Learning from suicides

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2010

document version
Publisher's PDF, also known as Version of record

Summary

In the Netherlands, a supervision system of suicides in mental health care aims to protect and improve the quality of care provided within mental health services. The aim of the current thesis is to evaluate the functioning of this supervision procedure.

In Chapter 1, the research questions of this thesis are presented. Furthermore, this chapter contains information about supervision by the Health Care Inspectorate and the background and aims of supervision of suicides by mental health care patients.

The Health Care Inspectorate uses the standards accepted within mental health services to assess suicide notifications, but a national interdisciplinary guideline for good clinical practice is not available in the Netherlands. Therefore, an overview of national and international guidelines for the treatment of suicidal patients is provided in Chapter 2, as is a conceptual framework for good clinical care. In the guidelines reviewed, main components in the treatment of suicidal patients are regular assessment of the suicide risk, adequate treatment of psychiatric disorders and suicidal impulses, involvement of family members and significant others, and continuity of care.

In Chapter 3, patient and treatment characteristics of 505 suicides by mental health care patients are provided, including the results of internal evaluations by clinicians involved. Results show that the majority of these patients died by suicide when hospitalised in a mental health care service or within 3 months of discharge (54%). More than two thirds (68%) expressed suicidal ideation or behaviors in the two months preceding the suicide, and the majority had a history of suicidal ideations or behavior (94%). Main diagnoses in the sample were depressive disorders (43%), schizophrenia and other psychotic disorders (28%), and substance disorders (8%).

In 26% of the 505 suicide notifications, the clinicians involved or the medical director reported that lessons were learned after the suicide, or that policy changes were installed. Most frequently, these lessons concerned improving communication among clinicians and continuity of care (n=52), improving suicide risk assessment procedures (n=32), more involvement of relatives in the treatment (n=16)and the use or adjustment of treatment guidelines (n=15).

In Chapter 4, responses made by the inspectorate to the sample of 505 suicide notifications (see chapter 3) were studied. In the total sample, 227 notifications received follow up: for 104 notifications this concerned requests for further information, for 106 notifications inspectors gave remarks or suggestions for improvement, and for 17

notifications the clinicians or services involved were contacted. Responses made by inspectors most frequently addressed whether a suicide had been evaluated by the clinicians involved, and what the results of this evaluation were. Also, the adequacy of treatment for psychiatric disorders, use of treatment guidelines and collaboration with other practitioners or services were important themes in the responses made by inspectors. Follow-up by the inspectorate was more likely when a suicide involved a patient treated in a mental health care setting for less than a year (χ^2=4,39, df=1, p=0.04), or when the notification was accompanied by the mental health institution's plans for improving its policies (χ^2=14,41, df=1, p<0.01). Further questions or remarks posed by the inspectorate occurred less often when a patient was discharged from inpatient care in the three months before the suicide (χ^2=4,52, df=1, p=0.03). In only one notification, the inspectorate addressed the use of no-suicide contracts, although the use of a contract was brought up in 23% of the notifications. Compared to 1996-2001, responses made by the inspectorate more frequently emphasized the importance of suicide risk assessment in the period 2002-2006 (37% vs 19%; χ^2=6.4, df=1, p=0.01). In conclusion, chapter 4 suggests that the inspectorate might improve supervision on suicides in mental health care by continuing their emphasis on systematic suicide risk assessment, and by giving more attention for the treatment for patients recently discharged from inpatient care, and more focus on a restrained use of no-suicide contracts.

Chapter 5 reports on a study undertaken to examine the views of medical directors (n=28), clinicians (n=30) and inspectors (n=15) on the suicide notification system in the Netherlands. Results of the interviews indicate ambivalence in both medical directors and clinicians concerning the effectiveness of the suicide notification procedure.

The evaluation of events and care preceding a suicide of a patient was unanimously seen as positive in the interviews. Supervision by the inspectorate was experienced to underline the importance of suicide prevention and to keep both the medical directors and clinicians alert. Another positive aspect of the procedure according to the interviewees was that the supervision system provides external monitoring of quality of care, ensuring detection of malfunctioning institutes or clinicians if necessary. In addition, the inspectorate has stimulated the development of policies for the treatment of suicidal patients. The main criticism on the suicide notification procedure provided by both medical directors and clinicians concentrates on the atmosphere of guilt or blame surrounding suicides in treatment settings.

It is concluded that the inspectorate has a stimulating role, motivating mental health care directors to critically self reflect, and opening discussion about suicide risk assessment, use of no-suicide contracts, continuity of care and the involvement of family members in the treatment of suicidal patients. Main points of criticism seem to center around the issue of guilt implied by the preventability driven work of the inspectorate and the focus on individual notifications instead of structural problems.

In Chapter 6, the use of no suicide contracting is discussed. In 23% of the 505 suicide notifications studied in chapter 3 and 4, a no-suicide arrangement was entered. However, clear evidence on the effects of a no-suicide contract is lacking. No-suicide contracts are no guarantee that a patient will not die by suicide, and they can have negative side effects. Alternatives to a no-suicide contract are proposed, such as suicide risk assessment, commitment to treatment statement and a postponement agreement, with potentially less negative side effects or more positive outcomes.

In Chapter 7, psychiatric and demographic characteristics collected in the study described in chapter 3 and 4, are used to answer the question if psychiatric diagnoses were associated with suicide methods. The results showed that psychotic disorders were associated with jumping from heights ($OR=3.42$, $p<0.05$), and substance-related disorders were associated with self-poisoning ($OR=4.13$, $p<0.05$). Depressive disorders were not associated with any particular suicide method.

In Chapter 8, a study into policies in mental health care services for the prevention of post discharge suicides is presented. One out of 10 locations for mental health care services had a standard policy for the prevention of suicide after discharge from psychiatric care. Four locations had an informal policy and 5 an ad hoc policy. In conclusion, only half of the mental health institutions employed a preventive policy regarding post-discharge suicide. Possibilities for prevention might not be fully utilised.

In Chapter 9, the findings of this thesis are discussed and the main conclusions are presented. Several methodological issues concerning the validity of the study are discussed. Finally, a new model for supervision based on the results of this current thesis is presented. In this new model, it is recommended that mental health care services employ a suicide prevention committee and thoroughly implement guidelines for the care of suicidal patients. Furthermore, in the proposed model there is less attention and emphasis on individual notifications and more emphasis on structural problems in mental health care provision and general suicide prevention

policies within mental health care services. It is hoped that this thesis can contribute to the optimal functioning of the supervision system of suicides in mental health care.