Hospitalization for persons with self-harm [2015]

SCOPING QUESTION: Is hospitalization better than no hospitalization for persons with self-harm?

Background

Hospitalization for those who deliberately self–harm and/or attempt suicide is a widely spread practice in order to ensure their immediate safety and reduce the recurrence of the behaviour. However with hospitalization comes a myriad of risks and pitfalls that, for some individuals, have the potential to outweigh the benefits gained by inpatient admission. While poor decision-making in regards to hospitalization has the potential for a devastating outcome, the nature of the problem makes randomized control trials ethically unfeasible. As a result, there is no literature that directly addresses this question.

Population/Intervention(s)/Comparator/Outcome(s) (PICO)

Population:	persons with acts of self-harm
Interventions:	hospitalization after suicide or self-harm attempt
Comparisons:	no hospitalization
Outcomes:	repetition of suicide attempts or self-harm, suicide mortality
	self-report of stigma experiences,
	quality of life

List of the systematic reviews identified by the search process

Search strategy

Medline, Pubmed, PsychINFO, Google Scholar, Web of Knowledge, British Medical Journal Clinical Evidence, and the Cochrane Library databases, were searched. Titles, abstracts, and reference lists were examined for relevant literature. A systematic search was conducted via PubMed to identify reports evaluating suicide prevention interventions.

Persons identified with any of the other priority conditions will receive the corresponding effective interventions within the package; this evidence profile states ADDITIONAL interventions needed regarding thoughts, plans or acts of self-harm.

Key words: Stigma, hospitalization, voluntary hospitalization, involuntary hospitalization, detainment, higher level health care, suicide, suicidal behaviour, parasuicide, attempted suicide, self-harm, deliberate self-harm, suicidal mortality, risk factors, repetition of suicidal behaviour, quality of life, dignity, human rights, social disadvantages, benefit/risk of suicide hospitalization, patient outcomes.

Inclusion and exclusion criteria

Observational studies, non-systematic reviews, and systematic reviews, in English. No limitation for year of publishing.

INCLUDED IN GRADE TABLES OR FOOTNOTES

Hawton KKE et al (1999). Psychosocial and pharmacological treatments for deliberate self harm. *Cochrane Database of Systematic reviews,* (4):CD001754.

PICO Table

Serial no.	Intervention/Comparison	Outcomes	Systematic reviews used for GRADE	Explanation
I	General hospital admission / Discharge	Repetition of self-harm	Hawton KKE et al (1999)	One systematic review identified.

Narrative description of the studies that went into the analysis

Systematic review by Hawton et al (1999) reported that the odds ratio did not indicate a beneficial effect of general hospital admission following deliberate self-harm. It is important to note that only those attempters at low risk and without immediate medical or psychiatric needs could be considered for discharge without treatment. The follow-up period of 16 weeks was relatively short.

Author	Title	Reference	Study Design	Description	Results
Hawton KKE et al (1999).	Psychosocial and pharmacological treatments for deliberate self harm and attempted suicide.	Cochrane Database of Systematic reviews, (4):CD001754.	Randomized controlled trial.	Deliberate self-harm patients with no immediate medical or psychiatric treatment needs were assigned to either general hospital admission or discharge from hospital.	The odds ratio did not indicate a beneficial effect of general hospital admission following deliberate self-harm.

GRADE Tables

Table 1
Author(s): Fleischmann A
Date: 2009-08-19
Question: Should General hospital admission vs Discharge be used in Deliberate self-harm patients?
Settings: Hospital
Bibliography: Hawton KKE et al (1999). Psychosocial and pharmacological treatments for deliberate self harm. *Cochrane Database of Systematic reviews,* (4):CD001754 (Waterhouse & Platt,1990).

Quality assessment							Summary of findings					
							No of patients		Effect		Quality	Importance
No of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	General hospital admission	Discharge	Relative (95% CI)	Absolute		
Repetition of self-harm (follow-up 16 weeks; Interview, hospital records)												
1	randomized trials	serious[1]	no serious inconsistency	serious[2]	serious[3]	none	3/38 (7.9%)	4/39 (10.3%)	RR 0.75 (0.16 to 3.53)	26 fewer per 1000 (from 86 fewer to 259 more)	⊕OOO VERY LOW	CRITICAL
								0%		0 fewer per 1000 (from 0 fewer to 0 more)		
Suicide mortality												
0	no evidence available					none	0/0 (0%)	0/0 (0%)	RR 0 (0 to 0)	0 fewer per 1000 (from 0 fewer to 0 fewer)		
								0%		0 fewer per 1000 (from 0 fewer to 0 fewer)		

[1] Single-site study.
[2] Only one study, which leaves some possibility for bias.
[3] 77 subjects, 38 in the experimental group, 39 in the control group.

Additional information that was not GRADEd

While there are no randomized controlled trials to draw conclusions from, or research that directly addresses the scoping question, there are some studies from which we can make suggestions and form hypotheses.

Author	Title	Reference	Study Design	Description	Results
Bateman A, Fonagy P (1999).	Effectiveness of partial hospitalization of borderline personality disorder: a randomized control trial.	American Journal of Psychiatry, 156:1563-9.	RCT	Compared effectiveness of partial hospitalization with standard psychiatric care (including inpatient admission rate of 90%) for 38 patients with Borderline Personality Disorder over 18 months.	There was a significant decrease in self-mutilating behaviour in the partially hospitalised group (9 to 1/6 months), with no change in the control group.
Waterhouse J, Platt S (1990).	General hospital admission in the management of parasuicide: A randomized control trial.	British Journal of Psychiatry, 156:236-42.	RCT	Parasuicides with no immediate medical or psychiatric needs were randomly allocated to hospital admission (38) or discharged home (39).	274/351 patients who presented with parasuicide required urgent medical/psychiatric treatment. The range of admission was 10-88 hours. Of the eligible patients, at 1-week and 16-week follow-ups there were no significant differences on outcome measures between the groups.
Safer DJ (1996).	A comparison of studies from the United States	Annals of Clinical Psychiatry, 8:161-8.	Literature review	Compared rates of adolescent suicide-	Of particular interest: Safer reports a median

	and Western Europe on psychiatric hospitalization referrals for youths exhibiting suicidal behaviour.			behaviour based referrals to psychiatric hospitals from emergency rooms and characteristics of these youths, in the US and Western Europe.	of 39% of youths seen in US ERs were referred to psychiatric hospitals, compared to 12% in WE. However rates of completed suicides are lower in most WE countries than in the US.
Heila H et al (2005).	Mortality among patients with schizophrenia and reduced psychiatric hospital care.	Psychological Medicine, 35:725-32.		Investigated the mortality of schizophrenia patients in compared to the entire population in Finland during the reduction of psychiatric beds during 1980–1996.	The decrease in bed numbers did not generally increase the mortality of patients with schizophrenia. However, patients in their early years of illness experienced increased mortality after the steepest bed reduction.
Schnyder U, Valach L (1997).	Suicide attempters in a psychiatric emergency room population.	General hospital psychiatry, 19:119-29.		The study compared suicidal emergency room patients to the other emergency room population.	The suicide attempters seemed to be relatively well integrated in the occupational world and in private life. However suicide attempters were significantly more often hospitalized than other emergency room

					patients. Clinicians should not automatically refer suicide attempters for inpatient treatment.
Hunt IM et al (2009).	Suicide in recently discharged psychiatric patients: a case-control study.	Psychological Medicine, 39:443–449.	Observational: prospective case-control study.	Study compared characteristics and risk factors of suicidal patients who committed suicide within 3 months after hospital discharge, relative to living suicide patients 3 months after discharge. (N = 238 in both study groups).	43% of subjects that committed suicide, did so within a month post-discharge; 47% died before a follow-up appointment. Risk factors for suicide included: history of self-harm, affective disorder diagnosis and recent release. Suicide completers were more likely to have discharged themselves; detained patients were less likely to die by suicide.
Johannessen HA et al (2009).	Changes in institutional psychiatric care and suicidal behaviour: a follow-up study of inpatient suicide attempters in Bærum, Norway.	Social Psychiatry and Psychiatric Epidemiology, 44:845-851.	Observational: retrospective cohort study.	Investigated the impact of deinstitutionalization and reduction in psychiatric beds in Norway has led to a shorted length-of stay in psychiatric hospitals, for suicide attempters. Study also looks at whether changes in length of	Length of hospital stay was not a significant predictor of repeated suicidal attempts.

				hospital stays are associated with risk of repeated suicide attempts.	
Newton AS et al (2009).	Pediatric Suicide-Related Presentations: A Systematic Review of Mental Health Care in the Emergency Department.	Annals of Emergency Medicine, 56(6): 649 – 659.	Systematic review.	Evaluated the efficacy of interventions for pediatric (age 15-18) patients, including hospital-based interventions, outpatient and community-based interventions.	Limited evidence that some hospital (emergency department) based interventions may have efficacy on subsequent patient outcomes (i.e., treatment adherence, readmissions, suicidal mortality).
Kudo K et al (2010).	Study of the outcome of suicide attempts: characteristics of hospitalization in a psychiatric ward group, critical care center group, and nonhospitalized group.	BioMedCentral Psychiatry, 10:4-12.	Observational: retrospective cohort study.	Study investigated characteristics of suicide attempt patients (N = 1348) that visited a psychiatric emergency department in Iwate, Japan. Patients were categorized into 3 groups: "hospitalization in critical care center" (HICCC), "hospitalization in psychiatric ward" (HIPW) and "non-hospitalization" (NH). Based on characteristics of each	Severity of physical condition, suicide risk, age, gender, history of suicidal behaviours, psychiatric diagnosis, severity of psychiatric condition, strength of suicidal feeling / intention, and suicide or self-harm method were some of the key factors associated with clinician's decisions to admit vs. release suicide attempt patients.

				group, authors made predictions of potential patient needs and recommendations for follow-up care (e.g., requirement for hospitalization).	
Sinclair JMA et al (2010).	Six year follow-up of a clinical sample of self-harm patients.	Journal of Affective Disorders 121(3):247–252.	Observational: prospective cohort study.	Study reported clinical outcomes (both health outcomes: morbidity, mortality and repetition of self-harm, and social outcomes: perceived health status and quality of life) of patients presenting at hospital following suicidal behaviour (N = 150 at study entry). Outcome at 18 months and 6 years post-admittance is reported. Study also attempted to identify factors associated with patient outcomes.	2.8% of patients committed suicide post-hospital admission, and overall mortality rate was elevated compared to the general population; 57.4% patients repeated self-harm. Patients also reported diminished quality of life.
Miret M et al (2011).	The Role of Suicide Risk in the Decision for Psychiatric Hospitalization After a Suicide Attempt.	Crisis, 32(2):65–73.	Observational: retrospective cohort study.	Study aimed to determine whether suicide risk is predictive of hospital admission, following a	Suicide risk (based on: past psychiatric treatment, suicidal ideation, suicide planning behaviour,

				suicide attempt. Study compared characteristics and suicide risk of suicide attempt patients who were admitted (N = 180) with those who were discharged (N = 660).	medical lethality of suicide attempt, previous suicide attempts, attitude toward the attempt, and social or family support) is partially predictive of clinicians' decisions to hospitalize suicide attempt patients. Inclusion of additional variables such as gender, previous psychiatric hospitalizations, method and time to discovery, improves the predictive value of the model.
Hayashi N et al (2012).	Post-hospitalization course and predictive signs of suicidal behaviour of suicidal patients admitted to a psychiatric hospital: a 2-year prospective follow-up study.	BioMedCentral Psychiatry, 12:186-196.	Observational: prospective cohort study.	Study reports the post-hospitalization course and the characteristics predictive of recurrence of suicidal behaviour in post-hospitalized (minimum stay: 3 days) psychiatric suicidal or self-harm patients (N = 106 at start of study; N = 96 for 2 year follow-up).	67% of suicidal patients engaged in some form of suicidal behaviour, 38% made suicide attempts, 6% engaged in completed suicides and 61% were rehospitalized within 2 years post-admission. 61% of patients were Younger age, childhood maltreatment, history of suicidal behaviour,

				76% of patients were involuntarily admitted. 60% had a history of psychiatric hospitalization.	physical illness and anxiety and personality disorders had predictive value for repetition of suicidal behaviour.
Links P et al (2012).	Prospective study of risk factors for increased suicide ideation and behaviour following recent discharge.	General Hospital Psychiatry 34:88–97.	Observational: prospective cohort study.	Study examined patient outcomes at 1, 3 and 6 months post-hospitalization, as measured by suicidal ideation and behaviour. Patients with lifetime history of suicidal behaviour or suicidal ideation, at the time of admission, were included in the study (N = 120 at study start).	In spite of hospitalization and quality psychiatric care, 3.3% participants went on to die by suicide within 1 month of discharge; 39.4% reported self-harm or suicide attempts within 6 months of discharge. Risk factors such as levels of depression and hopelessness, female gender and number of past suicidal attempts were predictive of subsequent suicidal ideation or behaviour.
Kapur N et al (2013).	Does Clinical Management Improve Outcomes following Self-Harm? Results from the Multicentre Study of Self-Harm in England.	Public Library of Science (PLoS) One. 2013 Aug 1;8(8):e70434. doi: 10.1371/journal.pone.0070434.	Observational: multicenter prospective cohort study.	Investigated the correlation between hospital management and services received (i.e., psychological assessment, medical admission psychiatric	Admission to either general or psychiatric facilities was associated with a higher risk of repetition of self-harm, although this was

				admission and referral to community-based mental health specialist) on risk of self-harm repetition, in a large cohort (N = 35,938) of self-harm patients.	dependent on the specific center under study. At some centers, elevated risk of repetition was significantly higher in patients that were admitted.
Loch AA (2014).	Discharged from a mental health admission ward: is it safe to go home? A review on the negative outcomes of psychiatric hospitalization.	Psychology Research and Behaviour management, 7: 137-145.	Review.	Summarizes negative outcomes post-discharge from psychiatric institutions; includes both short- and long-stay admissions on self-harm patient outcomes.	Study found that for short-term stays, high readmission rates, mortality rates, and suicidal or violent behaviour, were major negative outcomes, especially for patients with psychiatry illness or those with a history of suicidal behaviour. For long-term stays, issues with readapting and reintegration into society and stigma were major negative outcomes.

Hospitalization is a costly treatment option, it should be used for specific treatment plans (Paris, 2004) and where possible alternatives should be sought (Comtois, 2002).

Methodological limitations

There is only one randomized control trial (RCT) evaluating general hospitalization versus discharge for treatment of attempted suicide. Evaluation of the scoping question in uncontrolled trials is not appropriate as large differences can be expected between those who are deemed safe enough to be discharged home after life-threatening behaviour, and those who are not. In addition, assessments of suicide rates have frequently described the suicide-attempters as a single cohort. This is important to acknowledge as suicide attempters are not a homogenous group; and many, but not all, will have a psychiatric disorder. As a result, the cause of the behaviour and the efficacy of available treatments will vary between psychiatric diagnoses. Similarly, the variability of hospitalization would make it difficult to identify the mechanisms and specific elements of hospitalization that account for any observed effects on prognosis (Cooper et al, 2013; Kapur et al, 2013; Saunders et al, 2012; NICE, 2011; Newton et al, 2009; Taylor et al, 2009.

Directness (in terms of population, outcome, intervention and comparator)

No studies provide a direct answer to the scoping question on psychiatric hospitalization. The comments and recommendations made here are based on related literature and expert opinion.

Narrative conclusion

There are no randomized control trials (RCTs) that address the issue of psychiatric hospitalization. There is only one randomized controlled trial on general hospitalization versus discharge with the outcome measure of repetition of self-harm. To randomly assign a suicidal individual to a non-hospitalized control group and, as such, refuse them treatment or at the very least immediate safety, is not an ethically viable protocol. Comparing cohorts of admitted and non-admitted suicidal populations is unhelpful as the severity of the presenting situations will be very different, e.g. presence or history of psychiatric illness, severity of psychiatric condition, history of self-harm or suicidal behaviour, number of past suicide attempts, age and sex, lethality of the self-harm method, gravity of the physical condition, attitude towards the attempt, and extent to which they have access to support systems, such as family support (Carroll et al,

2014; Bilén et al, 2013; Hawton et al, 2013; Kapur et al, 2013; Madsen et al, 2013; Olfson et al, 2013; Cooper-Kazaz, 2013; Hayashi et al, 2012; Links et al, 2012; Miret et al, 2011; NICE, 2011; Kudo et al, 2010; Fliege et al, 2009; Hunt et al, 2009).

Despite the lack of strong empirical evidence, it is widely believed that hospitalization is necessary to provide acute safety measures (Nemeroff et al, 2001; Cornelius et al, 2004; Overholser, 1995; Bilén et al, 2014; Hayashi et al, 2012; NICE, 2011; Bergen et al, 2010; Hunt et al, 2009). It seems to be acknowledged that, generally speaking, hospitalization is helpful in managing the acute stage but can potentially be more harmful than helpful for some patients in the long term. While it can expand the treatment team, the surrender of freedom/independence can result in regression and strain the therapeutic alliance, especially when involuntary (Goldblatt, 1994).

The costs and benefits of suicide are going to vary with culture, psychiatric diagnosis, and type of self-harm. In Asian cultures it is considered extremely disrespectful to your family to attempt-suicide (Tzeng & Lispon, 2004; Shahid et al 2009). As a result the embarrassment, need to hide the behaviour, and the experience of stigma will be stronger (Loch, 2014; Hunter et al, 2012). This has the potential to make the cost of hospitalization higher for individuals in these countries. For those with a psychiatric diagnosis, which is one of the strongest predictor of suicide (Pirkola et al, 2007; Madsen et al, 2013; Hawton et al, 2013), the benefit of hospitalization will be different for those without, and will also vary between diagnoses. Suicidal patients with Borderline Personality Disorder are recurrently self-harming, their cries for help can become repetitive and they learn to 'work the system', returning to hospital whenever life gets too difficult (Paris, 2004). These patients may benefit more from partial hospitalization (Marshall et al, 2011; Verhaeghe & Bracke, 2008; Bateman and Fonagy, 1999), which is accompanied by a decrease in stigma experiences related to social rejection (Verhaeghe & Bracke, 2008). The way in which people self-harm, and their reasons for it will also influence the costs and benefits of hospitalization. A sub-culture has formed in society today where 'cutting' has become a public sign of status where individuals take pride in their scars. This is an entirely different self-harm experience to those suffering from bipolar disorder, schizophrenia or severe depression. The individual experience of self-harm and stigma experiences must be taken in to account; suicide attempters should not be assessed in a single cohort.

It seems reasonable to suggest that most people would place the benefit of reduced mortality over any risks such as stigma or social disadvantages. What may be a more pertinent query is whether hospitalization is more effective at ensuring safety, both in the short and long terms, than partial hospitalization, an intensive form of outpatient treatment, or some other form of community aid.

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From evidence to recommendations

Factor	Explanation
Narrative summary of the evidence base	There is little data on the benefits and pitfalls of hospitalization for suicidal patients. It is an ethically challenging area in which to conduct research, and as a result much of the data focuses on the risk factors and prevention of attempted and completed suicide, rather than treatment after it has occurred. Self-harm can result in social stigma, as can mental illness, which is a common diagnosis among individuals who attempt suicide. Reducing the impact of a mental health diagnosis on an individual should result in a decrease in self-harming behaviour and stigma experiences.
Summary of the quality of evidence	The quality of the evidence in relation to the scoping question is low. The recommendations made here are formed from related literature and expert opinion.
Balance of benefits versus harms	The aim of hospitalization is to provide immediate, short-term safety for suicidal individuals, and begin to implement treatment to reduce the recurrence of self-harming behaviour. However hospital admission is associated with several potential risks and pitfalls, including stigmatization. This can be highly detrimental for some individuals, who may already be dealing with extremely low self-esteem by increasing their experience of being marginalized and of alienation. The risks associated with hospitalization are not limited to those proposed by the scoping question, but also the potentially negative effect of hospitalization on the outcome for sufferers of some psychiatric illnesses. For some, such as those with borderline personality disorder, inpatient admission has the potential to foster dependence, and therefore exacerbate the problem.
Values and preferences including any variability and human rights issues	Risk of stigma and social disadvantage is linked to hospitalization, but can vary significantly according to the country and culture.

Costs and resource use and any other relevant feasibility issues	Hospitalization is a costly treatment option, both financially and otherwise, and this increases the importance of ascertaining whether or not its use is actually beneficial for suicidal individuals. Moreover, the psychiatric assessment is not always available and is costly.

Recommendation(s)

Hospitalization in non-specialized services of general hospitals with the goal of preventing acts of self-harm is not routinely recommended for persons with self-harm. However, admission to general hospital for management of medical consequences of an act of self-harm may be necessary; in these cases close monitoring of the individual's behaviour will be necessary to prevent subsequent self-harm in the hospital.
Strength of recommendation: STANDARD

In situations where the health worker is concerned about imminent risk of serious self-harm (for example, when the individual is violent, extremely agitated, uncommunicative, etc.), urgent referral to a mental health service should be considered. However, if such a service is not available, family, friends, concerned individuals and other available resources should be mobilized to ensure close monitoring of the individual as long the imminent risk persists.
Strength of recommendation: STANDARD