Crisis and acute care in mental health

The aim of this assignment is to demonstrate an understanding on the nature of risk and risk assessment in relation to suicide. There are various risk assessments used within the field of mental health; this assignment will focus specifically on evaluating the actuarial and clinical approaches when assessing suicidal clients. To conclude it will explore some of the challenges faced by nurses 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). Predominantly these are people who have experienced depression, alcohol disorders, abuse, violence, loss, and consider their cultural and social background (World Health Organisation (WHO) 2011). Suicide is recognized as a severe worldwide public health dilemma. It is one of top 20 leading causes of death internationally for all ages. A considerable number of suicides have occurred during an episode of in patient care (Bertolote et al 2003).

The Department of Health (DOH 2002) issued the report saving lives: Our Healthier Nation (DOH 1999a), within this clear targets were set to reduce the death rates of suicide by 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) puts emphasis 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 the National Health Service's National Service Framework (DOH 1999) and provide a particular emphasis within the Care Programme Approach (DOH 2008), although Anderson & Jenkins (2006) argue that even though comprehensive strategies need to be in position the rate of suicide continues to be a concern. However recent figures show a decrease in suicide rates in mental health patients this is predominantly among

young men within an in patient setting. (National Confidential Enquiry into Suicide and Homicide by people with Mental illness 2010).

Risk assessment and risk management are very familiar to mental health nurses and play an imperative part in their role as a health care professional. However these concepts are taken for granted within mental health nursing as they play a central role in the defence against potential litigation (Crowe & Carlyle 2003). According to Tummey & Turner (2008) the concept of risk has displaced care when defining the significance of patient contact. Beck (1999) suggests that risk assessment is not in the best interest of the patient it is an attempt for the organisation to control the behaviour of patients and staff.

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 their clinical judgment to asses the severity of risk. However this approach has been criticized for being unstructured and subjective leading to inconsistency and unreliability. (Tummey & Turner 2008).

The drive to towards evidenced-based practice as a more objective and reliable means of risk assessment has led to the development of actuarial risk assessment tools (Tummey & Turner 2008). 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 from group data. They attempt to predict an individuals risk based on their future actions and look at the behaviour of others in comparable situations (Hart & Kirby 2004). According to Szmukler (2003) the actuarial approach eliminates the problem of subjective clinical judgement and focuses on the actuarial risk assessment to inform the decision making process, although Tummey & Turner (2008) would argue that an actuarial approach can create a deceptive sense of proficiency within clinicians particular for those who

are less experienced. Therefore it could be argued that actuarial approaches can be subjective in their outcomes depending on the skills of the clinician. The scientific validity of this approach is open to criticism; Hart & Kirby (2004) argue that humans act in very individual and random ways 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 the severity and circumstances of the suicide. Silver & Miller (2002) affirms that an actuarial risk assessment is more constructive in labelling an individual rather than considering why they are behaving in a particular way. According to Tummey & Turner (2008) actuarailism reduces an individuals risk to a range of changeable variables encompassed within a sequence of tick boxes. Research acknowledges that

the use of an actuarial approach over the clinical approach can cause considerable discussion. However Little child & Hawley (2009) suggest there must be a mix of actuarial and clinical risk assessments to guide the nurse to form an accurate risk assessment.

The structured clinical assessment utilises both the actuarial and clinical approaches. It draws on the science of 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 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 in order to gain a thorough risk assessment. Haques et al (2008) consider structured clinical risk assessments to be evidence-based, transparent and flexible and they encompass a collaborative approach. Crowe & Carlyle (2003), reports that structured clinical risk assessessments help clinicians to avoid missing potential information as they offer a means of clinical thinking. However Harrison et al (2004) argues that risk assessments are only of good quality if the information is present and this is only possible if the clinician is competent in risk assessing. Evidence suggests that there are no research instruments, scales or scores that can predict the risk with total precision. Research suggests that a combination of actuarial and clinical approaches

enhance the vigorous and continuous process of risk assessment and form the bases of a validated risk assessment tool (Doyle & Dolan 2002).

Beck et al (1979) developed a categorization system of suicidal behaviours, and assessment scales to assess suicidal intent. According to Anderson & Jenkins (2006) professional's world wide used these scales as they are reliable and have validity. The Beck Suicide Intent scale (SIS; Beck et al 1974) is a 15- item questionnaire intended to assess the severity of suicidal intent linked with an episode of self harm. Each item scores 0-2, with the total score ranging to 30. It is divided into two parts: the first 8 items focus on the circumstances of the act. The remaining items are part of the self report section this is based on the patient's account of the event and incorporates their feelings and thoughts at the time of the act (Harriss & Hawton 2005). Harriss & Hawton (2005) carried out a study which looked a number of patients who self harm between 1993 and 1997. It established that the suicide intent scale could not determine who would commit suicide but recognised the information gained about ideation and intent would be effective within 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 this could due to their mental illness or that they are embarrassed when discussing their suicidal ideation. The dilemma is that their reflective account of the situation may not be precise therefore it may be difficult for the clinician to gain a true and accurate picture based on the subjective account provided (Barker 2004).

Competent risk assessment, communication and management within an acute mental health setting can be a major challenge for nurses (Harrison et al 2004). According to

Anderson & Jenkins (2006) it is crucial that nurses are able to assess people who may be at risk of suicide. However Barr et al (2005) argues that for nurses to be able to risk assess effectively resources need to be in place. The DOH (2001) recommends that staff participate in risk assessment training at least every three years.

The trusting relationships between nurses and patients are vital when assessing a suicidal patient. However there a various factors which need to considered for this to happen. When people are acutely unwell it may be difficult for them to establish a rapport with staff. This may due to the nature of their illness or it could a cultural belief that prohibits them from discussing the topic of suicide (Tummey & Turner 2008). Therefore it is imperative that nurses use the correct risk assessment that is flexible and personal to the patient encompassed with good effective verbal and non verbal communication skills. Otherwise it will prove difficult for the nurse to illicit information to form an accurate risk assessment. When patient’s risks are considered to be high a multi disciplinary team will determine what the levels of observations to place them. Bouch & Marshall (2005) maintains that promoting the dignity, privacy and autonomy of the patient will endeavour to sustain the therapeutic relationship. However Harrison et al (2004) argue that the close monitoring of a patient continues to be a challenge for nurses as it can be perceived by patients as a policing exercise and could exacerbate their anxiety and have detrimental effect on the therapeutic

relationship. Consequently this will have a negative impact on the consistency and validity of the risk assessment.

In conclusion this assignment has demonstrated that risk assessment continues to a complex process for mental health nurses. It has demonstrated that there are a number of positive and negative aspects for both the actuarial and clinical approaches when assessing risk. Research illustrates that using a combination of actuarial and clinical risk tools will demonstrate a more versatile and reliable approach when assessing suicidal patients. Finally this assignment has discussed various challenges that nurses faces when risk assessing in acute care settings.