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The relationship between psychiatric inpatient length of stay and suicide prevention

Consolata Uzzi [1,*], Mujeeb Adedeji Salawu [2], Nkechinyere Mary Harry [3], Ibrahim Lanre Folorunsho [4], Olaniyi David Ogundeji [5], Adeniyi Kayode Busari [6], Chidalu Ibeneme [7] and Nnenna Okafor [8]

[1] *Bristol Myers Squibb Corporate Headquarters, Princeton, New Jersey, USA.*
[2] *University of South Wales, Cardiff's, United Kingdom.*
[3] *Vinnytsia National Pirogov Medical University, Vinnytsia Oblast, Ukraine.*
[4] *General Hospital, Department of Psychiatry, Ikorodu, Lagos, Nigeria.*
[5] *Johns Hopkins University, Department of Mental Health, Bloomberg School of Public Health, Maryland, USA.*
[6] *Emory University, Atlanta Georgia, USA.*
[7] *University of Toledo, Toledo, Ohio, USA.*
[8] *All Saints University School of Medicine, Saint Vincent and the Grenadines.*

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Abstract

Suicide prevention remains a critical concern within mental health care, particularly for individuals with psychiatric disorders. This review examines the relationship between the length of inpatient psychiatric admission and its effectiveness in preventing suicide. The study analyzes existing literature on admission duration, in-hospital and post-discharge suicide rates, and factors influencing these outcomes such as treatment quality, patient characteristics, and post-discharge support systems. While some evidence suggests longer stays may be beneficial for certain diagnostic groups, the quality and intensity of care during admission and robust post-discharge support appear equally crucial. The review highlights the importance of individualized care plans, comprehensive suicide prevention programs, and strong transitional support. It also discusses international perspectives, ethical considerations, and special populations. The paper concludes that an effective approach to suicide prevention should focus on tailored admission lengths, high-quality care, and seamless transitions to community support, rather than solely on extending lengths of stay.

Keywords: Psychiatric hospitalization; Suicide prevention; Length of stay; Post-discharge care; Suicide risk assessment

1. Introduction

Suicide remains a significant public health concern worldwide, with approximately 800,000 deaths annually (World Health Organization [WHO], 2021). Individuals with mental health disorders are at particularly high risk, with suicide rates among psychiatric patients significantly higher than in the general population (Chung et al., 2017). Inpatient psychiatric admission is often considered a crucial intervention for patients at high risk of suicide, providing a safe environment, intensive treatment, and close monitoring (Qin & Nordentoft, 2005).

However, the optimal length of inpatient stay for suicide prevention remains a topic of debate among clinicians, researchers, and policymakers. This research paper aims to explore the relationship between the duration of inpatient psychiatric admission and its effectiveness in preventing suicide, both during hospitalization and in the critical period following discharge.

* Corresponding author: Consolata Uzzi

The length of inpatient psychiatric stays has been declining in many countries over the past few decades, driven by factors such as deinstitutionalization policies, economic pressures, and the development of community-based mental health services (Allison et al., 2007). This trend has raised concerns about whether shorter hospital stays may compromise patient outcomes, particularly in terms of suicide prevention.

This comprehensive review will examine the existing literature on the topic, analyzing studies that investigate the correlation between admission length and suicide rates. It will also explore the various factors that influence this relationship, including patient characteristics, treatment approaches, and post-discharge support systems.

2. Methods

A literature search was conducted using electronic databases including PubMed and Google Scholar. The search terms included combinations of keywords such as "inpatient psychiatric admission," "length of stay," "suicide prevention," "suicide risk," and "post-discharge suicide." The search was limited to peer-reviewed articles published in English between 2000 and 2024.

2.1. Inclusion Criteria

Studies were included if they met the following criteria:

- Focused on adult psychiatric inpatients (age 18 and above)
- Examined the relationship between length of stay and suicide outcomes
- Reported quantitative data on suicide attempts or completed suicides
- Included a follow-up period of at least 3 months post-discharge

Relevant data were extracted from the selected studies, including sample size, diagnostic categories, average length of stay, suicide rates during admission and post-discharge, and any reported correlations between length of stay and suicide outcomes. A narrative synthesis approach was used to analyze and summarize the findings due to the heterogeneity of study designs and outcome measures.

3. Results

The literature search yielded studies encompassing a wide range of psychiatric diagnoses, including major depressive disorder, bipolar disorder, schizophrenia, and personality disorders. Sample sizes ranged from 98 to 75,689 patients, with follow-up periods varying from 3 months to 10 years post-discharge.

3.1. Length of Stay and In-Hospital Suicide Rates

Several studies examined the relationship between length of stay and suicide rates during hospitalization. A large-scale study by Johnson et al. (2018) analyzed data from 215 psychiatric hospitals in the United States, involving over 200,000 admissions. They found that the risk of in-hospital suicide decreased significantly after the first week of admission, with the highest risk occurring within the first 72 hours. These findings were corroborated by a European study conducted by Martelli et al. (2019), which examined 15,000 psychiatric admissions across 10 countries. They reported that the risk of in-hospital suicide was highest during the first 3 days of admission and decreased steadily thereafter. However, it is important to note that in-hospital suicides are relatively rare events compared to post-discharge suicides. The focus on preventing in-hospital suicides should not overshadow the importance of preparing patients for the transition back to the community.

3.2. Length of Stay and Post-Discharge Suicide Rates

The relationship between length of stay and post-discharge suicide rates is more complex and controversial. Several studies have found an inverse relationship between length of stay and suicide risk following discharge. A landmark study by Ho (2006) examined over 75,000 psychiatric inpatients in Taiwan over a 7-year period. The research found that patients with hospital stays shorter than 14 days had a significantly higher risk of suicide within the first month after discharge compared to those with longer stays. This association remained significant even after controlling for demographic and clinical variables. Similarly, a Danish register-based study by Nordentoft et al. (2013) analyzed data from more than 150,000 psychiatric admissions. They reported that patients with stays shorter than 7 days had a 3-fold increased risk of suicide within the first week post-discharge compared to those with longer admissions. However, not all studies have found a clear relationship between length of stay and post-discharge suicide risk. A meta-analysis by Chung et al. (2017) reviewed 31 studies examining this relationship and concluded that while there was a trend towards

increased suicide risk with shorter stays, the evidence was not conclusive due to methodological limitations and heterogeneity among studies.

3.3. Diagnostic Considerations

The impact of length of stay on suicide prevention may vary depending on the patient's primary diagnosis. A study by Gunnell et al. (2012) found that for patients with severe depression, longer hospital stays (>30 days) were associated with lower suicide rates in the year following discharge. However, this relationship was not observed for patients with other diagnoses such as schizophrenia or personality disorders.

In contrast, a study focusing on patients with borderline personality disorder by Barr et al. (2020) found that longer admissions (>14 days) were associated with increased risk of self-harm and suicidal behavior post-discharge. The authors suggested that prolonged hospitalization might reinforce maladaptive behaviors in this patient population.

3.4. Treatment Intensity and Quality

Several researchers have emphasized that the quality and intensity of treatment during admission may be more important than the length of stay itself. A prospective study by Zhang et al. (2016) examined 1,200 patients admitted for suicidal ideation or attempts. They found that patients who received intensive cognitive-behavioral therapy (CBT) during their stay had significantly lower suicide attempt rates in the 6 months post-discharge, regardless of the length of admission.

Similarly, a study by Kohe et al. (2021) investigated the impact of a specialized suicide prevention program implemented in 15 psychiatric hospitals. The program included comprehensive risk assessment, safety planning, and intensive follow-up. Results showed that patients who participated in this program had lower suicide rates in the year following discharge, even with shorter average lengths of stay compared to historical controls.

3.5. Post-Discharge Support and Continuity of Care

The transition from inpatient care to the community is a critical period for suicide risk. Several studies have highlighted the importance of post-discharge support in mediating the relationship between length of stay and suicide prevention.

A large-scale study by Smith et al. (2019) analyzed data from over 50,000 psychiatric admissions in the United Kingdom. They found that patients who received prompt follow-up care (within 7 days of discharge) had significantly lower suicide rates in the subsequent 3 months, regardless of their length of stay.

In addition, a randomized controlled trial by Chen et al. (2022) evaluated the effectiveness of an intensive post-discharge intervention program. Patients in the intervention group received weekly phone check-ins, home visits, and expedited access to outpatient services for the first month post-discharge. The study reported a 40% reduction in suicide attempts among the intervention group compared to treatment as usual, with the effect being most pronounced for patients with shorter inpatient stays.

4. Discussion

The relationship between inpatient psychiatric admission length and suicide prevention is complex and multifaceted. While some studies suggest that longer admissions may be associated with lower post-discharge suicide rates, particularly for certain diagnostic groups, the evidence is not entirely consistent (Chung et al., 2017). Several factors may contribute to the apparent protective effect of longer hospital stays. Longer admissions may allow for more comprehensive stabilization of acute symptoms and optimization of medication regimens (Gunnell et al., 2012). Extended stays provide more opportunity for patients to engage in therapeutic interventions and develop coping skills, as demonstrated by Zhang et al. (2016) in their study on intensive cognitive-behavioral therapy. Additionally, longer admissions may allow for better involvement of family and community supports in discharge planning, which Smith et al. (2019) found to be crucial for post-discharge outcomes. Extended observation periods can also facilitate more accurate diagnosis and risk assessment (Johnson et al., 2018).

However, it is important to recognize that length of stay alone may not be the primary determinant of suicide prevention outcomes. The quality and intensity of care provided during admission, as well as the robustness of post-discharge support, appear to be equally if not more important factors (Kohe et al., 2021; Chen et al., 2022). While longer admissions may offer potential benefits for suicide prevention, they also carry risks that need to be considered. Prolonged hospitalization can lead to dependence on the hospital environment and difficulties readjusting to

community life, a phenomenon known as institutionalization (Allison et al., 2007). Extended psychiatric admissions may contribute to increased stigma and social isolation, as noted by Thornicroft et al. (2009) in their cross-sectional survey on discrimination against people with schizophrenia.

Longer stays can also interfere with employment, education, and family responsibilities, potentially disrupting important social roles (Nordentoft et al., 2013). From a healthcare system perspective, extended admissions place a significant burden on resources and may limit access to inpatient care for other patients in need (Ho, 2006). In addition, in some cases, particularly for patients with certain personality disorders, prolonged admissions may inadvertently reinforce maladaptive behaviors, as suggested by Barr et al. (2020) in their study on borderline personality disorder.

Given the complex interplay of factors influencing suicide risk, a one-size-fits-all approach to determining optimal length of stay is unlikely to be effective. Instead, literature suggests that individualized care plans, taking into account the patient's specific diagnosis, risk factors, and treatment response, may be more beneficial. Kohe et al. (2021) demonstrated that implementing comprehensive, patient-centered suicide prevention programs can improve outcomes even with shorter average lengths of stay, which suggests that the content and quality of care may be more critical than duration alone.

A recurring theme in the literature is the critical nature of the immediate post-discharge period. Regardless of the length of inpatient stay, ensuring a smooth transition to community care appears to be crucial for suicide prevention. The study by Chen et al. (2022) highlights the potential of intensive post-discharge support in reducing suicide risk, particularly for patients with shorter admissions. This suggests that resources invested in robust discharge planning and follow-up care may be as important, if not more so, than extending inpatient stays.

4.1. International Perspectives on Inpatient Psychiatric Care and Suicide Prevention

Approaches to inpatient psychiatric care and suicide prevention vary significantly across different countries and healthcare systems, reflecting diverse cultural, economic, and historical factors. This international variation provides valuable insights into the relationship between length of stay and suicide prevention outcomes.

The United States is characterized by relatively short hospital stays and a focus on community-based care. According to the Agency for Healthcare Research and Quality (2021), the average length of stay for psychiatric inpatients in 2018 was 7.5 days. This approach emphasizes crisis stabilization and rapid transition to outpatient care. The short-stay model is partly driven by insurance constraints and a push for cost-effectiveness (Allison et al., 2007). However, this approach has raised concerns about "revolving door" admissions and inadequate care for complex cases. Studies like that of Olfson et al. (2016) have highlighted the elevated suicide risk in the immediate post-discharge period following these brief admissions, underscoring the need for robust transitional care programs.

In contrast to the U.S., the United Kingdom's National Health Service (NHS) provides universal coverage with longer average psychiatric inpatient stays. NHS Digital (2021) reported an average stay of 25 days in 2019-2020. The UK system places a strong emphasis on community mental health teams and crisis resolution home treatment teams. This model aims to provide a more gradual transition from inpatient to community care. While longer stays may allow for more comprehensive treatment, they also raise concerns about resource allocation and potential institutionalization effects. Studies like that of Gunnell et al. (2012) have examined the impact of these longer stays on post-discharge suicide rates, finding potential benefits for certain diagnostic groups.

Germany is known for even longer average stays, with the Federal Statistical Office (Statistisches Bundesamt, 2021) reporting an average of about 23 days in 2019. The German system emphasizes a more gradual transition to outpatient care and places a strong focus on psychotherapy during inpatient treatment. This approach reflects a cultural emphasis on thorough treatment and a healthcare system that supports longer stays. Research by Wolfersdorf (2000) has highlighted the potential benefits of this intensive inpatient psychotherapy approach in reducing suicide risk, particularly for patients with depression.

Japan presents a unique case, with one of the longest average psychiatric hospitals stays globally. Oshima et al. (2014) reported that many patients stay for months or even years. This has led to significant concerns about institutionalization and has sparked efforts to promote deinstitutionalization. The long-stay model in Japan is rooted in historical factors and societal attitudes towards mental illness. While it may provide extensive support for severely ill patients, it raises serious concerns about patients' rights, quality of life, and social reintegration. Recent policy efforts have focused on reducing these lengthy stays and developing community-based alternatives (Kasai et al., 2017).

Australia adopts a mixed approach, balancing shorter stays with comprehensive community support. The Australian Institute of Health and Welfare (2021) reported an average length of stay of about 16 days in 2018-2019. There's a growing emphasis on early intervention and youth mental health services, exemplified by initiatives like headspace (McGorry et al., 2007). This model aims to intervene early in the course of mental illnesses to prevent long-term disability and reduce suicide risk. Australian research, such as that by Large et al. (2011), has contributed significantly to our understanding of the complex relationship between length of stay and suicide risk.

Countries like Sweden and Denmark have moved towards shorter hospital stays (average 11-14 days) combined with well-developed community mental health services (NOMESCO, 2017). This approach reflects the strong social welfare systems in these countries and a cultural emphasis on community integration. The Nordic model demonstrates how shorter stays can be effectively combined with robust community support to manage suicide risk. Studies like that of Nordentoft et al. (2013) in Denmark have provided valuable insights into post-discharge suicide risk and the effectiveness of intensive community-based interventions.

These variations highlight the need for culturally sensitive approaches to suicide prevention that consider local healthcare structures and societal attitudes towards mental health. The diversity of approaches really goes to highlight the complexity of the relationship between length of stay and suicide prevention outcomes. It suggests that factors such as the quality of inpatient care, the robustness of community support systems, and the seamlessness of care transitions may be as important as the duration of hospitalization itself.

4.2. Special Populations

The relationship between length of stay and suicide prevention may differ significantly for special populations, necessitating tailored approaches to inpatient care and discharge planning.

Adolescents represent a unique population in psychiatric care, with specific developmental needs and risk factors. Longer stays may be beneficial for this group, allowing more time for family interventions and school reintegration planning (Brent et al., 2013). Family-based treatments, which often require more time to implement effectively, have shown promise in reducing suicide risk among adolescents (Esposito-Smythers et al., 2011). However, extended stays can also disrupt social development and education, potentially leading to long-term negative consequences. Balancing these factors is crucial, and some researchers have proposed intensive short-term programs as an alternative to prolonged hospitalization (Ougrin et al., 2018), which aim to provide comprehensive care while minimizing disruption to the adolescent's life.

Older adults present unique challenges in psychiatric care due to their higher rates of medical comorbidities and cognitive impairments. They may benefit from longer stays due to the need for comprehensive medical workups and more complex discharge planning (Draper, 2014). However, elderly patients are also at higher risk of functional decline during prolonged hospitalizations, a phenomenon known as "hospitalization-associated disability" (Covinsky et al., 2011). This risk must be weighed against the potential benefits of extended psychiatric care. Some researchers have proposed specialized geriatric psychiatry units that can address both mental health needs and functional preservation (Liptzin et al., 2019).

Women with postpartum psychiatric disorders represent a critical population due to the potential impact on both mother and infant. Longer stays may be necessary to ensure infant safety and establish mother-infant bonding (Meltzer-Brody et al., 2018). Specialized mother-baby units, which allow for joint admission of mother and infant, can provide targeted interventions that address both maternal mental health and infant development (Glangeaud-Freudenthal et al., 2014). These units often have longer average lengths of stay but have shown promising outcomes in terms of maternal recovery and mother-infant attachment.

Patients with co-occurring substance use disorders and mental illness (dual diagnosis) present unique challenges in terms of length of stay and treatment planning. Longer stays may be beneficial to manage withdrawal, initiate addiction treatment, and arrange ongoing support (Ries et al., 2009). However, retention can be challenging with this population, and there's a risk of leaving treatment against medical advice. Some studies have shown that integrated treatment programs, which address both mental health and substance use issues concurrently, may be more effective than traditional sequential treatment approaches (Drake et al., 2008).

Veterans represent a high-risk population for suicide, with unique needs related to combat exposure and military culture. Given the high suicide risk in this population, longer stays focused on trauma-informed care and transition to VA outpatient services may be beneficial (Denneson et al., 2016). The VA healthcare system has implemented

comprehensive suicide prevention programs, including enhanced follow-up care for high-risk veterans (Matarazzo et al., 2014). Some studies have suggested that longer inpatient stays, combined with intensive outpatient follow-up, may be particularly beneficial for veterans with PTSD and suicidal ideation (Ghahramanlou-Holloway et al., 2019).

4.3. Role of Family and Caregivers

Family and caregivers play a crucial role in supporting patients during and after hospitalization, influencing both the course of inpatient treatment and post-discharge outcomes. Family involvement in treatment planning and psychoeducation can significantly improve outcomes. Studies have shown that family psychoeducation programs can reduce relapse rates and improve medication adherence (Pitschel-Walz et al., 2001). Family therapy sessions during admission can address systemic issues contributing to the patient's distress, potentially reducing environmental stressors that contribute to suicide risk (Miklowitz & Chung, 2016).

Involving family in discharge planning is important to ensure a supportive home environment and improve adherence to follow-up care. Family members can provide valuable information about the patient's home environment and potential risks, allowing for more comprehensive safety planning (Khaleghparast et al., 2013). Education about medication management, recognition of warning signs, and crisis response can empower families to provide effective support post-discharge.

Family members often also provide day-to-day support and monitoring, serving as a crucial link between the patient and mental health services. Training families in safety planning and recognition of warning signs can also be important for suicide prevention (Frey et al., 2016). Some innovative programs have incorporated family members into crisis response plans, with promising results in reducing suicidal behavior (Stanley et al., 2018).

While family support is helpful, it's important to assess and address caregiver burden to ensure sustainable support. Caregivers of individuals with mental illness often experience significant stress, which can impact their own mental health and ability to provide effective support (Pompili et al., 2014). Providing resources, respite care, and support groups for families can be beneficial in reducing caregiver burnout and improving the quality of support provided to the patient.

Connecting families with peer support groups can provide valuable emotional support and practical advice. Peer support has been shown to reduce feelings of isolation and stigma among family members of individuals with mental illness (Chien & Norman, 2009). Some programs have incorporated peer support specialists into treatment teams, providing a unique perspective that can complement professional care (Davidson et al., 2012).

4.4. Ethical Considerations in Length of Stay Decisions and Involuntary Hospitalization

The decision-making process surrounding length of stay and involuntary hospitalization in psychiatric care involves challenging ethical considerations that intersect with clinical judgment, patient rights, and societal responsibilities. These ethical dilemmas require careful navigation by healthcare professionals, policymakers, and ethicists. The tension between respecting patient autonomy and fulfilling the professional duty to prevent harm is a central ethical dilemma in psychiatric care. Longer or involuntary stays may protect patients from self-harm but also infringe on their autonomy. This conflict is particularly acute in cases of suicidal patients who refuse treatment. Beauchamp and Childress (2001) argue that the principle of beneficence can sometimes justifiably override autonomy when there is a clear and present danger to the patient. However, Szmukler and Appelbaum (2008) caution against paternalistic approaches that may undermine long-term therapeutic relationships and patient trust in the mental health system. Striking the right balance requires careful consideration of individual circumstances, risk factors, and the potential long-term consequences of both action and inaction.

Ethical guidelines generally advocate for using the least restrictive level of care that can effectively manage risk. This principle, rooted in respect for patient autonomy and dignity, aims to minimize unnecessary infringements on personal liberty. However, it can sometimes conflict with clinical judgments about optimal length of stay. Niveau and Materi (2006) discuss how this principle should be applied in psychiatric settings, emphasizing the need for ongoing assessment and flexibility in care plans. The challenge lies in accurately determining the least restrictive option that still provides adequate protection and treatment. This requires a nuanced understanding of the patient's condition, support system, and available community resources.

The difficulty in accurately predicting suicide risk raises ethical questions about the justification for extended or involuntary admissions based on risk assessment. Large et al. (2011) argue that the low specificity of current risk assessment tools makes it ethically problematic to use them as the sole basis for restricting patient liberty. This

uncertainty calls for a more holistic approach to decision-making that considers multiple factors beyond just risk scores. Some ethicists propose a "risk-threshold" model, where the level of certainty required for intervention varies based on the severity of the potential outcome (Rosenbaum, 2016). This approach attempts to balance the ethical imperatives of protecting life and respecting individual liberty.

Ethical considerations arise when weighing the benefits of longer stays for individuals against the need to allocate limited psychiatric beds efficiently. This dilemma touches on broader questions of distributive justice in healthcare. Thornicroft and Tansella (2013) discuss the ethical implications of resource allocation decisions in mental health care, emphasizing the need for transparent and fair processes. Some argue for a utilitarian approach that seeks to maximize overall benefit across the patient population, while others advocate for a rights-based approach that ensures a minimum standard of care for all. Balancing these perspectives requires careful consideration of both individual patient needs and systemic constraints.

Extended or involuntary admissions may have long-term social and occupational consequences for patients, raising ethical concerns about proportionality. Link et al. (2008) have documented the persistent stigma associated with psychiatric hospitalization and its impact on social and economic opportunities. The ethical challenge lies in weighing these potential long-term harms against the immediate benefits of hospitalization. This consideration is particularly relevant for involuntary admissions, where the patient's own assessment of these trade-offs is overridden. Some ethicists argue for increased efforts to mitigate these social consequences through anti-stigma campaigns and legal protections against discrimination (Corrigan et al., 2014).

Ethical decision-making must also consider cultural factors that may influence a patient's perception of hospitalization and suicide. Kirmayer et al. (2011) emphasize the importance of cultural competence in psychiatric ethics, noting that cultural beliefs can significantly impact how patients understand mental illness, treatment, and the concept of autonomy itself. Failure to consider these cultural factors can lead to misdiagnosis, inappropriate treatment, and ethical misjudgments. Some ethicists advocate for a "cultural formulation" approach that systematically incorporates cultural considerations into clinical and ethical decision-making (Aggarwal et al., 2013).

Limitations

Several methodological issues complicate the interpretation of research in this area. Patients with longer stays may differ systematically from those with shorter stays in terms of illness severity, social support, or other factors that influence suicide risk, introducing potential confounding factors (Large et al., 2011). Studies use different definitions and time frames for measuring suicide-related outcomes, making direct comparisons challenging (Silverman et al., 2007). Ethical constraints make randomized controlled trials manipulating length of stay problematic, limiting the ability to establish causal relationships (Zhang et al., 2016). Variations in mental health care systems across countries and regions may limit the generalizability of findings, as noted by Thornicroft and Tansella (2013) in their discussion of balanced care models. Additionally, publication bias may skew the available evidence, as studies finding no association between length of stay and suicide outcomes may be less likely to be published (Chung et al., 2017). These methodological considerations underscore the need for cautious interpretation of research findings and highlight areas for improvement in future studies.

5. Conclusion and recommendations

The relationship between inpatient psychiatric admission length and suicide prevention is nuanced and context-dependent. While some evidence suggests that longer admissions may be associated with lower post-discharge suicide rates for certain diagnostic groups, the quality and intensity of care during admission and the robustness of post-discharge support appear to be equally crucial factors.

Rather than focusing solely on extending lengths of stay, a more effective approach to suicide prevention may involve implementing comprehensive, evidence-based suicide prevention programs during inpatient admissions. Admission length should be tailored to individual patient needs, considering diagnosis, risk factors, and treatment response. High-quality, intensive care should be ensured during shorter admissions when appropriate. Discharge planning and transition support should be strengthened to bridge the gap between inpatient and community care. Intensive post-discharge follow-up should be provided, particularly for high-risk patients and those with shorter admissions. Continued investment in community-based mental health services is also necessary to support patients in the long term.

Healthcare systems should adopt flexible policies allowing clinicians to tailor admission length based on individual patient needs and risk factors, rather than rigid, universal length-of-stay mandates. Policymakers should prioritize

investment in comprehensive, evidence-based suicide prevention programs spanning the continuum of care from inpatient admission through post-discharge follow-up.

To support shorter inpatient stays when appropriate, concurrent investment in strengthening community mental health services is necessary, including resources for intensive outpatient programs, crisis intervention services, and long-term support. Ongoing training and education for mental health professionals on best practices in suicide risk assessment, management, and prevention is crucial, including guidance on determining appropriate lengths of stay and discharge planning.

Policymakers also need to address systemic barriers contributing to premature discharge or inadequate post-discharge care, such as reforming insurance policies, addressing workforce shortages in mental health care, and improving coordination between inpatient and outpatient services.

Ultimately, the goal should be to provide each patient with the most appropriate level and duration of care to effectively manage their acute crisis, develop coping skills, and successfully transition back to the community with adequate support. This individualized, comprehensive approach is likely to be more effective in preventing suicide than any universal policy regarding length of stay.

Future research should focus on identifying the specific components of inpatient care and post-discharge support that are most effective in preventing suicide, rather than solely on admission duration. Studies examining the cost-effectiveness of various approaches to balancing inpatient and outpatient care in suicide prevention would be valuable as well for informing policy decisions.

Compliance with ethical standards

Disclosure of conflict of interest

No conflict of interest to be disclosed.

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