The role of the inspectorate in suicide prevention

Annemiek Huisman
Ad Kerkhof
Paul Robben
VU University Amsterdam
Research Questions

• Historical analysis 1996-2006: Which aspect of mental health care are focussed on by inspectors in suicide notifications?

• What is medical directors' and therapists' evaluation of the notification procedure of suicides?
Study into suicide notifications

505 suicide notifications (1996-2006) have been studied on:

• Demographics and treatment characteristics
• Aspects of good clinical care
• Responses by the inspectorate
Patient characteristics (n=505)

55% men 45% women

46% depressive disorder
28% psychotic disorders
7% manic depression
7% substance related disorders
4% anxiety disorders
9% other

at least 214 (43%) patients had a personality disorder
Treatment characteristics

351 (70%) ambulatory treatment
154 (30%) inpatient setting
117 (33%) within 3 months of discharge from inpatient care

17% was non-compliant, 35% missed appointments regularly, didn't take medication prescribed, etc.

8% was admitted involuntarily, for 17% involuntary addmittance was considered preceding the suicide

In 17% of the notifications, a full suicide risk assessment is given.

In about 116 (23%) cases, a no-suicide contract was arranged.
Results

25 % of the mental health services came up with evaluation point as a result of the evaluation of the suicide:

- 25% wrote, that with hindsight, things should have been handled differently (32)
- 9% formulated improvements in the aftercare of relatives of the patient (12)
- 66% (84) improvement in:
  - communication/continuity of care (36%)
  - suicide risk assessment (25%)
  - involvement of relatives during treatment (12%)
  - guidelines (11%)
# Results

Responses to suicide notifications

<table>
<thead>
<tr>
<th>Response</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>no further questions</td>
<td>278</td>
<td>55</td>
</tr>
<tr>
<td>further questions</td>
<td>104</td>
<td>21</td>
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<td>remarks/suggestions</td>
<td>106</td>
<td>21</td>
</tr>
<tr>
<td>contact</td>
<td>17</td>
<td>3</td>
</tr>
<tr>
<td><strong>total</strong></td>
<td>505</td>
<td>100</td>
</tr>
</tbody>
</table>
Results

analysis on content of responses by the inspectorate

60% evaluation of the suicide
38% treatment of psychiatric disorder
36% guidelines
29% collaboration and communication with therapists and institutions involved.
27% medication
27% suicide risk assessment
18% psychiatric assessment

15% continuity of care
15% involvement of relatives in the treatment
14% treatment of suicidality
12% the role of the psychiatrist in treatment
7% aftercare relatives
7% non compliance & involuntary admittance
Results

• remarks by the inspectorate:
  – insufficient involvement of a psychiatrist in the treatment
  – insufficient collaborations or communication
  – insufficient continuity of care
  – lack of guidelines for suicide prevention/treatment
  – inadequate suicide risk assessment
  – inadequate treatment of psychiatric disorder
  – not enough attention or communication with relatives of the patient
Results

• **more frequent responses by the inspectorate if:**
  
  * patient < 35
  * patient < 1 year treatment
  * other patients received signals of an imminent suicide
  * if it was unclear if suicidality was discussed with an inpatient
  * if point of learning were mentioned in the notification

• **less frequent responses by the inspectorate:**
  * if a patient had been discharged from inpatient care in the 3 months before the suicide
Results

Changes in responses through 1996-2006

In recent years (2002-2006), more attention was given to risk assessment, compared to 1996-2001 (19% vs. 37%, $X^2 = 6.4$, df=1, p=0.01).
Results

Suicide notifications without further questions or remarks (assessed by researchers):

- incomplete or inadequate risk assessment
- insufficient continuity of care
- no-suicide contracts
- inadequate decisions concerning admittance
- inadequate communication between parties involved
- inadequate supervision in inpatient settings
- inadequate communication with relatives
Conclusions

• Responses have become more in line with guidelines for suicide prevention (APA, 2003)

Possible improvements in supervision:

✓ more consequent supervision
✓ continuing emphasis on risk assessment by inspectors
✓ more emphasis on treatment of suicidal impulses
✓ more attention for older patients, patients who are chronically suicidal or discharged from clinical care
✓ more emphasis on a restraint use of no-suicide contracts
Study into the effects on mental health care

Interviews:

20 medical directors

20 therapists who recently sent a suicide notification
Results

medical directors:

• recent years more attention for the notifications by the inspectorate
• generally positive about procedure;
  - independent third party supervises
  - signal to personnel
Results

medical directors:

- the obligation to notify the inspectorate of every suicide implies that every suicide is preventable/a mistake has been made
- too much emphasis on risk assessment, role of the psychiatrist etc.
- questions are too detailed
Results

mental health workers:

• writing suicide notification is a manner to process the suicide and a dignified ending of the treatment
• sensitive for critisism
• fear for disciplinary case
Results

mental health workers:

• no further questions or remarks by the inspectorate are considered to be an approval by the inspectorate
Results

Openness in notifications:

Medical directors and therapist report to be open and frank in writing a suicide notification. Details sometimes are left out or the focus changed.

- problem: public nature of suicide notifications
Results

New format for notifications 2007

notifications are more similar

criticism:

too comprehensive

too much emphasis on risk assessment
Conclusions

- procedure has improved in recent years
- procedure is considered to be an effective instrument for supervision of calamities
- effectiveness in suicide prevention is not established
- there is uncertainty in mental health care field about the role of the inspectorate
Publications


