

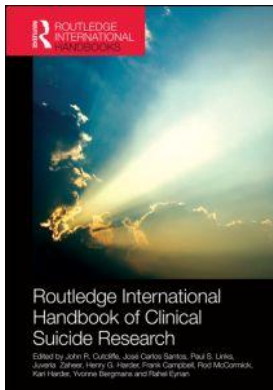
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3

A MIXED METHODS STUDY OF THE INCREASED RISK OF SUICIDE FOLLOWING DISCHARGE

A long road ahead

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There are no shortcuts to any place worth going.

Beverly Sills

Introduction

There is a significant body of literature which indicates that people whose mental health problems lead them to require psychiatric hospitalization are at a significantly increased risk for suicide (Appleby et al., 1999; Pirkola, Sohlman, & Wahlbeck, 2005; Troister, Links, & Cutcliffe, 2008). However, hospitalization for people at risk of suicide is only 'part of the bigger picture'; the period of time immediately following discharge after such hospitalizations, perhaps rather counter-intuitively,¹ appears to be a particularly high risk time (see Geddes & Juszczak, 1995; Geddes, Juszczak, O'Brien, & Kendrick, 1997; Goldacre, Seagrott, & Hawton, 1993; Ho, 2003; Lawrence, et al., 2001; Troister et al., 2008; Yim et al., 2004). Findings from studies conducted in various parts of the world have highlighted a number of variables which have been shown to be significantly related to suicide after recent discharge such as: previous suicide attempts (Fernando & Storm, 1984; King et al., 2001a; 2001b; King, Baldwin, Sinclair, & Campbell, 2001b; McKenzie & Wurr, 2001; Yim et al., 2004); presence of affective disorder/depressive symptoms, (King, Segal, Kaminski, & Naylor, 1995), unplanned discharge (King et al., 2001a, 2001b), and experience of negative life events following discharge (Pokorny & Kaplan, 1976). Conflicting findings exist regarding the link between duration of hospitalization and increased risk (Qin & Nordentoft, 2005; Ho, 2006).

While there is consensus within the limited literature concerning the existence of this increased period of risk, our comprehension of the phenomenon is in its infancy. Conflicting findings, for example, exist regarding the duration of hospitalization and any positive correlation with increased

suicide risk; different studies producing conflicting findings (Ho, 2006; Qin & Nordentoft, 2005). The studies that have been undertaken to explore this phenomenon represent only a ‘handful’ of mental health facilities and the particular experiences that contribute to this increased risk are far from complete. For instance, the authors could locate no qualitative studies that have systematically examined the post-discharge experiences of former hospitalized suicidal patients. Accordingly, this chapter reports on findings from a federally funded, mixed methods study which sought to do the following:

- 1 discover whether or not this increased risk of suicide post-discharge was ‘present’ at an Ontario health facility;
- 2 better understand the particular experiences associated with the observed increased risk for suicide following discharge from an inpatient psychiatric service(s).

The study combined a pre-test, post-test design (‘before and after’ design) with an intervention group and a control group with a hermeneutic, phenomenological design, using van Manen’s (1997, 2002) internationally established approach to phenomenology. Ultimately, the theoretical understanding of this specific high risk period can help lead to the development of selective prevention strategies that have the potential to assist in decreasing the risk for suicide and suicidal behaviour (Knox, Conwell, & Caine, 2004).

Methodological rationale and background

According to O’Cathain, Murphy and Nicholl (2007), there has been a recent surge of international interest in combining qualitative and quantitative methods in a single study, often called mixed methods research. This interest can be detected in the Canadian Institute for Health Research (CIHR) (<http://www.cihr-irsc.gc.ca/e/41382.html>, recovered 2012) information and associated positions with specific reference made to mixed method synthesis as an approach subsumed within the ‘Knowledge Translation’ initiative. Indeed, while a relatively recent development, the United States of America National Institute of Health (NIH) has embraced and endorsed mixed method research designs. The NIH Office of Behavioral and Social Sciences Research was among the first to publish guidelines for qualitative and mixed methods research and included models for combining qualitative and quantitative approaches. Similarly, the National Science Foundation (NSF) held a workshop on the scientific foundations of qualitative research, with five papers devoted to combining qualitative and quantitative methods. Following this, the NIH held their own mixed methods workshop,² sponsored by seven NIH institutes and this was followed by various private foundations holding their own workshops. The number of mixed methods studies reported in journal articles continues to increase and this reflects how mixed methods research is being utilized in more and more disciplines and fields of study (Plano Clark, 2005). Indeed, the level of interest has grown substantially to the extent that there now exists a journal which is devoted exclusively to publishing mixed methods studies and discussions about the methodology of mixed methods research;³ and international conferences dedicated to mixed methods research have been held in various countries since 2005.

The rationale or case for mixed method research designs can be advanced on several methodological and epistemological grounds. The central premise of such designs, it has been argued (Cresswell, 2003), is that the combination of quantitative and qualitative approaches provides a more comprehensive and complete understanding of problems than either approach can alone. Several authors have highlighted how mixed method research designs provide advantages/strengths that offset the limitations/weaknesses of both quantitative and qualitative

research (e.g., Cutcliffe & Harder, 2009; Goering & Streiber, 1996; Goldney, 2002, Leenaars, 2002; Lester, 2002). Greene (2007) highlights how mixed method research designs enable questions to be answered that cannot be answered by qualitative or quantitative approaches alone. Mixed methods, according to Cresswell (2003), enable researchers to use all of the tools of data collection available rather than being restricted to the types of data collection typically associated with qualitative research or quantitative research. Further, mixed methods designs encourage the use of multiple world-views or paradigms rather than the typical association of certain paradigms for quantitative researchers and others for qualitative researchers (Cresswell, 2003). This methodological consilience (Wilson, 1998) and the resultant unification of ways of knowing (and associated ways of conducting research) are highly congruent with complex, multi-dimensional health care problems.⁴ Professor of Psychiatry Goldney (2002, p. 70) makes this point most clearly: “It is increasingly more difficult for even the most partisan of researchers to ignore the nexus between the qualitative and quantitative approaches.”

Despite these methodological and epistemological exhortations, mental health or/and psychiatry, it has been argued, are still somewhat lagging behind other disciplinary/academic groups when it comes to embracing qualitative and mixed methods research designs (see, for example, Bassett, 2010; Whitley, 2009). Mixed methods research is inherently pragmatic; researchers are unrestricted in selecting all methods possible to address a particular research problem. Further, the methodological pragmatism extends to enabling researchers to solve problems using data in the form(s) of numbers and words; to combining inductive and deductive thinking.

Research design and method: the quantitative component

This study was carried out in a large urban general hospital with an active inpatient psychiatric service between May 2007 and December 2009. High-risk patients admitted to the inpatient psychiatric service and a short-stay crisis stabilization unit with a lifetime history of suicidal behavior, accompanied by some level of intent to die and current suicidal ideation based on self-report or chart documentation, were eligible to participate in the study. After receiving permission to approach patients from their treatment team, newly admitted patients were asked for their consent to participate in the investigation. After providing signed informed consent, patients participated in the baseline assessment during their hospital admission. Given the ‘vulnerable’ nature of the population, and the potentially sensitive nature of the phenomenon of interest, particular attention was devoted to considered ethical issues before commencing the study. Though the research team recognizes that qualitative research interviews do not *ipso facto* re-traumatize interviewees (see Cutcliffe & Ramcharan, 2002; Ramcharan & Cutcliffe, 2001), they were cognisant of the potential risks and so provided a number of ‘safety measures’ for the participants. All the information collected was treated confidentially and any information provided that could compromise the confidentiality of the person or the programs, was disguised. All electronic data files were protected by a password system and the study computer remained within a locked office. The study received research ethics approval from the hospital Research Ethics Board.

Baseline measures for the quantitative component

While in hospital, the participants were assessed for baseline suicidal ideation measured with the clinician-administered version of the Scale for Suicide Ideation⁵ (SSI), (Beck, Kovac, & Weissman, 1979) on the day of the interview and during the preceding week. This scale has

demonstrated internal consistency, inter-rater reliability, and concurrent validity (Beck et al., 1979) and adequate predictive validity significantly predicting eventual suicide (Brown, Beck, Steer, & Grisham, 2000). The SSI was administered at 1, 3, and 6 months after hospital discharge. At the sixth month follow-up appointment, participants were asked to report on any self-injury events without intent to die or suicide. A number of other measures and instruments were used in the study and details of these are reported in Links et al. (2012).

Outcomes

For suicidal ideation the authors considered two outcomes: (1) change in SSI scores from baseline to 1 month post-discharge; and (2) SSI scores at 1, 3, and 6 months post-discharge dichotomized as ≥ 3 (indicating that the patient is positive for suicide ideation) and < 3 (negative for suicide ideation). We used these SSI categories due to the high proportion of zero scores at follow-up. For suicide behavior we used the composite of the indicator of self-injury or suicide attempts within 6 months of hospital discharge or death by suicide after discharge.

Research design and method: qualitative component

For the qualitative, phenomenological component, the research team used Van Manen's (1997) interpretation of hermeneutic phenomenology. The researchers obtained a purposive sample of 20 former inpatients, each of whom met the inclusion criteria, (see Box 3.1). Interviews took place at (or close to) the end of the first month following their discharge from the inpatient psychiatric service. Demographic details of the sample are displayed in Table 3.1.

Box 3.1 Participant inclusion criteria

- 1 Had to be willing to participate and talk about their experiences.
- 2 Aged 18 years or over.
- 3 Must have been admitted to hospital with suicidal ideation or/and a lifetime history of suicidal behaviour.
- 4 Must have subsequently stabilized based on the inpatient psychiatrist's assessment.

Data were collected from the participants as a result of hermeneutic interviews, lasting between 1 and 2 hours; these occurred in a quiet, peaceful environment of the participant's choosing. At the beginning of the interview, the research team was concerned only with attempting to build rapport and helping the participant to feel at ease. While adopting a reflexive technique to qualitative interviewing (Kvale, 1996), the research team were seeking to elicit specific descriptions of the lived-moments of the experience of discharge; therefore certain types of questions needed to be asked to assist the participant in accessing the moment as lived. For example:

- If you could focus on an example of your post-discharge suicidal experience which stands out for its vividness, can you describe your experience of being discharged following your admission for suicidal ideation, as you live(d) through it?

Table 3.1 Socio-demographics of the sample

<i>Socio-demographic</i>	<i>N (%)</i>
Age mean (SD)	36.3 (10.7)
<i>Gender</i>	
Males	10 (50.0)
Females	10 (50.0)
<i>Race/Ethnicity</i>	
Caucasian	13 (65.0)
Black	1 (5.0)
Asian	0
Other	6 (30.0)
<i>Marital status</i>	
Single	14 (70.0)
Married/Common-law	2 (10.0)
Divorced/Separated/Widowed	4 (20.0)
<i>Diagnoses</i>	
Affective disorder	7 (35%)
Affective disorder and borderline personality disorder	8 (40%)
Affective disorder and schizophrenic disorder	1 (5%)
Neither borderline personality disorder nor affective disorder nor schizophrenic disorder	4 (20%)
<i>Education</i>	
Less than high school	1 (5.0)
High school	5 (25.0)
College/University/Graduate school	14 (70.0) ¹
<i>Current place of residence</i>	
Shelter	2 (10.0)
Living with parents/family	1 (5.0)
Rent	14 (70.0)
Own	3 (15.0)
<i>Source of income in the past year</i>	
Disability pension	9 (45.0)
Other	11 (55.0)
<i>Current employment status</i>	
Full-time	6 (30.0) ²
Part-time	6 (30.0)
Unemployed	2 (10.0)
Disabled	6 (30.0)

Notes: 1 It might be noteworthy that this is a high percentage of participants who have a higher education background. While this may be a nuance or idiosyncrasy of this particular sample, it is also possible that this high number reflects the greater degree of comfort that higher educated individuals feel when participating in research interviews. That is to say that individuals with a higher education background are more likely to be familiar with the research process per se and arguably, less intimidated by this.

2 It might be noteworthy that these figures represent higher percentages than are typically associated with the adult population. While sampling for phenomenological studies seek informants who can provide the richest, deepest understanding into the phenomenon and thus deliberately eschew random (representative) samples, it remains possible that different findings may have been discovered from a sample that was representative of the adult population.

Definitions: Affective disorder = bipolar or major depression; Schizophrenic disorder = schizophrenia or schizoaffective.

- Can you try and describe the experience from the inside, as it were? What were your feelings, your mood, your emotions, your thoughts?

And

- Could you describe how your body felt at that time, how things smelled, how they sounded?⁶

Furthermore, given the reflexive nature of hermeneutic interviews, some questions were asked in order to provide clarity in response to initial questions and in response to potential key moments described by the participants. Interviews ceased when the participants felt they had said all they had to say about the experience and when prompts from the interviewer did not elicit any new information.⁷

Following verbatim transcription of the interview(s), the whole research team read the entire transcript. This process has been described as giving the researcher(s) a global sense of the whole (Kleiman, 2004) and/or a feeling for the subject's inherent meanings (see Colaizzi, 1978). The first author then undertook a second reading of the transcript and asked questions of the text such as: What is going on here?, What is this an example of? This enabled the first author to divide the data in meaningful sections and then integrate those that had a similar focus or content. The first author then took each of these sections and formulated meaning in the context of the subject's own words/terms. This was achieved by asking questions of these collated sections such as: What does this passage of text, or more accurately, the collections of passages, say about the essence of the experience of being discharged after receiving inpatient mental health care for the risk of suicide? These meanings, drawn from a number of interviews, are then grouped or clustered (or even reduced) together, as a result of individual meaning units having shared and/or common patterns, content, or trends, into themes. Further, in the repeated examination of the transcripts, themes were supported or exemplified by highlighting and 'lifting' appropriate phrases or capturing singular key statements (thematic statements). Following this, the themes texts were shared with all members of the research team who were encouraged to re-write them as a means

Table 3.2 Initial questions posed during phenomenological interviews

Perhaps if you could focus on an example of your post-discharge suicidal experience which stands out for its vividness, can you describe your experience of being discharged following your admission for suicidal ideation, as you live(d) through it?

Please describe the events leading up to that particular moment. Any events that you feel impacted on and influenced your experience?

Can you try and describe the experience from the inside, as it were? What were your feelings, your mood, your emotions, your thoughts?

Can you describe what your 'world' and those in it, both in a local and wider sense, felt like to you during the moments of dealing with being discharged following your admission for suicidal ideation?

Can you focus on a particular example or incident? Can you describe specific events, particular happenings?

Can you tell me what were you aware of during the experience of feeling suicidal following your discharge?

Could you describe how your body felt at that time, how things smelled, how they sounded?

to enhance the richness and depth of the text. The team then revisited the interview transcripts once more as a means to ensure that their interpretations could be substantiated by reference to the raw data.⁸ Consequently, this process of writing and re-writing was used to make aspects of the lived experience reflectively understandable and was guided by van Manen's (2002) recent text on phenomenological writing. Furthermore, the interdisciplinary nature of the research team meant that each member was able to bring his or her particular disciplinary experience and expertise to the data analysis; to the re-writing of the phenomenological text.

Post-discharge elevated risk of suicide: quantitative and qualitative results

At baseline (n = 119), our quantitative measures indicated that discharged clients remained at an elevated risk of suicide; in some cases for many months subsequent to discharge. Further, our qualitative, phenomenological data confirm these quantitative findings whereby, despite the inpatient hospital stay being concluded, (and one could therefore assume that the client was deemed to be 'well' enough to be discharged), a theme of the induced lived experiences indicates that suicide remained an option. For instance, the Scale for Suicide Ideation (SSI) baseline scores ranged from 10 to 31, with a mean of 23.6 and standard deviation of 3.8. Mean (SD) scores post discharge were 7.9 (9.0), 6.6 (7.8), 5.7 (7.8) at 1 month (n = 100), 3 months (n = 96), and 6 months (n = 98), respectively. So while these scores appear to indicate some diminution in suicide ideation between baseline and discharge (and follow-up), the data also clearly indicate that SSI scores remained quite high for some people. It is also important to note that the incidence of death by suicide during the study period was 3.3% (95% confidence interval [CI] = 0.9%–8.3%): 1 participant died (0.8% or 1 in 120) while hospitalized and 3 participants (2.5% or 3 in 120) within 1 month of hospital discharge. Moreover, 41 of 104 (39.4%) (95% CI = 30.0%–49.5%) participants reported self-injury or suicide attempts within 6 months of hospital discharge. Accordingly, our quantitative findings from the prospective cohort design adds to the existing retrospective studies of the risk of suicide in recently discharged patients by confirming the remarkable risk for suicide in recently discharged patients.

When these quantitative results are combined with the phenomenological findings, the post-discharge continuation of elevated suicide risk becomes more difficult to dismiss or refute.

One of the induced sub-themes, "Suicide remains an option – "But I still feel suicidal"" (see Cutcliffe et al., 2012a, 2012b) describes how for some of the participants in this study, suicide very much remained an option even after they are discharged. Thoughts of ending their lives occurred to some participants on the very day that they were discharged; for others, thoughts of suicide and/or suicide remained in their consciousness as a viable solution to their problems, persisting for many months after discharge and in some cases, years after. These suicidal thoughts/feelings were described by the participants as residing in different (metaphorical) places in their minds. Some referred to how these thoughts/feelings were at the forefront of their minds. Others described a more subconscious location, i.e. at the back of my mind, and yet this location could and did change. Participants referred to how, usually, they became more conscious, more aware of suicide as an option, when times got harder, and/or when they felt more stressed. Others still referred to suicide residing in their unconscious and manifesting itself in their dreams. Perhaps somewhat counter-intuitively, some participants described their suicidal thoughts/feelings as being worse after they were discharged. Participants described, again perhaps somewhat paradoxically, that having suicide as an option for them post-discharge actually served as a 'security blanket'. There was a sense of participants being willing to try and resolve their issues but if they couldn't, if they couldn't cope . . . then they still had a way out in the form of suicide. Participants were very clear that, for the most part, the act and

experience of being discharged in no way prevented them from still feeling suicidal. Just because the formal mental health care system (services) had decided that it would be safe to discharge someone, did not necessarily mean that the person's suicidality had been resolved; that the suicidal 'episode' was now concluded. It may well have been the case that the crisis point or highest point of risk had elapsed, but participants were adamant that they left the hospital still feeling suicidal. Some participants described their experiences as the system letting them down; they described not getting their issues resolved or that their 'recovery' was incomplete. For some, the experience of being discharged before they felt that they had resolved their suicidal issues actually served to potentially increase their risk. Some participants referred to the increased sense of hopelessness that resulted from going to a place/organization where they were expecting things to improve, and yet they didn't improve. There was a sense of "Where can I get help? If I can't get help from these guys, the formal mental health services, then where can I get help?" Some participants' experiences appeared to indicate that it takes a great deal longer to resolve these complex issues and that at times, their experience of the health care system was one characterized as a 'Band-Aid' approach. Evidence of the continued elevated risk of suicide post-discharge was captured by the research participants in their quotes:

I'm probably going to still be depressed and, you know, suicide will be on the table, um, you know, kind of as one of the options.

Interview 4

What was going through your head on the day of discharge? I'm going to end my life.

Interview 13

Yeah, yeah, and, ah, basically, you know, before being admitted and after being admitted I pretty much just think about like suicide all the time, you know, it's, um, you know, I know people sit there and just say change your attitude or go for a walk or blah, blah, blah . . . and when I got home, for the first week, it's actually, it's actually getting a little worse.

Interview 20

I was still suicidal when they let me go but they did what they were supposed to do. They upped my drugs, they gave me some sleeping medication and they were all kosher like everything was cop esthetic, and it doesn't matter where you're at, and so I'm still struggling with it.

Interview 9

Well, Thursday, when I had told the nurse that I was having suicidal thoughts, she told me that my, the psychiatrist wanted, said that I would be discharged Friday, that was the first I had heard anything of it. I just knew by Friday morning that if I had told them I was still having suicidal thoughts, I'd still be in restraints, so I lied, and I was taken out of restraints, two hours later, I was discharged and then two days, two or three days later I ended up at (mental health facility name).

Interview 7

I think the burden part is kind of not never ending, cause even, now I, I, very rarely tell my parents, um, more than they really need to know, um, but in terms of the fear

and, um, you know, the thoughts of suicide and things like that, that's still in hospital and right after getting out of hospital.

Interview 4

When my doctor told me I was being discharged, I was very, very sad because I was, like, I don't understand what I did . . . I don't understand what I am supposed to do. I felt much more lost and so much more worried.

Interview 16

Like, I immediately want my safety blanket of suicide and for me that's a safety blanket, that's where I want to be. It's hard, like, day-to-day is a struggle and you're always in fluctuation with your emotions. You can't control them. You can't trust your relationships. You're always trying to figure things out. It's very tiring.

Interview 9

It came, it just came to that, to that mind space that it's like, okay, I can't deal with this, you know, and it's like I have a way out and, um, you know it, there's just like so much anxiety around it and I just felt like, okay, you're sending me home, I understand that I need to go home but it's like I don't feel like I'm ready to go home, you know, it's like because all the problems are still there.

Interview 20

Not really, because when they discharged me I was still suicidal, and even more so because of the fact that, you know, that I was hopeless in a way and they were happy. You know, like, the mental health system was happy because they decided to discharge me and it didn't matter where I was.

Interview 9

No, I think it's the same. It hasn't changed with me. I'm on very high antidepressants, like the maximum you could take and, um, no I still want to kill myself, I'm still there.

Interview 11

It remains but you get better at hiding it. It's a matter of hiding it and trying not to feed it, um, I try to distract myself from it and I try to get on board with trying to connect with my boyfriend although I can pretend and I can mimic, um, but it doesn't go deeper than superficial and I know that's a problem. But I'm getting good at mimicking and pretending but I guess that's why I stay suicidal. You know it seems like I never know when it's going to hit and yet the outside factors are detonators for action.

Interview 9

Um, that's the mind space was just, like, the only thing that I really remember was the fact that it's like I'm not ready, and I can't deal with this, and that I was just going to go home and, and like overdose and then everything would be okay.

Interview 20

Discussion

Combining the quantitative and qualitative findings in this study results in robust evidence to suggest that the risk of suicide continues long after the client has been discharged. Given these findings the need for a range of post-discharge support orientated 'interventions' is indicated such as: scheduled visits in the community from a mental health clinician, follow-up phone calls, text messages, emails, and/or postcards. If the client is willing to give his/her consent, the discharge process might also be adapted to include notification sent to family, friends and formal carers (e.g. managers of homeless centres). There is some corroboration within the, albeit limited, empirical literature⁹ that supports such amendments to practice. Driscoll (2001), for example, found that carers who were present with their patients when they received information concerning post-discharge care experienced a decrease in anxiety during their patients' convalescence at home, greater satisfaction with the information they received, and their patients experienced fewer medical problems post-discharge. More specific to follow-up care for suicidal people, the novel studies by Motto and Bostrom (2001) and Carter and colleagues (2005; 2007) show that simply utilizing letters or postcards as an intervention following discharge suggests that social connectedness, feeling that somebody still cares, may be a crucial component of post-discharge support. Other qualitative findings in this study indicated that there were a range of experiences (and variables) which contributed to this ongoing, elevated risk of suicide post discharge including: participants feeling scared, anxious, fearful and/or stressed; the degree of preparedness felt by the participants; participants' sense of leaving the place of safety; their sense of feeling like they were a burden; participants' ongoing need for post-discharge support; participants' sense of feeling lost, uncertain, disorientated, and feeling alone and/or isolated.

The reported sense(s) of fear, dread and anguish about leaving their 'place of safety' and being sent 'back into the lion's den' was lessened when the participant felt more prepared; felt that he/she had a degree of control over when and how this happened. While mindful of the many factors that influence (if not drive) decisions regarding discharge, relatively slight alterations in current practice appear to have potential and significant utility in helping to alleviate this post-discharge problem. Involving patients in the decision-making process, encouraging expression and 'ventilation' of fears/anxieties; acknowledging that such fear is to be expected; seeking and taking account of the patient's views *vis-à-vis* readiness for discharge; where possible, addressing specific concerns and exploring what can be put in place to help patients feel more supported, and, wherever possible, not forcing the discharge on patients who do not feel ready and/or prepared, would appear not only to be indicative of good practice but simultaneously would potentially reduce the risk of further suicide attempts post-discharge. Similar calls for involving patients (and their family carers) in discharge decision-making have been advocated in the United Kingdom (see Social Care Institute for Excellence Research Brief 12, accessed 2010) and are common in policy documents (see, for example, Department of Health, accessed 2010). However, the norm is that people are not usually consulted about the planning of their discharge or care (SCIE, accessed 2010). Indeed, the limited literature shows that a 'top-down' or 'paternalistic' approach is the norm for discharge planning (Bull, Hanson, & Gross, 2000; Cornes and Clough, 2001; Mountain and Pighills, 2003). And yet the empirical findings, such as they are, indicate that patients who perceived that the time of discharge was consistent with the stage of their illness experienced significantly higher recovery (Schröder, Larsson, & Ahlström, 2007).

Further practice implications arising out of these findings include the need to commence the discharge process as soon as possible after admission, and in this way, being discharged can then be experienced as a gradual process, one where the patient has time to prepare and plan. If possible, and the authors are mindful of the possible logistical difficulties, it would be prudent to

introduce the patient to his/her post-discharge support staff before the discharge occurs (and thus enhance the continuity of care). The findings also indicated that a variable (or dynamic) that appeared to be contributing to the post-discharge continued elevated risk of suicide was that of the major disconnect between the expectations of admitted patients and what realistically could be offered by the formal mental health care services. For example, some participants referred to the expectation of getting fixed or cured; they expected¹⁰ that being admitted to inpatient care would result in the cure/solution to their problem. The difficulties associated with misconceptions/unrealistic expectations about formal psychiatric care have been documented previously (see, for example, Douglas, Noble, & Newman, 1999). Such disconnections are linked with drop-out rates (Bunn et al., 1997) and levels of satisfaction (Balogh et al., 1995). Interventions to enhance the congruence between patients' expectations and what the mental health care services can realistically offer have resulted in improved attendance/satisfaction and decreased anxiety (Webster, 1992). Accordingly, the authors assert that early exploration of and reconciling patients' expectations regarding inpatient care for their suicidality might be an intervention that could diminish the post-discharge risk for further suicide attempts; though this hypothesized intervention requires further empirical testing.

A further variable (or dynamic) that appeared to be contribute to the post-discharge continued elevated risk of suicide was that of participants reporting how when they arrived home, they did not know what to do next; they were uncertain about so many aspects of their lives. Accordingly, there appears to be significant utility in creating a post-discharge plan, working in collaboration with the client; which can subsequently explore pragmatic issues such as: What to do now/next? What needs to be addressed first and what can wait? How to begin re-engaging in life? How to pick up the threads of one's life again? Where can the client go for additional help/support? Providing information of post-suicide support groups, be they physical 'face-to-face' groups and/or 'virtual' online groups, might also be useful. This ongoing, post-discharge support can be offered from both the mental health services and the voluntary sectors (including peer support) and should logically include some work on helping the client become more comfortable with this sense of uncertainty, helping the client understand that this sense of being 'dazed' is normal, is to be expected and that this too shall pass. Mental health services might similarly think about augmenting their discharge process by producing some post-discharge literature and/or pamphlets. Perhaps analogous to current best practice in some medical/surgical situations, for example, patients about to be discharged following a new diagnosis for diabetes, or the patients about to be discharged following a myocardial infarction, are inevitably provided with pamphlets and literature regarding their ongoing, post-discharge recovery and how to reduce the risk of post-discharge complications.

While there is little evidence in the extant suicidology literature regarding post-discharge interventions, valuable lessons can be learned by drawing on related practices in other areas of health care. For example, in their thorough meta-analysis, Phillips et al. (2004) found that comprehensive discharge planning plus post-discharge support for older patients with congestive heart failure (CHF) significantly reduced readmission rates and may improve health outcomes such as survival and Quality of Life without increasing costs. The ongoing suicide risk, particularly in recently discharged patients admitted for suicidal behaviour, with high levels of depression, hopelessness or impulsivity must be monitored at discharge and in the early weeks and months following discharge (Links et al., 2012). In conjunction with ongoing risk, monitoring clinicians should help clients to understand that, even after discharge, there remains much work to be done; that the recovery from suicide can take a considerable length of time; that the short inpatient stay for the suicidal crisis can be just the beginning of their holistic recovery. In conjunction with this is the need for the suicidology community to perhaps re-visit what we consider to be an

appropriate time frame for dealing with suicidality. There is a need to reflect how, for many suicidal patients, (see, for example, Maris, 1981; Beautrais, 2013), a more useful and accurate perception of the formal mental health care response to high risk suicidal clients would be to regard the inpatient care as the acute, crisis stabilization necessary as a preface to a longer-term, community-based recovery period. In such a model, the suicidology community would then acknowledge that the majority of the recovery work is likely to be undertaken post-discharge.

Some support for such a conceptualizations can be found in the relevant theoretical and empirical literature. While acknowledging its vintage yet significant status, the work of Maris (1981), *Pathways to Suicide*, drew attention to the notion of suicidal careers. The central premise of his thesis was that individuals who took their own lives had long suicidal careers involving complex mixes of biological, social and psychological factors. More recently, Joiner's (2005) illuminating book contains three central premises: (1) that people who make a serious attempt to end their own lives feel real disconnection from others; (2) they feel that they are a burden on others; and (3) the ability to enact the lethal self-injury is acquired. Relatedly, Beautrais' important work on looking at the trends and outcomes of all admissions for suicide attempts to a New Zealand hospital over ten years, reports similar findings. Beautrais (2013) argues that her results clearly show that suicidal behaviour, for many, is a chronic condition, not just a single, impulsive event and rather worryingly, for many the situation does not change much following a suicide attempt, because people do not get the help they need. Beautrais concludes that suicide is a complex response by vulnerable people who need extensive long-term treatment, care and support.

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Notes

- 1 One would expect that hospitalization ought logically to improve (or in some cases even 'cure') the situation.
- 2 Which was entitled, 'Design and Conduct of Qualitative and Mixed-Method Research in Social Work and Other Health Professions', and ran in 1994.
- 3 *Journal of Mixed Methods Research*, editors J. W. Creswell, A. Tashakkori, & V. L. Plano-Clark, published by Sage.
- 4 And here the authors will not belabor the obvious utility of undertaking mixed-methods studies in suicidology given that the multi-dimensionality and complexity of suicide have been very well documented, perhaps even to the extent that the multi-dimensionality and complexity of suicide are now regarded as axiomatic.
- 5 This is a 21-item, interviewer-administered rating scale that measures the current intensity of the participants' specific attitudes, behaviours, and plans to die by suicide.
- 6 A full list of our initial interview questions is provided in Table 3.2.
- 7 For hermeneutic phenomenology, the act of writing is not something that occurs ex-post-facto; writing is closely fused into the research activity. However, for ease of understanding, here the authors describe their approach to data analysis in a linear rather than cyclic (or iterative) fashion.
- 8 Please see the direct quotes from the interviews that substantiate the induced themes.
- 9 In terms of quantity and scope.
- 10 Analogous to their experiences of receiving care for physical/medical problems.

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