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

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## Summary

The aim of this thesis was to contribute to better care for suicide attempters by studying several aspects of their assessment and management. In the first part of the thesis, the role of guidelines was studied resulting in suggestions for improvement. In the second part, the role of factors is studied that, as experience in clinical practice suggests, may hamper proper assessment and management.

In our first study, the availability of guidelines for the assessments of suicide attempters in hospitals and their observance were examined. Although guidelines were available in the seven hospitals studied, the execution of the recommendations in practice was not in concordance with these guidelines, especially concerning the coordination of care (Chapter 2). For example, most of the guidelines instructed that information about the patient should always be obtained from the general practitioner, mental health care provider, and family, but in practice this was not done.

Additionally, the availability, content, and quality of guidelines presently available for the assessment of suicide attempters were studied in university hospitals, general hospitals, and institutions for mental health care (Chapters 3 and 4). Only a minority of hospitals and institutions had local guidelines. Hence, their content and quality was not satisfactory. Remarkably, not all local guidelines described instructions for the provision of psychiatric consultation to every suicide attempter. Moreover, instructions for determining suicidality, performing psychiatric examinations, detecting risk factors, and psychosocial stressors were noted in 45% or less of the hospitals. Application of the quality AGREE-instrument indicated that the majority of guidelines in the university and general hospitals could not be recommended. The mental health institutions also appeared to have guidelines in a minority of cases. Although their content and quality was modest, significantly more guidelines from these institutions could be recommended than those from the hospitals.

Next, we studied two factors that influence proper assessment and management of suicide attempters; the amnesic effects of benzodiazepines and changes in the psychopathology and attitude of patients between admission and five days after discharge. It was found that suicide attempters who took a benzodiazepine overdose had worse memory function at the first assessment

than they did 24 hours later, comparable to the anterograde amnesia reported from benzodiazepines, even in subjects who, according to their own and the clinician's opinion, were not sedated (Chapter 5). The poorer outcome of the first memory assessment in suicide attempters could also be caused by other factors such as the stress of the attempt and subsequent admittance to the hospital. Therefore, we studied the strength of the relationship between the anterograde amnesia and the blood levels of benzodiazepines and its active metabolites. A significant inverse relationship between diazepam equivalents in blood and verbal recall was found. Comparing the assessments immediately after admittance to the assessments made the next day, more than 30% of the increase in verbal recall could be explained by a decrease in diazepam equivalents (Chapter 6).

In order to obtain information about the contribution of the stress of admission to memory impairment, we evaluated a group of subjects who had to undergo heart catheterization using the same parameters as in the benzodiazepine overdose study. Before heart catheterization, significantly higher scores on a verbal recall test were found than 24 hours later (Chapter 7), although, on both occasions, scores were within normal limits. It was concluded that admission to the hospital itself was not an important factor causing memory impairment in these cardiac patients. The same may be true in suicide attempters, strengthening the role of the benzodiazepines.

The assumption that the assessment of suicide attempters during their stay in the hospital is hampered by the unfavourable circumstances in the emergency room or somatic ward and the patients' condition, led to a study in which suicide attempters were reassessed at home shortly after discharge (Chapter 8). Patient's opinions about intention and motives to attempt suicide proved not to be significantly different on both occasions. Also, scores on a questionnaire measuring psychopathology did not differ significantly. However, at home patients stated that the motive for the suicide attempt had been less impulsive than they had reported in the hospital. The higher scores on worrying and the lower scores on self-esteem at home might suggest that these patients were in a worse condition than in the hospital some days before. Moreover, an alarming number of patients forgot what arrangements for aftercare had been made, although they were provided with a summary in written form in the hospital. Maybe the modest degree of compliance of suicide attempters with treatment is due to many patients forgetting their arrangements for help anyway. The finding of our study that most patients who rejected help in the hospital changed their minds about accepting aftercare a few days later, is hopeful. So, a reassessment after discharge in patients who rejected help might be worthwhile.

In the General Discussion the studies were critically reviewed and the consequences were described. From the studies in part 1, it was concluded that the available evidence suggests that guidelines for the assessment and management of suicide attempters differ to a large extent with respect to their content, that only a minority can be recommended based on an evaluation of their quality according to the AGREE instrument, and that they are probably not implemented properly. This leads to a plea to update the Dutch guideline, made 15 years ago, and to develop procedures that may promote implementation. From the studies of part 2, it was concluded that professionals should be alert on patients forgetting relevant aspects of the assessment. Furthermore, although a systematic assessment in the hospital is comparable to a reassessment at home, for a subgroup of patients there is concern about their condition after discharge, and their tendency to forget the arrangements made for treatment after discharge from the hospital. So, additional strategies to the assessment in the hospital should be developed.

In the Appendix, recommendations are given regarding development and implementation of guidelines for assessment and management of suicide attempters.

