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

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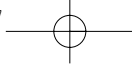
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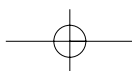
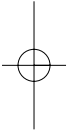
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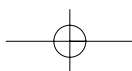
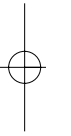
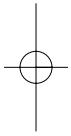
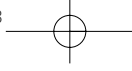
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Appendix





**RECOMMENDATIONS CONCERNING GUIDELINES
FOR THE ASSESSMENT AND MANAGEMENT
OF SUICIDE ATTEMPTERS IN THE GENERAL HOSPITAL**

As an appendix to this thesis, recommendations for guidelines are given based on the results of this thesis and those in the literature. Firstly, recommendations are proposed for a new national guideline. In addition to an updated Dutch national guideline, local guidelines or protocols should be developed (or updated) in each Dutch general and university hospital (together with their collaborating mental health institutions) to implement the national guidelines in the local setting. This is desirable, as there are large differences between regions with respect to the professional help available.

Secondly, recommendations are given for the implementation of the guideline in the hospital setting.

UPDATING THE DUTCH NATIONAL GUIDELINE

We recommend updating the Dutch national CBO-guideline from 1991 (Centraal Begeleidingsinstituut voor de Intercollegiale Toetsing, 1991). Based on the results of our studies on availability, content, and quality of guidelines for the assessment of suicide attempters and on the literature, the further recommendations can be made as follows:

- Update and develop the guideline by using a quality evaluation instrument, such as the AGREE instrument (www.agreecollaboration.org) (2001). This instrument might help to avoid the writing of a document that has no practical consequences.
- The guideline should contain paragraphs on the assessment, management, and treatment of suicide attempters.
- Base the guideline on existing international guidelines, primarily on the APA guideline, and expert opinions. Beside the former Dutch CBO-guideline, the Council Report 'Assessment following self-harm in adults' of the Royal College of Psychiatrists can be used as a starting point because of its concise descriptions of several aspects of the assessment of self-harm (Royal College of Psychiatrists, 2004). It identifies the competencies expected of both general and specialist staff, describes standards for organization and planning of self-harm services, for procedures and facilities, and for training and supervision. These are specifically described for the emergency department, the general hospital, the community setting, and the psychi-

atric in-patient unit. Furthermore, detailed advice is given regarding particular patient groups: the intoxicated patient, the 'repeater', and the patient who is reluctant or appears to refuse intervention.

- Discuss how to test the guideline on intentions and use for further validation prior to publication and implementation. Patients should also participate in the development process; for example, they can provide information on their experiences and expectations for care after a suicide attempt. An implementation process should be developed, and observance should be enhanced by monitoring the use of the guideline by the professionals. This is necessary to guarantee the best quality of care.
- Plan when and how evaluation of the guideline will be conducted.

RECOMMENDATIONS CONCERNING THE CONTENT OF THE DUTCH GUIDELINE

- In the national guideline an organizational protocol should be proposed with agreed-upon rules about care for suicide attempters provided by the existing regional hospital(s) and institution(s) for mental health care, general practitioners, ambulance service(s), police, municipalities, and general practitioners. This should include rules on emergency care and aftercare. All should be sensible about their role in the process of the managing and assessing suicide attempters.
- Separate but coherent guidelines describing the tasks of each professional involved need to be part of the guideline. Nurses, security guards, and somatic and psychiatric specialists should develop their own recommendations and these should be evaluated by the other disciplines and finally, integrated with each other.
- Recommendations should be developed to handle problems that frequently hamper adequate management and assessment. At minimum, the following subjects should be discussed: how to guarantee the safety of the patient and staff; staff attitude towards the patient; how to handle difficult patients; legal issues; and rules for who is responsible for the patient at each moment during admission.
- Providing patients with a written form containing the aftercare arrangements made with them in the hospital is recommended (see Figure 9).¹
- In order to make implementation of the guideline easier, a chronologically arranged checklist of the necessary actions that should not be forgotten

¹ This form was used for the last study of this thesis.

- by the mental health care provider should be summarized on one page (see Figure 10). This checklist can also be used for educational purposes.
- A short-term follow-up (by telephone or possibly at home) after discharge should be considered, especially for patients who used psychopharmacological drugs, (especially benzodiazepines); who repeated their suicide attempt; who do not have an adequate supportive network; whose relevant problems and needs for help are not clear; who will need support until after-care is organized; and who reject help, but for whom involuntary admission is not required.

**RECOMMENDATIONS FOR DEVELOPING A LOCAL GUIDELINE
OR POLICY DOCUMENT FOR THE ASSESSMENT AND MANAGEMENT
OF SUICIDE ATTEMPTERS**

- The initiator should ask or propose instructions of the hospitals' management and medical staff to develop an infrastructure for the assessment of suicide attempters in the general hospital. Define one or more goals of these guidelines. Without pretending to be complete, some of the goals might be to organize the assessment of suicide attempters presenting to the emergency department, determine who is responsible for the suicide attempter during the different phases of management and assessment in the emergency department, or ensure the safety of the suicide attempter when staying in the somatic ward or emergency department.
- Organize a hospital commission that will develop the recommendations formulated in the national guideline as well as the recommendations for the local setting that follow from them. Be sure that esteemed representatives of the professional groups involved in the care for suicide attempters participate in this commission. This implies participation of at least the consulting internist, surgeon, a representative of the emergency room-staff, the management of the emergency room, consulting psychiatrists, consulting psychiatric nurses, and the final responsible manager.
- Preferably, representatives from local mental health institutions and organizations of patients are invited to collaborate.

Most suicide attempts present to the hospital in the afternoon or evening. This should be taken into account by planning for professionals to work in the emergency room during these hours. For larger hospitals, a self-harm service can be developed that consists of trained professionals such as a psychiatrist, a resident, a nurse, a psychologist, and a social worker. In smaller hospitals, a

specialised consultation-liaison professional (consultation-liaison nurse, nurse practitioner, social worker or psychologist) should be available. Access to these professionals by emergency room staff should be easily available at all times (24 x 7), and can help standardize assessment and management directly as soon as the patient arrives. If necessary, somatic first aid is given, this professional can start obtaining information from the patient and others (significant others, general practitioner, or health care worker). Information from and about the patient will thus be available sooner, and can be used for further planning their management and treatment. This procedure might facilitate the coordination of care for the patient that in practice has been found to be difficult to realize.

Of course, the professional in charge should have the option to involve a psychiatrist 24 hours a day. In all cases, assessment by a psychiatrist should always be performed, preferably when the patient is alert.

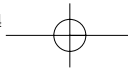
STRATEGIES TO ENHANCE USE OF LOCAL GUIDELINES OR PROTOCOLS

It has been proven that the development of guidelines does not guarantee their use (Feder, Eccles, Grol, Griffiths, & Grimshaw, 1999) (Grol & Grimshaw, 2003). Approaches on different levels (doctors, team practice, hospital, wider environment) tailored to specific settings and target groups are necessary to change medical practice. In the management and assessment of suicide attempters, the following strategies might be helpful:

- Nominate an administrator who calls together the hospital or regional commission that developed the guidelines on a regular basis, for example once every year.
- Nominate one or more persons to develop a training program for the disciplines involved with the management and assessment of suicide attempters.
- Nominate one person who is assigned to monitor the literature on new perspectives regarding the several guidelines.
- Nominate one person who is responsible for evaluating the guidelines annually.
- Choose at least one recommendation per guideline to evaluate within a particular time period and provide feedback to the users as soon as possible after the evaluation is done.
- Developing critical quality characteristics and indicators of quality can be chosen to guarantee quality of care.

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Arrangements for (name)

The first days after discharge you will stay at

The person(s) who is (are) willing to support you after discharge

The following medication(s) that are advised for you to use is (are)

In case of (renewed) suicidality you can

call _____ (name of significant other)

do _____ (other interventions)

The professional(s) who is(are) available or reachable for help, advice, and aftercare

_____ (name and telephone number)

The mental health care provider will inform your GP and your aftercare provider on the next working day

_____ (name)

An appointment for you has been made

at _____ (institution)

with _____ (name)

on _____ (date and time)

You have discussed with a professional whether you will be/not be reassessed

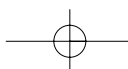
at home or _____ (place)

on _____ (date and time)

by _____ (name of professional)

Other arrangements

Figure 9 Information for patient about arrangements for short-term aftercare



Don't forget

- To appraise capacity, alertness, cooperation
- To check the somatic assessment and possibly treatment (are vital signs known, has evaluation of risk in the short and long term been done?)
- To assess suicidality (intentions, motives, actual suicidal ideation or plans)
- To determine psychiatric disorders (also substance disorders)
- To detect risk factors for repetition

Note! When in doubt about alertness of the patient, a reassessment should be made later

- To assess psychosocial factors related to suicide attempt
- To gather information about significant others *
- To gather information about health care providers (GP, social worker, psychologist/ psychiatrist)*
- To communicate decisions regarding discharge or admission to patient and significant others

Note! Arrangements for aftercare have been made

- To discuss where the patient will stay during the first few days after discharge
- To discuss who is (are) willing to support the patient after discharge
- To discuss if (and what) medication(s) eventually will be used by the patient
- To discuss what to do in case of (renewed) suicidality
- To discuss which professional(s) is(are) available or reachable for help, advice, and aftercare
- To provide a written form with aftercare arrangements and information to the patient
- To inform GP and aftercare provider the next working day
- To consider reassessment at home

* if available

Figure 10 Checklist for the assessment of suicide attempters

