Crisis and acute care in mental health

Health & Medicine, Mental Health

Introduction

The purpose of this assignment is to demonstrate an understanding on the nature of risk and risk assessment in relation tosuicide. There are a number of risk assessments used within the field of mentalhealth, but for this assignment we will focus specifically on evaluating the actuarial and clinical approaches when assessing suicidal clients. To conclude it will explore some of the challenges that nurse faces when assessing suicidal clients in crisis and acute care settings.

It is well established that people who have mental health problems are a high risk group for suicide (The National Suicide Strategy for England 2006). Primarily these are people who have experienceddepression, alcohol disorders, abuse, violence, loss, cultural and social background (WHO, 2011). Suicide is recognized as a serious and global public health problem. It is among the top 20 leading causes of death globally for all ages. It has been identified that a significant number of suicides occurred during a period of in patient care (Bertolote et al, 2003).

The Department of Health (DOH 2002) issued the report saving lives: Our Healthier Nation and set clear targets to reduce the death rates by suicide by at least a fifth by 2010. The national strategy highlighted that there needs to be a systematic approach to reduce suicide. Standard 7 of The National service framework for mental health (DOH 1999) emphasises on local trusts to implement policies to reduce the rates of suicide. All individual Trusts have developed a toolkit to work towards a trust wide suicide prevention

framework. According to Morgan (2007) mental health services have become ‘ operationalized’ through practice guidance from a central theme in the National Health Service’s National Service Framework (DOH 1999) and provide a particular emphasis on Care Programme Approach (DOH 2008). Anderson & Jenkins (2006) argue that although comprehensive strategies need to be in place the rate of suicide continues to be a concern. However recent figures show there has been a decrease in suicide rates in mental health patients particularly among young men in in- patient settings (National Confidential Enquiry into Suicide and Homicide by people with Mental illness 2010).

Risk assessment and risk management are concepts that are very familiar to mental health nurses and it encompasses the majority of nurse’s work. However Crowe & Carlyle (2003) argues these are taken for granted as a necessary and an unavoidable role within mental healthnursingas they defend nurses against potential litigation. According to Tummey & Turner (2008) the notion of risk has arguably displaced care when defining the purpose of patient contact. Beck (1999) suggests that risk assessment in the mental health care setting is an attempt to control the behaviour of patients and clinicians for the interests of the organisation rather than the best interest of the patient.

There are three types of risk assessment: the unstructured clinical approach, the actuarial approach and the structured clinical approach (DOH, 2007). Historically mental health practitioners used the unstructured clinical approach this was guided by intuition, experience and individual judgment to

determine the severity of risk. This approach has been criticized for being, unstructured, informal, and subjective consequently leading to a lack of consistency and reliability. (Turner & Tummey, 2008).

The drive to towards evidenced-based practice as a more objective and reliable means of risk assessment has led to the development to the actuarial risk assessment tools (Tummey & Turner 2000). This approach was derived from the insurance industry; it uses mathematical means to establish the outcome. Actuarial risk assessments are based on statistical probability they produce an estimate of risk collated form group data. They attempt to predict an individuals risk based on their future actions and look at the behaviour of others in similar circumstances (Hart & Kirby, 2004). According to Szmukler (2003) the actuarial approach eliminates the problem of the subjective clinical judgement and focuses on the actuarial risk assessment to form that decision making process. Tummey & Turner (2000) argue that an actuarial approach can create a false sense of expertise within clinicians particular for those who are less experienced. The scientific validity of this approach is open to criticism, Hart & Kirby, (2004) argue that humans act in very individual and unpredictable ways so therefore the scientific principles do not work. Bouch & Marshall (2005) recognises that the problem with this approach is that it focuses on the statistical outcomes rather than on gaining an understanding on the severity and the circumstances of the suicide. Silver & Miller (2002) affirms that an actuarial risk assessment is more useful in labelling an individual rather than understanding why they are behaving in a particular way. According to Turner & Tummey (2008)

actuarilism reduces an individuals risk to a range of inconsistent variables encompassed within a series of tick boxes. Research findings that support an actuarial approach over the clinical approach are controversial and cause considerable debate. Little child, B & Hawley, C (2009) suggest that there must be a mix of actuarial and clinical risk assessments to aide the clinician to gain a thorough risk assessment.

The structured clinical assessment utilises both the actuarial and clinical approaches. It draws on thescienceof actuarial approaches but attempts to take advantage of an informed clinical judgement through patient assessment (Conroy & Murrie, 2007). According to Doyle & Dolan, (2002), this approach is person specific and is based upon gaining the individuals history; present mental state and other relevant information to establish the risks for the individual, gathering this information is imperative due gain a thorough risk assessment. Structured clinical risk assessments are evidence-based, transparent, and flexible, and are aimed at establishing a collaborative approach (Haques et al 2008). Crowe & Carlyle (2003), reports that structured clinical risk assessessments aid clinicians to avoid missing potential information as they provide a way of organising clinical thinking. However risk assessments are only as good as the information they include and it is also dependent on the skills of clinician carrying out the risk assessment (Harrison et al 2004). Evidence suggests that there are no research instruments, scales or scores that can predict the risk with total accuracy it recognises that a combination of actuarial and clinical approaches enhance the dynamic and continuous process of risk assessment

(Doyle & Dolan, 2002). It is evident that the majority of research suggests that a risk assessment should encompass a mixture of an actuarial approach with a clinical approach to form the bases of a validated risk assessment tool.

Beck et al (1979) developed a classification system of suicidal behaviours, and assessment scales to assess suicidal intent. According to Anderson & Jenkins (2006) these assessment scales are an accepted, reliable and valid method used by professional's world wide. The Beck Suicide Intent scale (SIS; Beck et al 1974) is a 15- item questionnaire designed to assess the severity of suicidal intent associated with an episode of self harm. Each item scores 0-2, with the total score ranging to 30. It is divided into two sections: the first 8 items focus on the circumstances of the act (such as planning and attempts to avoid rescue). The remaining items are part of the self report section this is based on the patientreconstructionon their thoughts and feelings at the time of the act. Harriss & Hawton (2005) carried out a study which looked at 4, 156 deliberate self harm patients between 1993 and 1997. It concluded that the suicide intent scale could not predict who would commit suicide but noted the information gained about ideation and intent would be useful in a clinical risk assessment. Suominem et al (2004) argues that the scale is time consuming therefore a shortened version of the scale would be far more beneficial to use in clinical practice. Research suggests that this scale has some weaknesses over the value of self report. There may be bias within this section due to the fact that people may be ambivalent when answering questions regarding self harming and suicidal intent. Their

reflective account of the situation may not be a precise therefore it is difficult for the clinician to gain the correct information to use within the risk assessment tool (Barker, 2004). Risk assessment can have differ in results when different professionals complete them therefore the risk undoubtfully weakens the reliability on risk measurements with all risk tools.

Competent risk assessment, communicationand management within an acute mental health ward can be a major challenge for nurses, irrespective of their experience (Harrison et al 2004).

LOOK AT CHALLENGES NURSE FACE WHEN ASSESSING ACUTELY UNWELL PATIENTS FOR RISK OF SUICIDE. ?? IS THIS BARRIERS TO ENGAGEMENT IE RELIGION LANGUAGE BARRIER, ACUTELY UNWELL, ENVIRONMENTOF WARD , RACE GENDER, AGE ??? SECT 17 LEAVE OBS ETC ABSCONDING ????

Conclusion

Risk assessment continues to be a complex and

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