Don't forget : contributions to the assessment and management of suicide attempters in the general hospital

Verwey, Bastiaan

PART I – GUIDELINES FOR THE ASSESSMENT OF SUICIDE ATTEMPTERS

Chapter 2 – Guidelines and their observance in the psychiatric care of suicide attempters in general hospitals

BAS VERWEY, GERRIT T. KOOPMANS, BRENT C. OPMEER, FRANS G. ZITMAN AND FRITS J. HUYSE

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ABSTRACT

Objective

To gain insight into guidelines established for the care of suicide attempters in general hospitals, and into the degree to which these guidelines are observed in practice.

Design

Descriptive, retrospective.

Method

An inventory of recommendations for the care of suicide attempters was made by interviewing psychiatrists on the staff of seven general hospitals. The inventory was limited to recommendations concerning access (interval between admission and referral/consultation), and coordination of the care (i.e. adjustment to the patients' condition, transfer of information). Subsequently, using data from a more extensive European study that included all cases of suicide attempters admitted to the seven hospitals in 1991, it was studied how these recommendations were observed in practice.

Results

In all seven hospitals there appeared to be regulations for management and assessment of suicide attempters. Recommendations concerning accessibility of care were fairly similar in the various hospitals. Regarding the coordination of care, more local variants were found to exist. The accessibility of care was found to be mostly in accordance with the recommendations. There were more deviations from the recommendations concerning the coordination of care; in addition, there were substantial differences between hospitals in the degree to which deviation from the guidelines occurred.

Conclusion

Guidelines for the care of suicide attempters admitted to general hospitals were not similar in all respects; the observance differed markedly, especially regarding the coordination of care.

INTRODUCTION

About 30% of patients who attempt suicide are being admitted to a general hospital (Kerkhof, 1985). The reason for admittance is usually the somatic condition of the patient. Not only are observation and taking care of patients' safety necessary, but a psychiatric assessment needs to be done as well. In order to ensure quality, guidelines for the assessment of suicide attempters have been developed (Centraal Begeleidingsinstituut voor de Intercollegiale Toetsing, 1991).

Patients have to be admitted to a ward where they can get the somatic care they need. The psychiatrist should be involved as soon as possible in the care needed for suicide attempters, and must be able to provide the needed care quickly, even outside office hours. Suicide attempters who are not alert during their first consultation with the psychiatrist should be reassessed at a later time (Laan & Verwey, 1992). A hetero-anamnesis as well as information from (former) care givers is often needed, especially with patients who are intoxicated, in order to make an accurate assessment. Gaining information about the cause of the attempted suicide, and preparing for care after admission may be reasons to talk not only to the patient but also to others. In order to increase the chance of the suicide attempter receiving adequate aftercare it is, of course, important to have contact with the aftercare provider.

In the study presented here an attempt has been made to gain insight into the quality of care given in general hospitals to suicide attempters. The research focused especially on aspects of quality of accessibility and coordination of care (Harteloh & Casparie, 1991). The following key questions were asked:

- Which guidelines concerning accessibility and coordination of care do hospitals use for the management of suicide attempters?
- To what extent is the provided care in accordance with the guidelines used?

PATIENTS AND METHODS

This study was carried out in 2 academic and 5 general hospitals in the Netherlands. Selection of hospitals was based on participation in a more extensive European study: the 'European Consultation Liaison Workgroup (ECLW) Collaborative Study'. Described elsewhere is how this research was developed and which method was used (Huyse, 1991; Huyse, Herzog, Malt, & Lobo, 1996; Lobo, Huyse, Herzog, Malt, & Opmeer, 1996; Malt, Huyse, Herzog, Lobo, & Rijssenbeek, 1996). In this study data were collected of patients admitted to

general hospitals in 1991 who had been referred to the psychiatric consultation liaison service. For the present study, an inventory was made as to which guidelines were used in the different hospitals. Patients were then selected from the ECLW study who had been referred because of a suicide attempt (n = 348). Patients who were only assessed in an Emergency Department were excluded.

To determine if guidelines existed for the management of suicide attempters, interviews were held with the psychiatrists of the hospitals that are included in this study. In 5 of the hospitals there were written guidelines in 2 there were verbally agreed upon guidelines. Especially those recommendations were investigated that had to do with the degree to which care was available (accessibility) and the degree to which care was adapted to the patient (coordination: is the care given at the right place and at the right moment and how does transfer of information take place?).

For the statistical analysis, differences between hospitals were tested using the $\chi 2$-test.

RESULTS

Hospital and service characteristics. The psychiatric consultation services of the 7 hospitals differed with regard to the availability of staff: the largest service had a personnel capacity of 0.38 so-called fulltime equivalent (fte) for 1000 admissions and the smallest service one of 0.07 fte for 1000 admissions. Most of the services had about 0,2 fte for 1000 admissions. The percentage of suicide attempters as a part of the total number of psychiatric consults varied from 9.8 to 41.1 with an average of 17.9.

Patient characteristics. Women were somewhat more represented and almost half of the referrals were young adults. The majority of the patients (70%) were single, divorced or widowed. Almost 35% lived alone (Table 1).

A large number had a psychiatric history: almost 35% had been admitted to a psychiatric hospital one or more times in the previous 5 years. Around 35% was already receiving treatment from an outpatient facility for mental health care (GGZ) (Table 2).

Guidelines. The various recommendations used in the different hospitals for the management of suicide attempters are noted below. Also noted is whether the ECLW study contained criteria to determine the observance of the recommendation.

– Psychiatric consultation should be requested within 24 hours after admittance. All hospitals required this recommendation. Date of admission and date of request for consultation were registered in the ECLW study.

Table 1 Demographic characteristics of 348 patients who were admitted to a general hospital because of a suicide attempt in 1991

	N	(%)
Sex		
Male	160	(46.0)
Female	187	(53.7)
Unknown	1	(0.3)
Age in years		
< 18	4	(1.1)
18-34	167	(48.0)
35-50	109	(31.3)
51-64	25	(7.2)
65-74	14	(4.0)
≥ 75	16	(4.6)
Unknown	13	(3.7)
Marital status		
Unmarried	178	(51.1)
Married	97	(27.9)
Divorced	52	(14.9)
Widowed	14	(4.0)
Unknown	7	(2.0)
Living situation		
Alone	121	(34.8)
With others	222	(63.8)
Unknown	5	(1.4)

Table 2 Psychiatric history of 348 patients who were admitted to a general hospital because of a suicide attempt in 1991

	N	(%)
Psychiatric care (previous 5 years)		
None	113	(32.5)
General practitioner	17	(4.9)
Outpatient	89	(25.6)
1 or 2 admissions	76	(21.8)
3 or more admissions	45	(12.9)
Unknown	8	(2.3)
Somatic care (previous 5 years)		
None	122	(35.1)
General practitioner	70	(20.1)
Outpatient	41	(11.8)
1 or 2 admissions	60	(17.2)
3 or more admission	20	(5.7)
Unknown	35	(10.1)
Actual outpatient treatment		
None	161	(46.3)
Social worker	9	(2.6)
General practitioner	35	(10.1)
Outpatient psychiatric	123	(35.3)
Own consultation-liaison service	12	(3.4)
Unknown	8	(2.3)
Psychiatric diagnosis (ICD-10)		
None or	61	(17.5)
F0 – organic syndrome	16	(4.6)
F1 – use of psychoactive substances	58	(16.7)
F2 – schizophrenia	58	(16.7)
F3 – mood disorders	38	(10.9)
F4 – other	117	(33.6)

ICD = International Classification of Diseases, 10th version

– The consultation should be carried out on the same day as the request. Date of request and date of first consultation were registered in the ECLW study.
– The psychiatric consultation service is available during as well as outside office hours, but consultation requests should be made as much as possible during office hours. This applied to all hospitals.
– Patient is assessed when alert (6 hospitals) or immediately (1 hospital). To determine patients' alertness at the moment of first consultation the 'Reaction level scale –85' was used. This scale distinguishes 8 degrees ('alert', 'drowsy or confused', 'very drowsy or confused', etcetera), depending on how patients react to stimuli (being talked to, touched, yelled at, shaken or having pain administered) (Starmark, Stalhammar, & Holmgren, 1988).
– Patients who were not alert during the first consultation should be given a follow-up consultation. How often a patient was given a follow-up consultation was registered.
– Information from general practitioner, mental health care provider and significant others (family) should always be collected (5 hospitals) or only after indication (2 hospitals). It was registered whether information was collected from medical sources, social sources, mental health service institutions, family and others as well as other sources.
– Family is, if possible, always present during the consultation (5 hospitals) or only if the psychiatrist thinks this is necessary (2 hospitals). It was registered to whom the psychiatric treatment or behavioural approach was directed: patient, family or staff.
– Communication with the aftercare provider should always be carried out by telephone and in writing (4 hospitals), always by telephone (2 hospitals) or always in writing (1 hospital). It was registered whether the aftercare provider was informed and, if so, how: by telephone, in writing, by both telephone and in writing.

Performance of the recommendations. A statistically significant difference was found among hospitals concerning the performance of the recommendation that a consult should be requested within 24h after admittance (Table 3). In 33% of all cases in one hospital a consult request was made on the day of admittance while in another hospital that applied to 68% of the cases.

There was also a significant statistical difference among hospitals in performing the recommendation that consultation occur on the same day as the request. For the two hospitals that were below the average, 62% and 75% respectively of suicide attempters were assessed on day of admittance, according to the recommentation.

Also, a statistically significant difference was found in the percentage of

Table 3 Performance of recommendations in 348 patients who were admitted to a general hospital in 1991*

	Hospital								
	1 (n = 59)	2 (n = 45)	3 (n = 47)	4 (n = 26)	5 (n = 40)	6 (n = 85)	7 (n = 46)	Total (n = 348)	*P***
Request for consult < 24 h	47	60	68	58	48	53	33	52	< 0.05
Consultation on day of admission	86	87	94	62	75	87	85	84	0.000
Consultation within office hours	63	69	66	85	93	82	76	76	0.008
Patient alert at first consultation	63	87	75	75	83	72	89	77	0.02
Reassessment of non-alert patients	90	75	67	100	29	95	80	81	≥ 0.05
Collection of information	86	49	81	100	38	71	85	72	
Family participation	50	18	14	47	14	38	30	31	< 0.01

* percentages are given for observance of recommendations

** the value *P* represents the difference among hospitals in the observance of recommendations (χ2-test)

consultations for suicide attempters occurring outside office hours. In 3 hospitals almost one third of consultations were performed outside office hours.

An average of 77% of the patients was alert during the first consultation, 17% was drowsy and 5% very drowsy or unconscious. The hospitals differed statistically significantly concerning the percentage of patients being assessed when alert. At hospital 3, where the recommendation existed to perform consultation immediately for all patients, the percentage of non-alert patients was not the highest, while in one of the hospitals that recommended consulting alert patients only, almost 40% of the patients was not alert.

Often (81% on average), patients who were not alert were seen for a follow-up consult. In 1 hospital this percentage was considerably lower (29%). These numbers were too small to interpret statistically.

In an average of 72% of the cases information was collected from one or more external sources. The degree to which information was collected from external sources differed among hospitals, but evaluation of the differences was not useful because 2 different recommendations were being used. One of the 2 hospitals (2 and 7) with the recommendation that only information be collected on indication was found to have collected information for more than the average (85% of the cases). In hospital 5, where the recommendation prescribed collection of information, it only happened in 38% of the cases.

When only patients who lived with others were examined, in a small number of cases the family was involved during consultation (mean 31%; range 14-

50). Hospitals differed significantly on this point. In hospitals (1,3,4,5,6) that recommended family involvement, it was found that this occurred in 2 hospitals in only 14% of the cases.

Communication with an aftercare provider took place in an average of 86% of the cases. Only written communication took place in just 22% of the cases, only by telephone in 32% of the cases, and by telephone and in writing in 46% of the cases. Because 3 different recommendations were used, analysis was not useful. One hospital communicated with aftercare providers in 100% of the cases, while in another hospital no form of communication whatsoever was carried out in 33% of the cases. The hospitals that followed the recommendation to communicate in writing as well as by telephone proved not to communicate on a regular basis in writing (one hospital failed to do this in more than 15% of the cases). The hospital that claimed to prefer written communication achieved the highest score: in 87% of the cases the aftercare provider was informed in writing. The hospitals that preferred to communicate by telephone did not show better results on this point (see Table 3).

DISCUSSION

In all hospitals agreed-upon rules existed for the assessment and management of suicide attempters. The recommendations concerning accessibility of care showed a greater similarity than those concerning coordination of care. With regard to the carrying out of the recommendations, there was a substantial discrepancy with the norm that they had created themselves.

The validity of the developed criteria can be criticized, because the data were collected from a study with a more extensive goal. Criteria that directly evaluated the recommendations that were used proved more sound than others. A criterion of measuring the time in days between date of admittance and date of consultation is very much reliable for studying the observance of the recommendation that a suicide attempter must be assessed within 24 hours after admittance. This is much less the case for the criterion where one tests whether the family participated in the consult.

All of this implies that the sometimes large discrepancies that were found cannot be labeled as inadequate care. Nevertheless, the results do show a certain pattern for which we think we can offer some tentative conclusions.

Concerning the accessibility of care it was found that clinical practice was, to a fair if not high degree, in accordance with the recommendations. In general, there was a prompt response to requests for consultation, especially in case of emergency, while at the same time, most consultations were performed dur-

ing office hours. However, in many cases consultation was not requested within the time period that was recommended in the guideline.

Concerning the coordination of care, the recommendations themselves showed not only a large diversity, but the degree to which they were carried out also varied. All but 1 of the hospitals had recommended that patients should be alert when assessed, but the results show that in practice this was not followed in almost a quarter of the cases. The recommendation of participation of family during consultation that was prescribed by 5 of the 7 hospitals appeared to be difficult to achieve by all. Communication with aftercare providers that was prescribed by all hospitals as necessary was performed well by some of them, but in one hospital this did not occur in about a third of the cases.

Especially those recommendations in which several parties were involved seemed rather fragile. Recommendations for which only the consultation service was responsible, as in the case of response time on requests and also in reassessing non-alert patients, were carried out well by the majority of the services.

Perhaps suicide attempters receive primarily 'first aid' care with other care being given less precisely (meaning: according to the guidelines). Because the care that follows 'first aid' care is very intensive, there might be a relationship here with available manpower. Taking into account the small number of hospitals participating in this study, it is not possible, within the boundaries of this study, to prove this. However, ECLW study data showed that total time spent on a case was in 76% of the cases no more than 120 minutes (and in 41% of the cases a maximum of 60 minutes). If patients must be assessed in that amount of time and relevant information must be collected from others (family, general practitioner) and communicated, this seems too little time for this.

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