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Editorial

# Delayed or Denied? Lack of Prompt Follow-Up for Older Adults Hospitalized After Suicide Attempt or Self Injury

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In this issue of the journal, Schmutte et al.[1] used large-scale claims-based data to show that the majority of older adults admitted for a suicide attempt, ideation, or deliberate self-harm, were not seen within 7 days of discharge be it a general or psychiatric hospital. Granted the data is from 2015, but with hospitals and mental health centers overwhelmed by the COVID-19 pandemic, the current reality is likely much worse. Patients discharged from psychiatric hospitals fared somewhat better but the current shortage of psychiatric beds and extended boarding times spent in emergency rooms awaiting a psychiatric admission provide scant comfort. The stigmatization of the mentally ill, mental health providers, and old age is often cited as the patient-based cause of inadequate follow-up. Yet there is a growing awareness that lack of access not stigma is the major obstacle to behavioral health care. But ack of access is not the only complicating factor.

In a previous publication[2] Schmutte et al. using data from 2003 to 2016 in the National Violent Death Reporting System found that most older men and women who died by suicide did not have a known psychiatric disorder and the most common precipitating factor was a physical health problem. Among these decedents the most common means of death was a firearm totaling 80% of men and nearly 45% of women. Among those with a known psychiatric disorder, 70% of men and 30% of women used a firearm. These decedents had either a history of a prior attempt, had disclosed suicidal intent, were depressed, or had a substance use disorder. However, in both groups three quarters had not disclosed suicidal intent.

Gawande[3] describes a primary care team community-outreach model from Costa Rica in which health services are focused on public health rather than office encounters and procedures. At first glance the

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door-to-door service seems impossible in the United States yet in Costa Rico it has reduced maternal and infant mortality and infection with diseases that can be prevented with vaccines substantially below that observed in the United States. And life spans of middle aged and older adults now exceed those recorded in the United States. Older Americans who die by suicide are twice more likely to see their primary care provider than a mental health specialist in the month prior to death. And because life-life suicide is overwhelming related to long-standing firearm possession among older white males rather than identified mental illness, social interventions may be currently the most effective means of risk reduction.[4]

The primary care approach advocated by Gawande has been described as "Hospital-at-Home" in the United States and has too many citations to be listed in a short commentary. But ii also would address the "Five-Ds" of suicidal risk in late life[5] which include deadly means, depression, disease/disability, development, and disconnectedness. Obviously, enhanced primary care could address disease, disability, and depression but by providing an engaging team of providers it could reduce the sense of disconnectedness and the anxious attachment that grew out of developmental stress which lead to isolation. Again, it is important to reflect on the impact of the pandemic on public health. Telepsychiatry, not widely available before the pandemic has emerged as a major advance for both patient and providers.[6] Billable encounters by video or phone are also a significant improvement in primary care. Moreover, follow-up telephone contact and virtual check-ins for persons with a prior suicide attempt substantially reduces recurrence.[7] The New York State Office of Mental Health certification article 31 requires that patients discharged from an emergency department or inpatient psychiatric unit receive an urgent appointment defined as occurring five business days since discharge. This is a laudable policy but added resources would be needed if primary care is to be included.

In summary, reducing suicide in old age is complicated by the prevalence of lethal means, lack of disclosed intent, lack of prior attempts, and association with physical illness rather than known psychiatric disorders. This suggests that enhancements in primary care may be the most effective means of reducing the risk particularly in the aftermath of the COVID-19 pandemic. Shifting the focus and the necessary resources to community based primary care may mean that preventive contact to reduce the risk of death would be neither delayed nor denied.

## AUTHOR CONTRIBUTION

Gary J. Kennedy MD is the sole contributor to this editorial.

## DISCLOSURE

*Gary J. Kennedy MD does not have any conflicts to declare. The data has not been previously presented orally or by poster at scientific meetings.*

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