019 “Lessons from an Inpatient Suicide”
- August 11, 2020 “Above-Door Alarms to Prevent Suicides”
- September 22, 2020 “VA RCA’s: Suicide Risks Vary by Site”
- February 2, 2021 “MGH Protocols Reduce Risk of Self-Harm in ED”
- June 22, 2021 “Remotely Monitoring Suicidal Patients in Non-Behavioral Health Areas”

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Mental Health Environment of Care Checklist (VA)
http://www.patientsafety.va.gov/docs/MHEOCCed092016508.xlsx
http://www.patientsafety.va.gov/professionals/onthejob/mentalhealth.asp

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Mills PD. Use of the Mental Health Environment of Care Checklist to Reduce the Rate of Inpatient Suicide in VHA. TIPS (Topics in Patient Safety) 2016; 16(3): 3-4
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