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

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Chapter 4 – Guidelines for the assessment of suicide attempters in institutions for mental health in the Netherlands: investigation into availability, content, and quality

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ABSTRACT

Background

Suicide attempts are frequent occurrences, also in Mental Health Institutions (MHI). Various countries have published guidelines for assessing suicide attempters and in 1991, the initiative was taken to produce a Dutch version. The World Health Organization (WHO) makes the case for developing and implementing such guidelines in MHI.

Aim

To establish the availability, content and quality of guidelines for assessing suicide attempters in MHI in the Netherlands and to compare these with similar guidelines used by university and general hospitals.

Method

All MHI were asked in writing whether they had a set of guidelines, when these had been drawn up, whether they were regularly revised and whether compliance with the guidelines was tested. Criteria for assessing the content of available guidelines were derived from the literature. In addition, the guidelines were assessed using the AGREE, a tool developed to evaluate guideline quality.

Results

Thirty-eight of 48 (79.2%) MHI responded and access was given to a total of 12 sets of guidelines. Two of these were more than 5 years old and virtually none had been revised. In a third of the guidelines monitoring with staff compliance was required. Instructions for addressing staff attitude towards patients were described least, and those for somatic assessment, patients' safety and coping with non-cooperative patients appeared in fewer than two-thirds of the guidelines. Instructions for carrying out a psychiatric consultation and the accompanying tasks were often described extensively. Instructions for involving 'significant others' in the assessment were found most frequently.

In the AGREE domains 'Clarity and Presentation' and 'Scope and Purpose' an average of more than 60% of the maximum score was found; the scores in the other domains were less than 30%. Ten guidelines were designated 'to be recommended (with provisos or alterations)'. A comparison of the content and quality of such guidelines of MHI with those of university and general hospitals revealed several differences, with the guidelines of the MHI scoring, on the whole, better.

Conclusion

Guidelines are only available in a minority of MHI, and the same is true for university and general hospitals. Although the content of the guidelines could be considered to be adequate, certainly if compared with the guidelines of hospitals, some important criteria were lacking. The quality of MHI guidelines, as measured with the AGREE, was low but better than that of the guidelines of the hospitals.

INTRODUCTION

Between 1997 and 2002, some 1500 people in the Netherlands committed suicide (CBS, 2004), about 9 per 100.000 residents. Annually there are about 15.000 suicide attempts. Some 23% of the suicide attempters try more than once (Bille-Brahe et al., 1997; Owens, Horrocks, & House, 2002) and a long-term follow-up study established that at least 1% succeeded in killing themselves within one year and at least 2% within 10 years (Hawton & Fagg, 1988; Hawton, Zahl, & Weatherall, 2003; Suokas, Suominen, Isometsa, Ostamo, & Lonnqvist, 2001). Longer term follow-up revealed even higher percentages (Suominen et al., 2004). The World Health Organisation (WHO) argues for prevention programs which address different areas of health care (WHO, 2000). Mental Health Institutions (MHI) are advised to draw up and implement guidelines for assessing suicide attempters. Approximately 15 years ago, the development of such guidelines was initiated in the Netherlands by the National Organization for Quality Assurance (Centraal Begeleidingsinstituut voor de Intercollegiale Toetsing, 1991). At that time, a workgroup of professionals produced 'a first draft for a protocol for assessing suicide attempters' in the general hospital. This was meant to assist carers 'in the integral care of suicide attempters', and, as far as we know has not undergone further development or testing.

During the past few years, professional groups in the USA, the UK and Australia have produced proposals for the assessment of suicide attempters and developed and published official guidelines (American Psychiatric Association, 2003; Boyce P., Carter G., Penrose-Wall J., Wilhelm K., & Goldney R., 2003; Goldberg, 1987; Hirschfeld & Russell, 1997; Isacsson & Rich, 2001; Lonnqvist & Suokas, 1992; Royal College of Psychiatrists, 2004; Simon, 2002; Packman, Marlitt, Bongar, & Pennuto, 2004).

Investigations into compliance with such guidelines are limited. It has been demonstrated that a psychiatric assessment has the effect of reducing the risk of a repeated attempt or even of suicide itself (Hickey, Hawton, Fagg, & Weitzel, 2001; Suokas & Lonnqvist, 1991). It is apparent from the few studies on the implementation and execution of guidelines or recommendations for assessing suicide attempters, that these leave a lot to be desired. (Barr, Leitner, & Thomas, 2005; Hawton & James, 1995; Hengeveld, Kerkhof, & van der Wal, 1988; Hulten et al., 2000; Owens & House, 1994). In the Netherlands, a study on guideline quality in seven hospitals established that there could be considerable differences in content and compliance, in particular with regard to the coordination of care for suicide attempters (Verwey, Koopmans, Opmeer, Zitman, & Huyse, 1997).

Recently, whether a study was carried out into Dutch university and general hospitals have their own set of guidelines for assessing suicide attempters and those available were studied for content and quality (Verwey et al., 2006). Because suicide attempters are also encountered within MHI (as out-patients, by the emergency service, in the institution), the hospital study was followed by an investigation into the availability, content and quality of such guidelines in MHI; the results are described in this article. Where possible, a comparison is made between the results of this study in MHI and those in university and general hospitals.

METHOD

In 2005 a short questionnaire with reply envelope was sent to the senior clinicians of all MHI (n = 48). Addresses were obtained from GGZ-Nederland, the organisation to which all MHI in the Netherlands are affiliated. All members running an integrated MHI or a RIAGG were included in the investigation. Four questions were asked: 'Does your institution use a guideline for the assessment of suicide attempters?' (yes/no); 'If so, since what year?' (year); 'From what year dates the most recent update?' (year); and 'If available, has the observance of the guideline been tested?' (yes, once; yes, regularly; no). The clinicians were asked to return their answers together with a copy of the guidelines if available. After a period of 4 weeks all those who had not yet responded were telephoned and again asked to cooperate with the investigation.

MEASUREMENTS

A. *Content of the guidelines*

Criteria to evaluate the content of local guidelines for assessing suicide attempters were adopted from the guidelines of the American Psychiatric Association (American Psychiatric Association, 2003), those of the College of Psychiatrists (Royal College of Psychiatrists, 2004) and those of the CBO (Centraal Begeleidingsinstituut voor de Intercollegiale Toetsing, 1991). Topics described in all three sets of guidelines as being important for assessment were considered to be a criterion. Specifically, we assessed whether the guidelines provided instructions to:

- 1 the 24-hour availability of a relevant expert (psychiatrist or other psychiatric carer) for the suicide attempter

- 2 address safety of the patient during the assessment process
- 3 promptly assess the physical condition of the suicide attempter (e.g. checking vital functions, referring to a physician, etc.), including the patient's level of consciousness
- 4 perform a psychiatric consultation for all patients, specifically to:
 - 4.1 perform a psychiatric examination
 - 4.2 assess suicidality
 - 4.3 identify patient factors associated with increased risk for suicide or repeated attempt
 - 4.4 assess stressors for the patient that may have caused the attempt
- 5 establish and maintain a therapeutic alliance between the professional and the patient
- 6 handle patients who were not cooperative or refused to be assessed
- 7 obtain information from others (heteroanamnesis)
- 8 assess significant others (partner, family, concerned parties)
- 9 organize treatment and/or aftercare
- 10 regional arrangements with institutions regarding the aftercare of suicide attempters

B. Guideline Quality

To evaluate the methodological quality of the local guidelines, we used the scale 'Appraisal of Guidelines for Research and Education' (AGREE) instrument (www.agreecollaboration.org) (2001). This validated tool has been developed by an international group of guideline experts and consists of 23 items organized in six domains. For most domains, Cronbach's α varied between 0.64 and 0.88 (2003). The tool is used in the evaluation of quality of guidelines for diagnosis and treatment of lung cancer (Harpole et al., 2003), guidelines for the treatment of depression in general hospitals (Voellinger et al., 2003) and guidelines for psychiatric treatments in Europe (Stiegler, Rummel, Wahlbeck, Kissling, & Leucht, 2005). Domains and items are as follows:

- 1 'Scope and purpose' (items 1-3). This domain scores the presence of specific descriptions of the overall objectives, the clinical questions covered, and the patients to whom the guideline is meant to apply.
- 2 'Stakeholder involvement' (items 4-7). This domain scores whether all relevant professionals participated in developing the guideline, whether the patient's view and preferences were sought after, whether the target users were defined and whether the guideline was pilot tested among users.
- 3 'Methodology' (items 8-14). This domain scores whether systematic methods were searched for evidence; whether the criteria for selecting the evi-

dence and the methods used to formulate the recommendations were clearly described; whether an explicit link was made between the recommendations and the supporting evidence; whether benefits, side-effects, and risks were considered when formulating the recommendations; whether the guideline was externally reviewed by experts prior to publication; and whether a procedure was provided for updating the guideline.

- 4 'Clarity and presentation' (items 15-18). This domain scored whether the recommendations were specific and unambiguous, whether the different management options were clearly presented, whether key recommendations were easily identifiable, and whether the guideline was supported with tools for application.
- 5 'Applicability' (items 19-21). Issues pertinent to guideline implementation were evaluated in this domain. Specific factors included organizational barriers, cost implications, and monitoring criteria.
- 6 'Editorial independence' (items 22-23). This domain scored whether conflicts of interest were recorded and whether the guideline was editorially independent. This domain was not used in this study because it was considered irrelevant to the subject. Some guidelines stated that the hospital administration or the medical staff had mandated that a group of cooperating professionals such as psychiatrists, nursing personnel, and managers develop the guideline.

The scores for each domain were obtained by summing up all the scores on an individual item in a domain and then standardizing them as follows:

$$\frac{\text{obtained score} - \text{minimum possible score}}{\text{maximum possible score} - \text{minimum possible score}} \times 100\%$$

The maximum possible score for each domain was the number of questions multiplied by the number of reviewers multiplied by four (i.e., the score for 'strongly agree'). The minimum possible score for a domain was the number of questions multiplied by the number of reviewers multiplied by one (i.e., the score for 'strongly disagree'). To understand the standardised scores see Table 6.

The final component of the AGREE instrument involves making a recommendation regarding the use of the guidelines in practice. The four categories are strongly recommended, recommended (with provisos or alterations), would not recommend, or unsure.

Three reviewers (B.V., J.v.W., and G.G.) independently scored the AGREE

instrument to evaluate the quality of the local guidelines. κ statistics were calculated for the agreement on recommendations of the guidelines, and the intra-class correlation coefficients were calculated for absolute agreement on the five domain scores. We used a mixed-effects model, because the only raters of interest were the three that participated in the study.

RESULTS

Response, availability of guidelines, date, revision and testing (Table 7)

Thirty-eight of the 48 MHI (79.2%) responded. Thirteen of the 38 (34.2%) MHI reported that they used local guidelines and 12 of these made them available for further scrutiny. Ten (83.3%) guidelines had been drawn up within the last 5 years. Two (16.7%) institutions stated that the guidelines were regularly brought up to date and that they had been revised within the past 2 years. Four (33.3%) reported that they regularly evaluated staff compliance with their guideline; the rest had not. Comparison with the guidelines of hospitals showed that with regard to response, availability and updating there were few differences. Hospital guidelines were significantly more frequently more than 5 years old, but were revised more often.

Criteria related to the content of the local guidelines (Table 8)

In 8 of the 12 guidelines (66.7%) it was indicated that a suicide attempter had the option of being assessed by a relevant expert 24 hours per day. Seven of the 12 (58.3%) gave instructions for guaranteeing the safety of the patient after the attempt. In 6 of the 12 (50.0%) guidelines, the first medical assessment was set out. Instructions for performing a psychiatric consultation by a psychiatrist (or other appointed psychiatric carer) after the attempt could be found in 10 (83.3%) of the local guidelines. Nine of these (75%) stated that psychiatric diagnosis should be carried out, 10 (83.3%) included a command to gauge suicidality, 9 (75%) included the establishment of stress factors in the patients leading to the attempt, and 9 (75%) guidelines described the need to perform an inventory of the risk factors. These last four criteria were mentioned significantly more often in the MHI guidelines than in those of the university and general hospitals.

Five of the 12 (41.7%) guidelines gave instructions on how to respond to the patient. Instructions on how to manage uncooperative patients or those who refuse to be assessed were provided in 6 of the 12 (50.0%). The importance of acquiring information from others was mentioned in 8 (66.7%) of the guidelines, and in 11 (91.7%) the importance of involving significant others in the

Table 6 Instructions for the overall assessment of guidelines using the 'Appraisal of Guidelines for Research & Evaluation' (AGREE)

Options:	Scores:	Practical consequence:
Strongly recommended	high (3 or 4) on the majority of items, and most of domain-scores > 60%	Guideline of high quality, that can be recommended for use in practice
Recommended (with provisos or alterations)	high (3 or 4) or low (1 or 2) on same number of items, and most domain-scores are > 30% and < 60%	Guideline of moderate quality by insufficient or lack of information in some items. When adjusted, the guideline can be appropriate to use in practice, particularly if no other guidelines are available
Not recommended	low (1 or 2) on majority of items, and most domain-scores < 30%	Guideline of low quality with severe shortcomings, that should not be used in practice

Table 7 Response to a questionnaire, and answers concerning availability, dating, updating and evaluation of staff compliance of guidelines for the assessment of suicide attempters of Mental Health Institutions, compared to those of university and general hospitals (Verwey et al., 2006)

	Mental Institutions N (%)	Hospitals N (%)	P*
Questionnaires sent	48	97	
Response	38 (79.2)	88 (90.7)	0.05
Local guideline available	13 (34.2)	34 (38.5)	0.64
Local guidelines submitted	12 (31.6)	27 (30.7)	0.92
Dated < 5 year	10 (83.3)	9 (33.3)	0.004
Updating	2 (16.7)	10 (37.0)	0.20
Evaluation of staff compliance	4 (33.3)	10 (37.0)	0.82

* Chi-square test

assessment was found. This criterion appeared significantly more often in the MHI guidelines than in those of the university and general hospitals. Description of the organization of aftercare appeared in 8 of 12 (66.7%) guidelines and 9 (75%) reported regional agreements on this point.

Scores in five of the six domains of the AGREE instrument (Table 9)

In the domain 'Scope and purpose' the average score was 63.6 (standard deviation SD 19.8), with 8 guidelines scoring > 60%. The average score for 'Stakeholder involvement' was 26.9 (SD 13.6), with none of the guidelines achieving > 60% and 6 even < 30%. No guideline was tested for implementation within the target group. The average score for the domain 'Methodology' was 16.3 (SD 13.0) and in 11 (91.7%) the result was < 30%. In none of the sets examined was a systematic literature search described as the basis for developing the guidelines. The domain 'Clarity and presentation' scored an average of 72.0 (SD 9.9), with 11 guidelines achieving > 60%. The domain 'Applicability' scored on average 20.1 (SD 8.7), with 11 guidelines scoring between 30 and 60%, and none of them > 60%. The average score of the MHI guidelines in the domain 'Scope and purpose' was significantly higher than that of the university and general hospitals. Although the average scores of the MHI guidelines were also higher in other domains, they were not significantly higher.

General assessment

The majority of the three assessors agreed that 1 of the local guidelines was 'strongly recommended' for use, that 10 were 'recommended (with provisos or alterations)' and 1 was 'not recommended' ($\kappa = 0.23$). The number of recommended MHI guidelines was significantly higher than was the case in the university and general hospitals.

DISCUSSION

The present study was the first to investigate the availability, content and quality of guidelines for the assessment of suicide attempters in MHI. It was an investigation of written agreements regarding the assessment of suicide attempters and not the established policy following a successful suicide during treatment of a patient or out-patient.

The collected data were compared to the results of a study carried out in all Dutch university and general hospitals (Verwey et al., 2006). The response to the written request to take part in this study was high (79.2%). A large minority of the MHI (34.2%) reported they had local guidelines for assessing suicide

Table 8 Criteria to evaluate the content of local guidelines for the assessment of suicide attempters of Mental Health Institutions (n = 12), compared to local guidelines of university and general hospitals (n = 27), (Verwey et al., 2006), in the Netherlands

Instructions to:	Number of MHI guidelines with instruction (%)	Number of guidelines of hospitals with instruction (%)	P
24 h availability of expert	8 (66.7%)	20 (74.1%)	0.71*
Address safety	7 (58.3%)	13 (48.1%)	0.56**
Prompt assessment of physical condition	6 (50.0%)	15 (55.6%)	0.75**
Perform psychiatric consultation	10 (83.3%)	19 (70.4%)	0.69*
Perform psychiatric examination	9 (75.0%)	10 (37.0%)	0.03**
Assess suicidality	10 (83.3%)	12 (44.4%)	0.02**
Identify risk factors	9 (75.0%)	11 (40.7%)	0.05**
Assess stressors	9 (75.0%)	10 (37.0%)	0.03**
Establish and maintain therapeutic alliance	5 (41.7%)	13 (48.1%)	0.71**
Handle non-cooperative or refusing patients	6 (50.0%)	17 (63.0%)	0.50*
Obtain information from others	8 (66.7%)	15 (55.6%)	0.73*
Assess significant others	11 (91.7%)	15 (55.6%)	0.03*
Organize aftercare	8 (66.7%)	16 (59.3%)	0.73*
Agreement with aftercare providers	9 (75.0%)	13 (48.1%)	0.12**

* Fisher Exact Test

** Chi-square Test

attempters, comparable to the situation in the hospitals. Considering that half of the guidelines is out of date after a period of 5.8 years (Shekelle et al., 2001), most MHI (83.3%) could be considered to have a recent one. This probably also explains why only a limited number of MHI guidelines has since been revised. Hospitals had significantly less recent guidelines. Maybe this can be explained by the fact that the CBO instigated the development of guidelines in general hospitals as early as 1991, while guideline development in MHI was only initiated a short time ago. After all, publication of guidelines by the Dutch Society for Psychiatry began in 1998. Also, from the point of view of practical application, it is important that staff compliance with the guidelines was only evaluated in one-third of the cases. In fact, the hospitals did not score much better in this respect (33.3% vs. 37.0%).

In the available institution guidelines, important matters such as the prompt assessment of the physical condition following a suicide attempt, safe-

Table 9 Domain-scores and overall assessment of the 'Appraisal of Guidelines for Research and Education' (AGREE) instrument of guidelines for the assessment of suicide attempters in Mental Health Institutions (n = 12), compared to guidelines of university and general hospitals (n = 27), (Verwey et al., 2006), in the Netherlands

AGREE domain	Mean score (%) of guidelines of MHI(SD)	Mean score (%) of guidelines of hospitals (SD)	P*
Scope and purpose (items 1-3)	63.3 (19.8)	43.3 (29.2)	0.05
Stakeholder involvement (items 4-7)	26.9 (13.6)	22.4 (17.5)	0.31
Methodology (items 8-14)	16.3 (13.0)	11.8 (11.0)	0.31
Clarity and presentation (items 15-18)	72.0 (9.9)	64.9 (16.0)	0.23
Applicability (items 19-21)	20.1 (8.7)	14.81 (12.4)	0.10
Overall assessment			P**
Not recommended by >1 appraiser (%)	1 (8.3)	16 (59.3)	
Recommended (with provisos and alterations) by >1 appraiser (%)	10 (83.4)	10 (37.0)	
Strongly recommended by >1 appraiser (%)	1 (8.3)	1 (3.7)	0.03

* Mann-Whitney U test

** Chi-square test

ty instructions and managing uncooperative patients were described in less than two-thirds of the cases. In the guidelines of the university and general hospitals, these were mentioned even less frequently. The need for a psychiatric consultation following a suicide attempt was described in the majority of MHI guidelines (83%), as well as the various duties of the psychiatrist or appointed psychiatric health carer. Indeed, general and university hospital guidelines also described psychiatric consultation as being necessary, but description of the various tasks was found significantly less often. It is in any case surprising that the first medical assessment and the psychiatric consultation following a suicide attempt were not described in all the guidelines.

Of all criteria investigated in MHI guidelines, those on how to respond to the patient following a suicide attempt appeared least often (41.7%). Perhaps those instructions are more appropriate in guidelines for hospitals, where so many different employees – not only those working in psychiatric institutions – are

involved in the assessment of the suicide attempter. In contrast to this, it is known that suicide attempters can elicit transference reactions (Roose, 2001), which actually argues for the inclusion in guidelines of instructions on how to establish and maintain a therapeutic alliance between the professional and the patient. Instructions to assess significant others were provided significantly more often by MHI guidelines than by those of university and general hospitals. A possible explanation is that MHI guidelines are usually devised from a social-psychiatric viewpoint and those of hospitals on the basis of a biomedical model.

The assessment of the quality of the guidelines of MHI using the AGREE tool produced a higher average score in each domain compared to hospital guidelines, but this was only significant in the domain 'Scope and purpose'. In both MHI and hospital guidelines, however, these scores remained under 60% in the majority of domains. Although AGREE does not describe a cut-off point between 'good' and 'bad' guidelines, this result points to a quality limitation. Nevertheless, the raters 'recommended (with improvements and provisos)' most guidelines from MHI and significantly more often than those from hospitals. A possible explanation for this difference in quality could be that more hospital guidelines are developed by carers on the work floor, while MHI guidelines are more likely to be devised by specially trained and appointed personnel. The domains in which improvement of the scores by trained personnel would be expected ('Methodology' and 'Applicability') did, however, have the lowest score. Another explanation is that many MHI have merged, meaning that employees from different organizations have had to cooperate, giving rise to the need for an adequate written working agreement or set of guidelines. No doubt this occurred less often in hospitals.

One must still mention inter-rater reliability. The kappa value is low but this is a consequence of the expected very high agreement due to the small variability in scores.

Considering the number of available international guidelines for assessing suicide attempters, few MHI made use of these data for drawing up their local guidelines. None of them mentioned a systematic literature search to support their assumptions and advice; nor did those of university and general hospitals.

Although only a limited number of MHI have guidelines for the assessment of suicide attempters, this does not mean that these patients are not properly assessed in these institutions. This study only addresses the availability of written guidelines and not, for example, current verbal agreements. Development and implementation of guidelines are a few of the various approaches to improving the quality of care, even though the effects are difficult to demon-

strate (Grol, 2001). To assess suicide attempters, not only further improvement in the content and quality of existing guidelines in psychiatric institutions and hospitals is necessary, but also investigation into compliance with such guidelines and the effect on patient care.

CONCLUSION

About one-third of the Dutch MHI have a written local guideline for assessing suicide attempters. Considering the size of the clinical problem posed by suicide attempts, this number is small. If there is already a guideline in the MHI, the quality of content can be considered good, but important topics may be lacking from a number of guidelines. Methodological quality, measured using AGREE, is limited. However, compared with such guidelines in university and general hospitals in the Netherlands, the MHI guidelines do score better. Further development and implementation of guidelines for the assessment of suicide attempters in all MHI is certainly necessary, as well as evaluation of staff compliance.

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