13th European Symposium on Suicide and Suicidal Behaviour, 1-4 September 2010, Rome, Italy

Development of a method to classify suicide risk and the level of observation in an acute closed ward


Introduction

The CCAP (Clinical Centre for Acute Psychiatry) is the largest acute closed ward in the Netherlands.

• Patients, in whom suicidal behaviour is recognised by a mental health worker, and have a high estimated suicide risk, are commonly admitted to an acute closed ward.

• Psychiatric inpatients are known to be highly at risk for committing suicide.1,2

• It is important to identify factors that are associated with suicide among inpatients to improve safety for patients as well as for the staff during hospital admission.3

• In July 2007 a method (‘safety plan’) was developed to estimate suicide risk and determine the clinical setting required for suicidal inpatients.

• Every patient receives a ‘danger code’, which is precisely described in a code manual developed by de Winter.4 This is summarised below in Table 1.

• This danger code is registered and evaluated on a daily basis during the reporting of the nursing to the medical staff.

Aim of this study

• Description of the safety plan and a preliminary evaluation of the experiences with this method over a 1-year period.

• Presentation of demographic and clinical characteristics of an inpatient population regarding the safety plan.

• Description of the experiences from working with this method among the staff of the CCAP.

Material and methods

• From 1st of January 2009 until the 31st of December 2009, 1283 patients were admitted. For 1281 patients (99.8%) the safety code and complete data were available.

• Patients (n = 137, 10.6%) with phase 4 and 5 (high suicide risk) were compared to patients (n = 1144, 89.4%) with phase 1, 2 and 3 (low suicide risk).

• The most frequently encountered clinical symptoms in acute psychiatry (e.g. depressive mood and suicidal behaviour) were closely monitored for each admitted patient.5

• During admission a DSM-IV diagnosis was assigned. Diagnoses were clustered in:

  1) Unipolar depressive disorder; 2) Bipolar disorder; 3) Psychotic disorders; 4) Substance abuse/dependence; 5) Alcohol abuse/dependence; 6) Anxiety disorder and 7) Personality disorders.

• An anonymous questionnaire was sent to the ward staff by www.thesis-tools.com, 36 staff members responded.

• Data analysis: Mann-Whitney U, t-tests and χ2 tests were used. The Statistical Package for Social Sciences version 17.0 (SPSS 17.0 INC, Chicago) was used for statistical analyses.

Results

Since the introduction of the safety plan in July 2007, 4 patients (2 females) committed suicide during admission (3 inside the clinic and 1 outside during leave). All suicides took place during data collection. One of these patients had been placed in one of the high risk phases (phase 4 and 5) during admission, the other 3 patients had been placed in phase 3 during the inpatient treatment. Ultimately 3 patients committed suicide during phase 3 and 1 during phase 2.

See Tables 2-5 for further information on demographic and clinical characteristics, and for the description of experiences from working with the safety plan among the staff.

Discussion

• The safety plan is used consistently, is clear for patients and staff, but it does not prevent suicide.

• The DSM-IV diagnose related highest to suicidal behaviour on this acute closed ward is unipolar depressive disorder.

• Symptoms related to a high estimated suicide risk are suicidal behaviour, self-injurious behaviour and depressive mood.

• Risk factors for suicide known within the general population differ from those among inpatients with a high estimated suicide risk on an acute ward.

Limitations

• The safety plan is a theoretically, non-empirically based, construct.

• Data on changes of the suicide risk codes over time were not collected.

• There is a lack of instruments for measuring psychopathology and for taxation of the risk of suicide.