Mental health nurses’ decision making for people presenting to the emergency department with deliberate self-harm

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STUDENT DECLARATION

This research arose out of my own reflective practice as a mental health nurse working in an emergency department (ED) for many years. It is also informed by my education which was primarily within humanities, hence the viewing through the lens of social psychiatry. Often, when in team clinical reviews, I would listen to case presentations and find myself arriving at different conclusions and dispositional decisions to those presented by colleagues. Legislation takes as a starting position that treatment in the patient’s own environment (the least restrictive environment) was the ideal, and that admission to hospital should be made on the grounds of risk. Increasingly, I was finding people admitted to hospital, often against their will, when it seemed that they might be managed in the community in the first instance. It was here that I started viewing risk assessment as mostly subjective. I began to question if this was personal, or a phenomenon that was influenced by other factors. There was no research that explored conformity in dispositional outcomes for this group of clinicians. There was some research that acknowledged that variability and attempted to explore patient variables influencing dispositional outcomes. Only one study by Engleman et al (1998) touched on clinician variables and it did not test for reliability. No material presented in this work has been accepted for an award of any degree or diploma at any university. All the material presented is the work of the author.
ACKNOWLEDGEMENTS

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ABSTRACT

Background

The management of deliberate self-harm presentations in Australia has increasingly become the responsibility of the hospital Emergency Department (ED). Assessment in Victoria is primarily the responsibility of mental health nurses who are based in the hospital EDs. They assess the presentation and implement appropriate disposition of these patients. The dispositional outcome depends on an assessment of the risks associated with the presentation and the principles of managing the patient in the least restrictive environment. In most cases the dispositional outcome and subsequent treatment is unremarkable and successful. When there is a suicide, there has been a tendency in the media to at times apportion blame to the clinicians for failing to prevent the patient killing themselves. The underlying assumption is that there is a “gold standard” and that clinicians should agree on dispositions for similar types of presentations. This assumption is not supported by research. The proposition that there is agreement in dispositional decision making throughout the industry is not examined in existing research. It is this gap that the present study sets out to explore.

Aims

1. To investigate variations in patient disposition decisions, following deliberate self-harm risk assessment by Australian mental health nurses.

2. To explore the demographic factors of clinicians that may affect dispositional decision making for deliberate self-harm risk assessment.
3. To explore the clinician’s reasoning processes, leading to their dispositional decision making.

**Conceptual Model**

A conceptual model of the safety and risk factors related to deliberate self harm presentations was developed and was informed by a literature review. This model was based on the demographic characteristics of the patient, level of social connectedness and intellectual functioning. This differed from the widely accepted model that utilises diagnostic categories and demographics. From this model a series of vignettes was developed. Two vignettes were designed to test the model (one that had very high safety factors and one with very low safety factors). A further seven cases were constructed with varying levels of perceived risk and safety. These vignettes were distributed to experts in the field to test for content validity and were found to be representative of typical deliberate self-harm presentations to EDs.

**Methods**

A cross sectional survey was administered to mental health nurses who were members of the Australian College of Mental Health Nurses. Questions were asked about the demographics of the participant along with a series of questions about the vignettes. Participants were asked about their perceptions of the deliberate self-harm intent of the subject and the disposition that the participant believed was appropriate for that vignette. For each of the questions, reasons for the decision were sought.
Results

The survey achieved 210 completed responses 56 of these were from the conference. Outcome was based on agreement and explanation. The quantitative results showed a significant agreement on deliberate self-harm intent across all but one of the vignettes by participants. The two test vignettes achieved agreement on disposition giving confidence in the model. The remaining seven vignettes, designed to balance safety and risk factors, showed poor levels of agreement for disposition. No demographic data consistently explained this variation.

In the qualitative analysis the reasons given for dispositional decision in some cases were as conflicted as the decisions themselves. Often the same justification was given for treatment in the community and for a decision to hospitalise.

Conclusion

Agreement was reached across clinicians on the assessment of deliberate self-harm intent. Only in one vignette was the null point included in the confidence intervals. There was a lack of agreement as to appropriate disposition between clinicians. This finding indicates a high level of subjectivity in dispositional decision making and suggests that for the same presentation different clinicians would make different dispositional decisions.

The current work has highlighted individual differences between clinicians assessing in isolation, further research is indicated to investigate the effect of team dynamics on decision making. The findings of such research may prove useful as a tool for testing the formative and normative functions of peer supervision within a team environment. This
may help understand the dynamics of decision making within the team and assist that 
team work towards understanding the dynamics at work in dispositional decision making.
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TERMINOLOGY

Clinician

Mental health crisis teams in Australia include health professionals from the disciplines of medicine, occupational therapy, social work, psychology and mental health nursing. In the public mental health system in Australia the majority are mental health nurses, for this reason they were the participants in this research.

Patient

The Victorian Mental Health Act (1986) defines a patient as a forensic patient; or an involuntary patient; or a security patient. It does not include people in hospital in an informal basis as they are not subject to the Act. For the use of this paper the term patient will be maintained for all who are receiving health care.

Self-harm

In this thesis the term deliberate self-harm will be used to cover all acts designed to inflict harm on oneself, regardless of intent. Suicide is the taking of one’s life as a result of deliberate self harm.

Risk assessment

Risk assessment, at its most basic, is the weighing of risk against safety factors in deciding disposition. The disposition is a balance between ensuring a person’s safety and treating in the least restrictive environment.

Disposition

The decision of what, if any, treatment is required, and where that treatment should take place is called the dispositional decision for the purposes of this thesis.
CHAPTER ONE

Introduction

This study aims to explore variation in dispositional decision-making among mental health nurses, for patients presenting to hospital EDs with thoughts of deliberate self-harm. This chapter presents the terminology used to describe self-harm. It provides an historical context for diagnosis within psychiatry. The process of assessment in an ED is outlined, along with the risk assessment process. The chapter concludes with a statement that summarises the significance of the study, and informs the research questions that are presented.

Deliberate self-harm

The terminology used to describe self-harm is poorly defined and contains different meanings depending on the person using the term.

Suicide is an imprecise term that at its simplest means to kill oneself but when examined in detail, has many permutations, meanings and synonyms. De Leo, Bille-Brahe, Kerkhof, & Schmidtke (2004), in their discussions of the definition of deliberate self-harm makes the point that, whatever the outcome and whatever the intent, the chain of events begins with a self-initiated destructive act. The term suicide literally refers to the taking of one’s own life, while attempted suicide covers all non-fatal self-harm. These two terms cannot convey the myriad of meanings and symbolism that threats or actions of self-harm represent.

A review of the literature provides many terms to describe self-harming behaviour, including “autoaggression, intentional self injury, malingering, Munchausen’s

Similarly, deliberate self-harm has been defined in many ways. Favazza believes the act must be deliberate, rather than by accident or neglect; direct, as opposed to indirect, destruction or alteration of body tissue (Favazza, 1998). Others believe that people may harm themselves, even seriously, with the belief that they will survive (Block & Singh, 1997). Ambiguity about the meaning of this behaviour has existed for decades; theorists have vacillated between medical and social explanations. Menninger (1936) offered this explanation in 1936 when he stated:

“Mutilation is an attempt at self healing...local self destruction being a form of partial suicide so as to avert total suicide.” (Menninger, 1936 p. 271)

Pattison and Kahan (1983), and Favazza (1998), discuss deliberate self-harm from a medical perspective, stating that it can be classified as an impulse control disorder (Pattison & Kahan, 1983). Clarke and Whittaker (1998) review other writers who agree with this view and compare deliberate self-harm with bulimia, gambling and alcoholism. These authors state that a person may stop abusing alcohol but move to pathological eating, cutting or gambling. The point is made that, whatever the conjecture of the medical profession it contributes little to understanding the behaviour. They quote a passage from Pembroke regarding a consumer’s experience (1991):

“My distress was acknowledged only within a medical framework which I do not share...my way of dealing with the official version of reality was unacceptable. My entire experience was objectified in a way I found dehumanising. I was never listened to. (p. 30)
A review of the literature by McAllister (2003) substitutes the term “self-soothing” to describe the intention behind an act of self-harm. This constructs the act as a coping mechanism. The salient point made by McAllister is that the language of labelling the behaviour is a very powerful one. A positive label may go some way towards countering the “negative and objectifying effects of various unhelpful labels” (McAllister, 2003 p. 178). The review goes on to state that once a stigmatising label has been applied, inquiry into the presentation tends to cease. A professional may see the diagnosis, not the person, and the problem is professionalised with the clinician as the expert. Locating the problem in pathology narrows the definition of deliberate self-harm (excluding such behaviours such as over work and heavy drinking) and locates the answer in the medical sphere, rather than the psychological or sociological.

**Historical context of Psychiatry**

Throughout history mankind has struggled to make sense of deviant behaviour. Hippocrates in the 4th Century B.C. believed illness was a result of an imbalance in the humours and attributed madness to a disturbance of black bile (melaina chole), later termed melancholia. Treatments for these disorders were aimed at restoring balance through purgatives, baths and diets. Plato believed irrational behaviour came from a lack of balance between the psyche or soul and the body or soma and could be overcome by rational thought. Aristotle sought to marry these views saying that bile mediated the mind and the body. Such views about the genesis of and associated treatment for deviant behaviour persisted for centuries (Pilgrim, 2007).

Later, medieval beliefs of mental illness reflected Christian dogma, and conceptualised madness as a punishment from God or due to possession by the devil.
Mental illness was therefore seen as a test of faith and treated with prayer, community involvement and hard physical work. In stark contrast to this view the Islamic world considered the mentally ill to be precious to God. Asylums were established in the 8th Century to care for them in a calm and relaxed environment (Merkel, 2003).

The 13th Century saw Thomas Aquinas attempt to marry Aristotelian thought with Christian dogma. He argued that the soul could not be sick and that madness must therefore be a somatic phenomenon.

With the urbanisation that accompanied the industrial revolution in the 17th Century, traditional supports for the mentally ill were lost. This resulted in the mentally ill increasingly being displaced into poverty, with a corresponding growth in institutions to protect society from their deviant behaviour. They became objects of ridicule and insane asylums like Bethlehem (Bedlam) in England would charge for tours. It was during this time that Descartes recognised that the mind and body interacted and that ideas developed from experience and sensation. This was the foundation of the empiricist school of thought. During this period there was a growth in the sciences and an increasingly mechanistic world view emerged. Anatomical studies of the human body were used to support natural, as opposed to spiritual, explanations for mental illness (Merkel, 2003).

In the 18th Century efforts were made to separate the insane from others in the almshouses, and dedicated facilities were built. William Battie published his Treatise on Madness in 1758 as an argument against the coercive custodial treatment offered in Bedlam. He believed that mental disorders were the result of an over-excitement of the
sensibilities and prescribed separation from the family, decreased stimuli and routine activity. This was the foundation of moral treatment. This started reform movements across Europe, calling for the cessation of cruelty to the mentally ill and advocating moral treatment. In France at this time Philippe Pinel led the emancipation of the mentally ill, removing shackles and employing the strategies of Battie. It was Pinel that first introduced the categories of mania, melancholia, confusion and idiocy (Pilgrim, 2007).

In the 19th century the German doctor Emil Kraepelin developed what was to become the model for psychiatric diagnostics. He set forth two major categories of mental disorder being dementia praecox (later to be named schizophrenia by Eugen Bleuler) and manic depressive psychosis. This was the start of the school of medical naturalism, this stated that all symptoms of mental illness were caused by diseases of the brain or nervous system. Within this school of thought, the assumption is that the categories of mental disorder consist of discrete symptoms that exist independent of diagnosticians. This model went through many evolutions until it was included in the sixth edition of the World Health Organisation’s (WHO) International Classification of Disease (ICD) in the mid 20th Century. For the first time there was an attempt to include a section for classifying mental disorders. These included groups of psychoses, psychoneuroses and disorders of character, behaviour and intelligence. Soon after this the American Psychiatric Association (APA) published the Diagnostic and Statistical Manual: Mental Disorders (DSM) (American Psychiatric Association, 1994). Both of these have been extensively revised over the last 60 years, with ICD-11 and DSM-5 currently being compiled and due for release in 2013. Throughout these revisions the
shifting nature of diagnostics has been displayed, for example, with the removal of homosexuality as a mental illness in 1980. It has been argued that this categorisation has helped both clinicians and researchers to explore epidemiology and disorder, in a way that would have been impossible without diagnostic categories.

In the 1960’s writers began questioning this model, Thomas Szasz (1960) reconstructed a person’s suffering as a problem of living rather than a medical illness, while R. D. Laing (1960) tried to find social meaning for symptoms that would be relevant to the sufferer. Erving Goffman (1961) questioned the utility of the construct of diagnosis for the person being diagnosed and was scathing of the treatment of people in institutions at the time. Szasz, Goffman and Laing all reported that the only ones to benefit from the medicalisation of mental disorder were the medical profession. They viewed psychiatric diagnoses as labels that reinforce stigma and are of no utility to the labelled. Within this school of radical constructivism diagnoses do not exist outside of the observer, they are simply medical constructs. Critics of this movement accused the proponents of being from the rival discipline of sociology, however, both Szaz and Laing were psychiatrists.

More recent criticism of diagnostic categories has centred on attempting to squeeze human behaviour into discrete boxes. An example of this is the diagnosis of obsessive-compulsive personality disorder, where a person must fulfil four of eight diagnostic criteria; two people with completely different symptoms can be given the same diagnosis (Krueger & Bezdjian, 2009).
An attempt to marry the opposing views of medical naturalism and radical constructivism is found in the school of critical realism where it is held that the symptoms exist but that their interpretation is subjective and open to interpretation (Pilgrim, 2007).

The formulation of both the ICD-11 and the DSM-5 has stimulated debate regarding the introduction of dimensional aspects of diagnosis and not persisting with a classification system that is polythetic and categorical (Demjaha, Morgan, Morgan, Landau, Dean, & Reichenberg, 2009). This approach moves toward the critical realism stance. Polythetic classification means that members of the same categorical group do not have to share the same properties: they must exhibit some, but not all properties in a list. The main argument for all categorisation is that diagnosis leads to treatment. This argument fails in psychiatry because the same diagnosis may be describing two very different presentations which may well respond to different treatments.

**Mental Health Presentations in Victoria**

When a person presents to the ED with thoughts of deliberate self-harm, they are first assessed by a triage nurse who determines the urgency of the patient’s condition. (Australasian College for Emergency Medicine, 2000) Triage assessment takes three to five minutes and the dispositional outcome is determined according to the assessment of the urgency of the presentation. This is done according to the Australasian Triage Scale (ATS) that prioritises all ED presentations and allocates a category, based on a time to treatment objective. Table 1 displays the categories of the Australasian triage scale with category descriptions and clinical descriptors for mental health presentations.
Once the triage has been completed the triage nurse will contact the mental health clinician to alert them to the presentation and triage category. In Victoria these clinicians are based in the ED.

The initial introduction and problem definition by the person is followed by a more formal assessment process. The level of clinical engagement with the person is critical to the process. This has been defined as the central skill in mental health nursing (Cutcliffe & Happell, 2009) where the nurse and the patient work towards resolution of the crisis. Using this process the clinician seeks to create a trusting and safe environment for a person in order to explore the reason for the crisis presentation. The reporting of this assessment follows a defined format however the assessment itself can be led by the patient, or gently directed by the clinician to ensure that all important areas are explored.

An important aspect of this interview is gathering a cogent history of the person, their family and background, work and relationship history. Previous levels of functioning and/or mental illness, treatments and interventions that have been utilised in the past are also canvassed. The current situation in terms of social supports and networks, employment and financial situation, and domestic arrangements are also explored. Finally, the crisis that has brought the person to seek help in the ED is determined. This assessment can all be achieved in an interview, using a combination of open ended questions and a semi-structured interview format. The reporting format of the assessment interview is as set out in the semi-structured clinical interview which is a diagnostic tool for psychiatry called the Mental State examination (MSE) as set out in Sadock & Sadock (2007) and is described in appendix C.
Table 1

**The Australasian Triage Scale (Australasian College for Emergency Medicine, 2000)**

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<td>Category 1</td>
<td>Immediate assessment</td>
<td>Severe behavioural disorder with immediate threat of violence</td>
</tr>
<tr>
<td>Category 2</td>
<td>Assessment starts within 10 minutes</td>
<td>Violent or aggressive, requires restraint, severe agitation or aggression</td>
</tr>
<tr>
<td>Category 3</td>
<td>Assessment starts within 30 minutes</td>
<td>Very distressed, risk of self harm, acutely psychotic, agitated/withdrawn</td>
</tr>
<tr>
<td>Category 4</td>
<td>Assessment starts within 60 minutes</td>
<td>Semi-urgent or under observation, no immediate risk</td>
</tr>
<tr>
<td>Category 5</td>
<td>Assessment starts within 120 minutes</td>
<td>Known patient with chronic symptoms, social crisis in clinically well patient</td>
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Once the cross sectional MSE is finished, the clinician formulates the current presentation. This includes a summary of the presentation, discusses risk minimisation and disposition, including referral and follow up. This would be done in consultation with the patient. The dispositional decision will make reference to the risk assessment carried out in the course of the interview.

**Assessing risk for deliberate self-harm**

When a patient presents with deliberate self-harm ideation, the clinician must make an assessment of the risk posed to the person’s life. This enables the clinician to frame an intervention that would provide safety for the patient, while enabling appropriate treatment. The assessment is global in nature taking in the full gamut of the psychological, social and biological aspects of the person. This requires balancing risk factors with protective factors. The socioeconomic status that affords access to stable
housing, employment, family support and access to the helping professions can mitigate risk. Intellectual functioning would be assessed, particularly the level of intoxication as this increases the likelihood of an impulsive act. The patient would also be assessed for any underlying mental illness such as depression that may be driving the presentation.

Many researchers have identified risk factors that indicate increased risk of completed deliberate self-harm (Douglas, Cooper, Amos, Webb, Guthrie, & Appleby, 2004; Hawton & van Heeringen, 2009; Repper, 1999). In assessing the risk, clinicians would ask about deliberate self-harm ideation, plan, intent and means to carry out the plan. They would also ask about previous attempts as this has proven to be an indicator of subsequent attempts and of increased mortality. A well established limitation of risk assessment is the problem of false positives; risk assessment is imprecise as demonstrated by Large, Sharma, Cannon, Ryan, & Nielsen (2011). Many tools have been developed for the assessment of deliberate self-harm risk but few are used clinically, with clinicians citing problems such as the time taken to administer them. In any event, these tools have been shown to be as accurate as a clinician’s global assessment (Repper, 1999). Indeed Muir cites the validation research on these tools to be unconvincing and reports they are of little use outside the research setting (Muir, 2004).

The inadequate predictive power of assessment was highlighted by a case control study carried out in Ireland that found that clinicians were unable to identify patients who had killed themselves from controls when reviewing case notes. (Fahy, Mannion, Leonard, & Prescott, 2004) The results showed that review by three consultant psychiatrists, three psychiatric registrars and an approved social worker revealed a predictive power no more accurate than chance.
A further study presented clinicians with vignettes of actual self-harm behaviour asking them whether the presentation was self-harm with deliberate self-harm intent (Wagner, Wong, & Jobes, 2002). In this study the vignettes of actual self-harm were distributed to two groups, one being expert suicidologists and the second a group of mental health professionals. The mental health professionals were randomly assigned to two groups, one of which received a definition of a suicide attempt. While they had agreement at the extremes, clinicians could not agree on the deliberate self-harm intent in the majority of cases, and the experts fared no better than the mental health professionals; the provision of a definition did not improve agreement within that group.

The accurate assessment of deliberate self-harm risk is notoriously difficult as the very nature of deliberate self-harm ideation is one of ambivalence. A study by Wyder (2004) interviewed 112 people following a deliberate self-harm attempt. She found that 51% of her sample had considered deliberate self-harm for ten minutes or less, but of those who had been affected by alcohol that number jumped to 93%. This underlines the importance of the role of intoxication in impairing judgement and as a dynamic factor influencing risk. When faced with this ambivalence and uncertainty the tendency may be to delegate decision referring to medical staff (Muir-Cochrane & Wand, 2005). If the decision is that the risks are not containable in the community, hospitalisation will be discussed with the patient as an option. If the patient is unwilling or unable to consent to admission, the decision is whether to invoke the Mental Health Act. In order to detain the person under the Mental Health Act (1986) the patient must fulfil certain criteria.
Legislative framework for the involuntary treatment of people with mental illnesses in Victoria Australia

Legislation governs the involuntary detention of patients under the Victorian Mental Health Act (1986). Section eight of the act sets out five criteria that must be met for a person to be detained involuntarily, these are:

(1) the person appears to be mentally ill; and
(2) the person's mental illness requires immediate treatment and
(3) that treatment can be obtained by the person being subject to an involuntary treatment order; and
(4) because of the person's mental illness, involuntary treatment of the person is necessary for his or her health or safety (whether to prevent a deterioration in the person's physical or mental condition or otherwise) or for the protection of members of the public; and
(5) the person has refused or is unable to consent to the necessary treatment for the mental illness; and
(6) The person cannot receive adequate treatment for the mental illness in a manner less restrictive of his or her freedom of decision and action.

Although these criteria appear clear cut, the very first one “the person appears to be mentally ill” requires interpretation. The legislation attempts to clarify this by the inclusion of Section 8(1A) which states that “a person is mentally ill if he or she has a mental illness, being a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory.” As can be seen by this clarifying inclusion, the Act is predicated on the basis that mental illness is a medical condition.
Within psychiatry there are two competing diagnostic systems namely the International Classification of Disease which is now at its tenth revision (ICD-10) with ICD-11 due in 2014, and the Diagnostic Statistical Manual in its fourth revision (DSM – IV) with DSM-5 expected in 2013. As noted earlier in the history of psychiatry the very idea of diagnostic categories is under attack, even within the profession itself. Katschnig quotes a definition of psychiatric diagnoses as being “fabricated non-validated psychiatric diagnoses out of the general human predicament” (Katschnig, 2010).

Whether a person is indeed mentally ill is a determination based on interpretation rather than a categorical diagnostic test. Summerfield for example explores the vexed question of diagnosing depression over sadness and states that there seems to be a “blurring between unpleasant but commonplace mental states, part of life, and those associated with objective dysfunction and breakdown, meriting medical attention.” (Summerfield, 2006)

Although legislation gives clinicians the authority to treat people involuntarily, the Victorian Mental Health Act also directs clinicians to treat people in the least restrictive environment. The Act states:

“It is the intention of Parliament that the provisions of this Act are to be interpreted and that every function, power, authority, discretion, jurisdiction and duty conferred or imposed by this Act is to be exercised or performed so that—(a) people with a mental disorder are given the best possible care and treatment appropriate to their needs in the least possible restrictive environment and least possible intrusive manner consistent with the effective giving of that care and treatment; and (b) in providing for the care and treatment of people with a mental disorder and the protection of members of the public any restriction upon the liberty of patients and other people with a mental disorder and any interference with their rights, privacy, dignity and self-respect are kept to the minimum necessary in the circumstances.” (Mental Health Act, 1986) Sec 4(2)
The question facing clinicians in acute psychiatry is when is a person's risk at a point where the only avenue left to contain risk is the deprivation of liberty? This becomes even more problematic when clinicians are faced with chronic risk to self, such as where a person who reports constant deliberate self-harm ideation with a plan and the means to implement that plan. Clinicians who err on the side of liberty have to be able to defend that decision in what Dixon has termed an “atmosphere of blame”. The accuracy of an assessment is less important than the ability to defend it (Dixon & Oyebode, 2007). She cites research pointing towards increasingly risk averse decisions as clinicians practice more conservatively. This is often to the detriment of patients as much research points to treatment carried out in the persons’ usual environment is more effective than that delivered in an inpatient setting (Pridmore, Ahmadi, & Evenhuis, 2006).

This is noted by Muir-Cochrane and Wand (2005) when they report the passing of responsibility for decisions up the organisational hierarchy. It appears the clinicians are looking to protect themselves in case the patient suicides. This often means referring decisions to medical staff with considerably less experience than the clinician making the referral.

Clinicians also assess patients according to their own constructs of risk. These constructs have been formulated, by integrating formal education, experience both in the form of mentors, aversive incidents and personal philosophy. Dispositional decisions incorporate the legislative framework within which clinicians work, as well as the policies of their workplace. However, the expectation of consistency in dispositional decision making, from the public and legal professions, does not always accord with what occurs in practice.
Uncertainty has been stated as being the defining feature of risk assessment (Rosenman 1998). This is not reflected in current research, Dixon et al state that, aside from boundary cases, research has treated risk assessment as “an objective test which is defined exclusively by its accuracy” (Dixon & Oyebode, 2007 p. 72).

Many studies have examined the reasons for admission to a mental health facility (see Table 1). These studies usually focus on patient factors such as demographics and presenting complaint. Few have focused on the clinician factors that affect dispositional outcomes. Of those studies that have, some have developed conceptual models that underpin dispositional decisions (Engleman, Jobes, Berman, & Langbein, 1998; Patel, Gutnik, Karlin, & Pusic, 2008).

The current study will explore consistency of dispositional decision making and, investigate how the characteristics within the clinician might influence decisions where inconsistencies exist.

Significance of the study

The deprivation of a person’s liberty for the enforced treatment of a mental illness has the potential to be an extremely traumatic experience. This may damage that person’s interaction with healthcare providers in the future. Identifying and addressing any factors outside of the person that influence decisions about the person’s treatment may lead to better decisions that ensure that “any interference with their rights, privacy, dignity and self-respect are kept to the minimum necessary in the circumstances.” (Victorian Government, 1986)
Given the subjective nature of risk assessment, it is important that clinicians are aware not only of their own personal bias within assessment, but also of any underlying systemic bias that may be influencing their judgement. This will enable an open and objective discussion of decisions, including whatever biases discovered in peer supervision.

**Research aims**

1. To investigate variations in patient disposition decisions, following deliberate self-harm risk assessment by Australian mental health nurses.
2. To explore the demographic factors of clinicians that may affect dispositional decision making for deliberate self-harm risk assessment.
3. To explore the clinician’s reasoning processes, leading to their dispositional decision making.

**Organisation of the thesis**

The thesis is organised into five chapters including this introductory chapter. Chapter two explores the literature examining the assessment of patients presenting with deliberate self-harm and studies that explain the process of clinical decision making. This chapter also provides models that underpin the dispositional decision. Chapter three provides the methodology for the study, including the model developed for the construction of the tool used for this study, and the data collection methods. Chapter four provides the statistical analyses of the data. Chapter five compares the results with those studies that exist and explores the findings. Implications for the findings and the limitations of the study are explored as well as suggestions for further research.
CHAPTER TWO

Literature review

Introduction

The purpose of this literature review is to critically appraise the literature that describes assessment for risk of deliberate self-harm. It will also review the clinical decision-making processes that underpin risk assessment for self-harm. The chapter will explore the literature describing risk assessment and theories of clinical decision making processes. Influences on decision outcomes for deliberate self-harm risk assessment will also be explored. The explanatory models flowing from these theories are discussed. From these models, factors influencing decision making will be examined under the headings of patient factors, contextual factors and assessor factors.

Search strategies and findings

A multi database search engine, Supersearch, was utilized for this review. This search engine allows the user to query a number of databases simultaneously. The set selected for this search included the University of Melbourne Library Catalogue, the Web of Science, Scopus (Elsevier), Medline, Cinahl, PsychINFO, and Pubmed. The key words of the initial search were deliberate self-harm and emergency department reported 3160 matches. The search was repeated using the terms suicide and emergency department. This search yielded 15195 matches. This was then refined using combinations of terms including disposition decision (7901 matches), treatment decision, (7329 matches) and risk assessment (4485 matches). Further combinations did not reduce matches significantly. The results in Supersearch are ranked according to
DISPOSITIONAL DECISION MAKING

relevance to the search terms and these were explored for relevant literature. The
abstracts of these were perused to determine their relevance to the study.

Once a relevant article was identified the reference list was examined for other
relevant articles. For example the article by Mihai, Allen, Beezhold, Rosu, Nirestean and
Damsa (2009) revealed a previously undiscovered piece of research by Engleman et al.
(1998). This proved to be an early piece of research in the field, providing a useful
model that became the theoretical basis for this thesis. In accessing this piece of research
the internet site highwire provides the facility to find other articles that have cited this
research, and also to search for other articles by the author. These search techniques,
used in an iterative process, yielded the articles that were utilised for the current review.

Community expectations of suicide risk assessment were explored by querying
the Google search engine using the combined terms suicide, coroner and mental health.
This approach provided access from multimedia sources such as newspapers and non-
peer-reviewed sources.

The Socio-political context for deliberate self-harm prevention in Australia

In 2007 in Australia 1881 people died by intentional self-harm (Commonwealth
of Australia, 2009). Table 2 shows the trends in Australia between 1997 and 2006.
Deaths peaked in 1998 when males had a rate in excess of 24 per 100,000 of population,
dropping to 13.9 per 100,000 in 2007. Female rates showed smaller fluctuations and in
2007 were at 4.1 per 100,000 of population (Commonwealth of Australia, 2009).

The steady increase in young male deaths from deliberate self-harm during the
90’s prompted a study in 1995-1999. The outcomes of this study are published in the
National Youth Suicide Prevention Strategy (NYS). The report recommends a series of strategies, coordinated at a national level, which included the funding of organizations such as Beyond Blue to improve access to information about mental health problems and help lines. The report also recommended increasing the capacity of existing mental health services to manage suicide risk effectively. It was at this time that mental health services were funded to provide a more comprehensive service for EDs. It is now accepted practice to have mental health clinicians embedded in the hospital ED, providing faster access to expert assessment and allowing for mental health consultation on a wider range of patients and issues. Since the release of the NYS report many consumer help lines and websites have been established in order to prevent deliberate self-harm attempts by offering counselling, early intervention and community education.

A review of Australian suicide data investigated the sharp decline in young male deaths by intentional self-harm between 1996 and 2006 to explore the effect of the NYS strategies (Morrell, Page, & Taylor, 2007). They concluded that there was strong evidence to support the conclusion that the NYS had been effective. Another analysis of Australian data from the same period agreed that the normalisation of help seeking behaviours through advertising campaigns may have affected the suicide rate. More importantly, they highlight the accompanying social shift with higher employment rates and increased affluence, factors that have been linked to decreasing male but not female suicide (McPhedran & Baker, 2008). They quote studies that male suicide rates are positively associated with measures of socioeconomic disadvantage. While the effectiveness of these suicide reduction campaigns has reduced the amount of people dying by deliberate self-harm, it is still a major cause of mortality in Australia.
Table 2

*Number of suicide deaths in Australia (Harrison, Pointer, & Elnour, 2009)*

<table>
<thead>
<tr>
<th>Year</th>
<th>Count</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Males</td>
<td>Females</td>
</tr>
<tr>
<td>1997</td>
<td>2,145</td>
<td>577</td>
</tr>
<tr>
<td>1998</td>
<td>2,150</td>
<td>533</td>
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<td>1,936</td>
<td>521</td>
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<tr>
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<td>1,658</td>
<td>444</td>
</tr>
<tr>
<td>2006</td>
<td>1,398</td>
<td>401</td>
</tr>
</tbody>
</table>

Assessment of deliberate self-harm patients in Australia

The decision of where to treat a person who presents to the ED with deliberate self-harm ideation is difficult. The question that needs to be asked is whether the patient requires the constant monitoring that can only be provided in an in-patient setting, or can they be adequately monitored and supported in their own environment? In most western countries it is legislated that treatment be provided in the least restrictive environment possible, with a minimum imposition on civil liberties. In making the decision of where to treat, the clinician must consider both patient and environmental factors. Those advocating that risk assessment is an objective exercise, would believe that the clinician enters the assessment as a *tabula rasa* and that their decision is based on information
collected from the patient and their environment. If this premise were true there would be consistency in assessment and disposition between clinicians.

With the mainstreaming of mental health services over the last 20 years and the relocation of specialist mental health resources in to the community, the ED has become the primary point of contact for people with mental health problems (Sands, 2007). There is a growing awareness of this trend and research is exploring appropriate triaging of these patients and acknowledging that mainstream ED clinicians are underprepared to meet this challenge (Clarke, Brown, & Giles-Smith, 2008). The Victorian government has recognized this problem by introducing a special scale for generalist triage nurses to assist with the appropriate assessment and prioritisation of patients presenting with mental health problems (Broadbent, Creaton, Moxham, & Dwyer, 2009). Once triaged, the issue is one of timely assessment of these patients by a specialist clinician.

In Victoria, there has been a move by the government to provide appropriate assessment of mental health presentations by placing mental health professionals in EDs. The document Mental Health Responses in Emergency Departments (State Government of Victoria, 2008) cites a range of mental health professionals that may work in the position, the majority of these positions are filled by mental health nurses. A recent literature review of models of mental health care delivery in the ED (Wand & White, 2007) concluded that a mental health nurse embedded in the ED “presents a cost-effective alternative that has transportability to most ED settings and enables timely access to expert mental health assessment, therapeutic intervention and coordination of care” (P. 789).
Assessment of Deliberate self-harm

The accurate assessment of deliberate self-harm ideation is notoriously complex, for example to quote Rosenman (1998) when talking of the complexity of deliberate self-harm ideation:

“For conditions with multiple risk factors... each factor adds a little to the risk, but only when it interacts with other factors. No single predictor or combination of predictors is present in every individual, and membership of the high risk group changes from moment to moment. Half a bottle of whiskey may create a high suicide risk within an hour.” (p100)

There is evidence that as well as the mutability that accompanies deliberate self-harm ideation, the patient may be reluctant to disclose deliberate self-harm ideation. This may be for a number of reasons ranging from previous negative experience with services to an inability to articulate the issue (Douglas et al., 2004).

In order to address the inherent difficulties in assessing deliberate self-harm ideation, several scales have been developed to objectify the process (Cooper, Kapur, & Mackway-Jones, 2007; Healy, Barry, Blow, Welsh, & Milner, 2006; Repper, 1999). Reports vary as to the validity of these scales but comparisons between clinician’s assessments and the Manchester self-harm rule, a questionnaire developed to identify risk, found the scale to be marginally better than clinician’s global assessment when comparing prediction or repetition of self-harm at 6 months (Cooper, et al, 2007). Another study that compared clinician’s global assessment with the use of the Beck scale for deliberate self-harm ideation found no significant difference in predictive power (Healy, Barry, Blow, Welsh, & Milner, 2006). They go on to make the point that “these data also highlight the complexity of assessing deliberate self-harm in an emergency...
room setting and how self-report of suicide is not the only factor clinicians consider when deciding whether to hospitalise patients” (p. 328)

Despite the existence of many scales, and evidence that risk assessment tools perform at least as well as a clinicians’ global assessment, there is evidence that only a very small number of clinicians use them in practice (Repper, 1999). Reasons given include the training needed to use them competently, that they do not inform clinical decision making and that they are time consuming to perform. Dixon et al states that, while research has focused on the actuarial approaches, there has been broad agreement that clinical assessment, perhaps informed by actuarial information is more likely to be used in a clinical situation (Dixon & Oyebode, 2007).

The nature of risk assessment in the business of mental health service provision in Australia exposes clinicians and employers to the possibility of litigious proceedings. There is the possibility for conflict between organisational demands and clinical practice where an organisation may wish a clinician to err on the side of caution in the face of good clinical practice (Callaly, Arya & Minas 2005).

Models explaining dispositional decision making

A complex set of variables interact when dispositional decisions are made, which involve judgements about where treatment will occur (Croskerry 2009). Data from around the world show differing rates of hospitalisation for people presenting with deliberate self-harm ideation. Admission rates vary from 12.8% of assessments of deliberate self-harm in England (Brooker, Ricketts, Bennett, & Lemme, 2007) to as many as 70% of assessments in North America (Goldberg, Ernst, & Bird, 2007). In Australia
the admission rate for people presenting with deliberate self-harm ideation has been shown in one single site longitudinal study to be 28.2% (Carter, Safranko, Lewin, Whyte, & Bryant, 2006).

Three variables contribute to dispositional decision making in a psychiatric emergency. These are patient factors, assessor factors and factors related to the therapeutic relationship (Hepp, Moergeli, Trier, Milos, & Schnyder, 2004). Hepp et al (2004) argue that the quality and quantity of clinical experience of the clinician may impact on their decision, although the quality of the impact is not discussed. They also mention that different clinicians weigh clinical information differently however, no discussion of this phenomenon is offered. In a study in Israel by Rabinowitz, Mark, & Slyuzberg, (1994) variability was found both between clinicians and between the study sites. The study does not however attempt to explain this variability.

A study carried out in Canada found contextual variables and organisational and governmental guidelines were integral to decision making in paediatric emergency triage (Patel et al., 2008). They make the salient point that availability of resources such as beds and general activity levels may have an impact on the decisions made. Unfortunately this model is applied to an emergency triage process with its necessarily tight time frames and although of interest has little generalisability to the mental health field.

In an American study, Engleman et al (1998) focussed on the effects of patient and clinician characteristics and bed availability on dispositional outcomes. The data utilised for this came from research where eighteen psychologists and social workers
from a community mental health emergency service were asked to complete a risk assessment questionnaire for 169 consecutive patients. A factor analysis was conducted and produced the model shown in Figure 1. This model breaks the decision making process into two steps. In the first step the influential factors proved to be patient factors, where the assessment occurred, the experience of the clinician, and the availability of voluntary diversion beds. This risk rating then becomes one of four factors that were found to contribute to the decision made in the second step. The other three factors were the setting in which the assessment took place, the availability of beds and the clinician detention ratio, that is, the clinician’s propensity for detaining patients.

The model developed by Engleman et al (1998) highlights the complexity of the decision making process for disposition of patients with thoughts of deliberate self-harm. While this was a small study completed in the United States (and will have some contextual influences) the reasons for detention given mirror those applied across the Western World. While this study was examining the decision to commit, it amounts to admission. This challenges the theory that involuntary commitment is decided only on strict legal criteria. As shown in this study, danger to self or others and substantial inability to care for self, were highly significant predictors of a decision to admit. These factors will influence the risk assessment, as will clinician experience. More experienced clinicians were more likely to rate risk highly (Rabinowitz, Massad & Fennig 1995). The setting where the assessment was conducted also had a bearing on dispositional outcomes. Assessments carried out in the community were considered more likely to carry higher risk ratings than those conducted in the ED. This phenomenon was explained by those patients in the ED being more likely to be help seeking. The other
variable impacting risk assessment was the availability of less restrictive alternatives to involuntary admission such as voluntary admission beds.

Once the overall risk rating was obtained by Engleman et al (1998), this became only one of a number of factors considered before admission was decided on. The setting again came into the decision but this was affected by the availability of involuntary detention beds, even though the possibility of patients being guarded in the ED was an option. The last factor that was significant in the decision to admit was a variable called the clinician detention ratio. This reflected the clinician’s tendency to detain patients in the three months preceding the study. The study examined the clinician’s admissions over the previous months and, seeing a difference decided to factor this in, putting the differences down to personal choice and experiences.

As has been demonstrated, it appears that dispositional decisions are influenced not just by patient (Hepp et al, 2004) and clinician but also vary across sites within countries (George, Durbin, Sheldon, & Goering, 2002; Suominen & Lonnqvist, 2006) and between countries.

The models described in this review point to factors influencing dispositional decision making. These factors will now be examined according to the model developed by Engleman et al (1998) as this was the only model that identified different variables that influenced decision making. The variables were identified as patient factors, clinician factors and contextual factors.
Figure 1.
Factors contributing to dispositional decisions (Engleman et al., 1998) p.944
Factors influencing dispositional decision making for self harm

The traditional view of deliberate self-harm was sociological and was posited by Durkheim in the late 19th Century (Durkheim, 1951). He believed that issues of social integration were the main causes of suicide. He put forward three types of suicide; these were egoistic; altruistic and anomic. Where suicide is egoistic, a person is considered inadequately integrated into society and seeks to escape the consequences of his actions. An example would be a criminal killing themselves prior to execution. In altruistic suicide a person is considered to be too integrated into the social group, for example in theatres of war where a soldier may sacrifice themselves in order to save the group. Anomic suicide is by far the most common type, Durkheim believed that this type of suicide occurs with the breakdown of social norms and traditional values and the person believes that they do not belong anywhere. This view conceptualises suicide as social phenomena. It also points to some demographic features in the person that highlights an increased risk of deliberate self-harm. These demographic characteristics are borne out in suicide statistics. Research indicates that males, who are unemployed, homeless, and have substance abuse issues - in other words those marginalised socially - are over represented in the suicide statistics. (Brooker et al., 2007; Carter et al., 2006; Repper, 1999; Wyder & De Leo, 2007)

Patient factors influencing dispositional decision making

A well accepted and tested psychological theory flows from Durkheim’s position. This is known as the interpersonal-psychological model which states that for death by suicide to occur the person has to have two interpersonal states, these being perceived burdensomeness (being a burden on society) and thwarted belongingness (feeling
alienated from friends and family) (Ribeiro & Joiner, 2009). This theory is supported in studies that examine the demographics of successful suicides where males outnumber females by at least 2:1, and where single marital status, unemployment, low socioeconomic status, substance abuse and compromised health all feature highly (Hawton & van Heeringen, 2009; Mann, 2002; Qin, Agerbo, & Mortensen, 2003).

An alternative causal theory for deliberate self-harm is that it is the result of a mental illness. This view has been supported by the conclusions drawn from the technique of psychological autopsy. This is where people who knew the deceased are interviewed and all relevant documents scrutinized to come to a reason for the suicide. This approach has resulted in some studies concluding that 90% of people who have killed themselves were suffering from a mental illness at the time of death (Gavin & Rogers, 2006). Hawton and van Heeringen report that the most common disorder leading to suicide is affective disorder followed by substance misuse and schizophrenia (Hawton & van Heeringen, 2009).

The view that self-harm is driven by mental illness is one that appears to underpin popular preconceptions of deliberate self-harm. If deliberate self-harm ideation is linked to mental illness, then treat the illness and resolve the deliberate self-harm ideation. This view was enshrined in 1992 when the United Kingdom Health of the Nation strategy (quoted by Repper) had as its only quantifiable mental health outcome the reduction of suicide. The overall purpose was to “reduce the ill health and death caused by mental illness by 15%” (Repper, 1999; Secretary of State for Health, 1992). This perspective appears to be the prevailing view held by society in general and is voiced by the media and coronial inquests.
A model of deliberate self-harm behaviour that attempts to marry the sociological, psychological and biological views has been developed (Mann, 2002). In this model Mann applies the stress-diathesis model. He asserts that some individuals have a hereditary predisposition to deliberate self-harm, encompassing “a combination of factors, such as sex, religion, familial and genetic components, childhood experiences, psychosocial support system, availability of highly lethal suicide methods” p. 302. He believes that, in a susceptible individual, a stressor such as a psychiatric disorder or psychosocial crisis can be enough to trigger a deliberate self-harm attempt (see Figure 2).

**Contextual factors influencing dispositional decision making**

Contextual variables that impact on the dispositional decisions of clinicians were the subject of the 1998 study by Engleman et al. They found that the setting where the decision is made may have impact upon the outcome. For example community based assessments were more likely to result in admission than those occurring in EDs. This finding may be due to those individuals presenting to the ED being help seeking and more amenable to community treatment than those who were assessed in the community (Engleman et al., 1998). Another significant factor influencing the decision to detain proved to be bed availability, both for involuntary and voluntary admissions. Engleman et al makes the point that an available alternative would be to have the patient under guard in the ED making bed availability a moot point in dispositional decision making, but the effect nevertheless remained significant.

A Canadian study that examined admission trends across two psychiatric crisis teams found that disposition varies across hospital sites and time of day (George et al., 2002). The study explains this by the lack of experienced clinicians to guide decisions by
registrars. Another finding is that bed availability was not a significant factor, when it comes to the dispositional decision, those in most need did get access to the beds regardless of availability.

*Figure 2.*

Stress-diathesis model (Hawton & van Heeringen, 2009) p. 1375
Assessor factors influencing dispositional decision making

In a retrospective study of 378 patients in Israel, Rabinowitz, Massad & Fennig (1995) found that patient psychopathology and dangerousness were the primary reasons for hospital admission. Findings also indicated that the professional discipline and experience of the clinician also had an effect on dispositional outcomes. The clinicians most likely to hospitalise are psychiatric residents, followed by psychiatrists, nurses, psychologists and social workers. The researchers also reported that as psychiatrists gain experience they are less likely to hospitalise.

Data collected on all presentations for attempted suicide to major hospitals in Helsinki in Finland over a 12 month period provided the basis for a further study (Suominen & Lonnqvist, 2006). After statistical analysis on the 1198 patients that comprised the study the conclusion was that age, psychopathology and a history of mental health issues were significant predictors of admission. They also found differences between admitting teams and centres that may indicate an influence by organisational culture (Suominen & Lonnqvist, 2006)

Engleman et al (1998) examined how clinician characteristics impacted decision making and found a complex interplay. Experience, while not affecting admission rates, was found to impact on the assessment of higher risk. The investigators also examined the detention records of the clinicians and found that some were more prone to admit than others. The researchers postulated that this finding was the result of personal choice of clinicians based on experiences that have been influential for the clinician (role models, litigation and personality).
Mihai et al (2009) examined the practice of six psychiatry residents, who saw 251 mental health presentations in a Romanian ED over a 3 month period. While there was no disparity between the genders on diagnosis, treatment or hospitalisation, a significant difference appeared in the rates of involuntary detention. Males were statistically significantly more likely to utilise involuntary detention than female clinicians.

A question that arises from this evidence is whether different methods of decision making are being employed by different clinicians. The theory underpinning clinical decision making divides broadly into two main groups, these are the intuitive and the analytical approaches (see Table 3).

According to Croskerry the analytical approach is more likely to be utilised by less experienced clinicians as they tend to rely on deductive logic in order to come to their decisions (Croskerry, 2009). In a similar theory, Muir quotes a seven stage feedback loop that can be repeated as needed (Muir, 2004 p.50).

1. Recognition of the situation
2. Formulation of explanation
3. Alternative generation of other explanations
4. Information search to clarify choices and available evidence
5. Judgement or choice
6. Action
7. Feedback
This would appear to be the ideal decision making process, one that allows for reflective practice, but also it takes time and a structured environment, something that is not always available in an ED.

The intuitive approach is dependent on the experience of the clinician. When this approach is utilised clinicians “recognise overall patterns (gestalt effects) in the information presented and act accordingly” (Croskerry, 2009 p.1022). While these decisions are made quickly they are based on first impressions, usually without all the information to hand. This approach appears to be the one most likely to be utilised in a busy ED.
Table 3

Comparison of Approaches to Decision Making (Croskerry, 2009) p. 1023

<table>
<thead>
<tr>
<th>Intuitive</th>
<th>Analytical</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Experiential-inductive</td>
<td>▪ Hypothetico-deductive</td>
</tr>
<tr>
<td>▪ Bounded rationality</td>
<td>▪ Unbounded rationality</td>
</tr>
<tr>
<td>▪ Heuristic</td>
<td>▪ Normative reasoning</td>
</tr>
<tr>
<td>▪ Gestalt effect/pattern recognition</td>
<td>▪ Robust decision making</td>
</tr>
<tr>
<td>▪ Modular (hard-wired) responsivity</td>
<td>▪ Acquired, critical, logical thought</td>
</tr>
<tr>
<td>▪ Recognition primed/thin slicing</td>
<td>▪ Multiple branching, arborisation</td>
</tr>
<tr>
<td>▪ Unconscious thinking theory</td>
<td>▪ Deliberate, purposeful thinking</td>
</tr>
</tbody>
</table>

Implications of this review for the thesis

The move from describing a symptom to treating syndromes has led to poorly defined diagnoses in psychiatry that are ambiguous and open to interpretation by clinicians (Pilgrim 2007). This is evidenced by the existence of co-morbidities where one person may carry many psychiatric diagnoses from within and between axes.

There is an attempt to address shortcomings by diagnostic system revisions moving to a more dimensional system of describing mental illness while maintaining the categorical nature on the manuals. The field of psychiatry continues to evolve, with both clinicians and researchers seeking to understand and communicate what is understood as mental illness.

The Victorian Mental Health Act (1986) asks that judgments be made about a person’s dangerousness, to themselves or others. Clinicians are asked to perform risk assessments and make judgements as to the immediacy of the risk and make disposition decisions based on those assessments.
It is assumed that this risk can be accurately assessed, but literature is emerging to contest that assumption. The challenging literature quotes research into the instability of deliberate self-harm ideation and the concomitant difficulty in quantifying risk of deliberate self-harm. This has been supported by a recent meta-analysis that found that the predictive power of risk assessment was poor (Large, Sharma, Cannon, Ryan, & Nielssen, 2011).

An extensive search of the published literature undertaken by the student researcher found no studies that investigated clinician’s risk assessment and dispositional decisions for patients presenting to ED with self-harm ideation. The models presented in the literature reviewed for this thesis identify many variables that could influence dispositional outcomes. These include patient factors, environmental variables and clinician preference. This study addresses the lack of research into variability in assessment and disposition. It also explores clinician factors that may contribute to variability. Understanding the dynamics of decision making will allow clinicians to fully understand and limit subjective influences in decision making.
CHAPTER THREE

METHODOLOGY

Introduction

The purpose of this chapter is to present the aims, design and approach used in the study. The development of the model underlying the instrument is explained. The process of developing and validating the instrument is then described along with the results of that validation.

Background

Mental health nurses perform initial assessments for people who have contemplated suicide (Anderson & Jenkins, 2006). In this context, a plethora of assessment scales are available (Cutcliffe & Barker, 2004; Stein, 2005). Research indicates that these tools lack predictive validity because of the many contextual factors that mediate risk for suicide (Hepp et al., 2004). No research has been identified in relation to the reliability of mental health nurses’ decision making for suicide risk assessment. Anecdotally there is discordance among clinicians about this aspect of their decision making and in particular, the transfer of the person to definitive care (called disposition). In Australia, mental health nurses who work in EDs routinely make autonomous dispositional decisions.

Aims

1. To investigate variations in patient disposition decisions, following deliberate self-harm risk assessment by Australian mental health nurses.
2 To explore the demographic factors of clinicians that may affect dispositional decision making for deliberate self-harm risk assessment.

3 To explore the clinician’s reasoning processes, leading to their dispositional decision making.

**Study design**

This study uses a mixed methods approach including cross sectional survey and qualitative description of rationale for dispositional outcomes. Mixed methods were chosen in order to investigate the reason participants gave for the decisions they made. The use of qualitative methods adds a level of explanatory power to the results gained in a straight quantitative design. Mixed methods are more time consuming than single method design but the richness of the data gained outweighs this weakness.

A cross sectional survey was developed based on nine clinical vignettes of people presenting to ED with deliberate self-harm ideation. Vignettes were chosen as an efficient and well tested method of data gathering. They may be defined as factual or fictional descriptions of life events which clinicians are asked to respond to a series of questions (Paddam, Barnes, & Langdon, 2010). The vignettes may take any form, be it visual, written or filmed. They aim to communicate a situation in which the researcher is interested in other’s responses.

The advantage of using vignettes over observational studies include cost, and confidentiality, they can also generate more data more quickly from a larger population (Hughes & Huby, 2002). Importantly for this research is the ability of vignettes to expose a large number of people to the same stimulus, and to elicit reactions to, and
about, the vignette. As stated, there may be client factors, contextual factors, and clinician factors at play in decision making, this methodology allows the client and contextual factors to be held static so that the only variable is the clinician factors.

Paddam et al (2010) summarises the arguments against vignettes in that they are monodimensional and lack the colour and emotion of real life situations, however, she quotes research that “compared the use of vignettes, video tapes and participant recall and found that all three methods produced consistent results” p. 62.

In summary Hughes argues that vignettes are valuable research tools, particularly for at risk participant groups (Hughes & Huby, 2002), the very nature of deliberate self-harm ideation makes the use of vignettes both safe and ethically acceptable.

**Instrument development**

A survey instrument was developed for this project. It comprised two components: demographic information and a series of nine vignettes that required a decision response. There was also a request for information on why the decision was taken. The demographic data covered areas such gender, age, and professional qualifications. Information about clinical practice was also requested, including area of practice, the demographic of population serviced and experience in acute psychiatry. The vignettes were presented and identical questions asked for each, covering the belief in the intentions of the patient and the dispositional decision, respondents were asked to explain why they came to the belief and dispositional decision.
Validity and reliability

When developing an instrument to test for reliability in assessment of deliberate self-harm people no gold standard could be identified. If no gold standard has been identified then any instrument developed must be tested to ensure that it is indeed measuring what it is intended to measure. Lynn (1986) set out a five step process of instrument development these are:

1. Identification of full content domain
2. Sampling and item identification
3. Assimilation of items into usable form
4. Judgment/quantification of content validity of items
5. Judgment/quantification of content validity of instrument

(Lynn, 1986 p. 383)

The first three of these stages may be viewed as construct validity – “a theoretically derived notion of the domains we want to measure. This theoretical framework provides the basis for understanding the behaviour we want to measure” p. 625 (Guyatt, Feeny, & Patrick, 1993).
Stage 1 – Development Stage

Identification of full content domain

An exhaustive review of the literature revealed no comprehensive study of the content domain, rather there were many studies identifying variables that may lead to admission after presenting with a suicide attempt/ideation.

In an Australian study 28.2% of presentations with deliberate self-poisoning were admitted to a psychiatric hospital. The variables shown to be most likely associated with decision to admit were single males over 25 years of age with both unemployment and homelessness being highly correlated. A previous history of self-harm and previous inpatient psychiatric admission also increased the chances of being admitted, as did high current deliberate self-harm level. Within data concerning “current diagnosis”, mood disorder and schizophrenia or other psychotic disorders were the groups most likely to be admitted. The most common stated aims of hospitalisation were: management of deliberate self-harm risk; treatment of psychiatric disorders; and resolution of interpersonal or social crisis (Carter et al., 2006).

In an English trial (Brooker et al., 2007) an admission rate of 12.8% of those referred for assessment was identified. They found no difference in either gender or age between those admitted and those not admitted, however, there was a significant difference in decision to admit according to socio-economic status with those from the most deprived areas four times more likely to be admitted than those from an affluent area. Clinicians in this trial stated that the key factors that influenced admission were level of risk (not defined) and the extent to which support was available to the patient in
their own environment. Further analysis showed the psychotic spectrum disorders and cognitive problems were more likely to gain admission than mood disorders.

An American study (Goldberg et al., 2007) found an admission rate of 70% among their study, the three variables found to most closely predict admission were presenting with psychosis, a history of attempted suicide and a deliberate self-harm plan, controlling these factors accounted for 80% of admission decisions. Souminen and Lonnqvist (2006) reported on suicide attempters in Helsinki, Finland over a 12 month period and found a 24% admission rate. However, of note is that they found a significant difference in admission rates between centres, and report similar findings in other studies.

Predictor variables associated with suicide were the focus of an Israeli study (Goldston, Reboussin, & Daniel, 2006). Depressive symptoms, hopelessness and psychic, global or trait anxiety were the factors identified as having the most predictive value. They call these variables being either enduring throughout the lifespan (traits) or transient (states).

Baca-Garcia et al (2004) surveyed an ED in Madrid and found an admission rate of 39%. They identified six variables that were associated with increased odds of hospitalisation, these were – intent to repeat the attempt, plan to use a lethal method, low psychosocial functioning before the attempt, previous psychiatric hospitalisation, suicide attempt in the past year, and planning that no-one would try to save their lives after they had attempted suicide (Baca-Garcia et al., 2004). The Swiss study completed by Hepp et al (2004) found an admission rate of 51.5%. They then performed a logistic regression analysis with decision to admit as the dependent variable. This highlighted the method of
self-harm, psychiatric history and psychiatric diagnosis significantly contributed to the decision to admit. The method of self-harm meant that more aggressive attempts were likely to have admission and within psychiatric diagnosis those within the psychotic spectrum were admitted. Of the demographic data those of an older age were more likely to be admitted while female sex and regular occupational activity were more highly correlated with outpatient treatment decisions.

In summary, males with aggressive, highly lethal attempts, psychiatric history and on-going deliberate self-harm ideation are more likely to be admitted. Contributing factors include social dislocation (unemployed, homeless, poor support group). It is of interest that no study mentions intoxication as a variable when a study by Wyder (2006) found that 65% of persons attempting suicide were substance affected. Protective factors are described as: the presence of strong supports in the person’s life along with other social connectedness indices (employment, stable relationships), perceived low lethality or an ambiguous intent, female gender and a diagnoses of personality disorder or a high prevalence disorder (anxiety, depression).

**Item identification**

The above mentioned factors may be distilled into three presenting diagnoses, psychotic spectrum disorders, affective disorders (mood), and other (for example, personality disorders and adjustment disorders). These diagnoses appear to be mediated by four other factors:
• Intellectual functioning: this depends on the level of intoxication, the substance and usual level of use, brain injury, clouded consciousness, intellectual functioning (dementia, disability).

• Social connectedness: implies social supports, living situation, employment, income, social network, social resources, family supports.

• Situational factors: include the current crisis, recent losses, current coping level, reason for presentation, physical illness, and accommodation.

• History of suicide attempts
Each of the first three mediating factors may act as either a risk or safety factor, and in the instrument development needs to be finely balanced in order to represent the complexity inherent in these types of presentations. Any history of suicide attempts has been shown by studies to increase the likelihood of admission, and indeed a history of attempts has been highly correlated with later, successful suicide attempts (Baca-Garcia et al., 2004).

Model Development

According to Guyatt, Feeny & Patrick (1994):

“The first step in construct validation is to establish a model or theoretical framework that represents an understanding of what investigators are trying to measure. That theoretical framework provides a basis for understanding the
behaviour of the system being studied and allows hypotheses or predictions about how the instrument being tested should relate to other measures.” P. 626

Using the variables described above the following model was developed to give a diagrammatic representation of the items identified for this study. In this representation an inverted triangle is used to demonstrate the importance of social connectedness and intellectual functioning in the assessment of safety and risk factors.
Factors in suicidal presentations

Figure 2
Proposed theoretical framework representing the domain of deliberate self-harm presentations for this study.
Assimilation of items into useable form

The next step in instrument development was to utilise the model to develop the vignettes, balancing risk and safety issues. In doing this there were nine vignettes developed three each representing three diagnostic categories being depressed, psychotic and other. Two were designed to test the model, one having high social connectedness and intellectual functioning (vignette three) and the other being the opposite (vignette two). For the remaining seven vignettes the risk and safety factors were finely balanced.

Vignette one (Depressed retired male)

Trevor is brought in from the scene of a single vehicle accident where his late model Volvo hit a tree at high speed, fortunately for him the air bags deployed and probably saved his life. His blood alcohol is 0.12 and he is sullen and non-communicative. His wife arrives in a distraught state showing obvious concern for him, she confides that he has been talking about how worthless his life is recently and has discussed a suicide pact with her which she laughed off. Trevor is a 68 year old man who lives at home with his wife, he has two adult children, he retired three years earlier as a senior partner in a law firm and his wife reports that he has not adjusted to retirement. While they have travelled and renovated the house he has not developed any interests outside the home and his alcohol consumption has been steadily increasing he says to manage his insomnia. For the past six months he has been becoming increasingly reclusive, not keeping in touch with friends and not interested in going out, his wife says that he has been losing weight recently. When he finally agrees to engage he states that the accident was just that and denies it was a suicide attempt although he admits to have
been fantasizing about death. He states that he has seen his GP and has been on Zoloft for about two months and is feeling much improved.

**Explanation**

Trevor is depressed and was drunk at the time of his accident. He has a supportive wife and is under treatment that he says is helping, he denies that this was a suicide attempt. This is balanced by increasing alcohol intake, the suicide pact suggestion, his age and gender and the fact that he hasn’t adapted to retired life.

**Vignette two (Male, homeless, intoxicated)**

Paul is a 28 years old gent who has a diagnosis of paranoid schizophrenia, he hasn’t been taking his medication which is Olanzapine 10mg mane and 20mg nocte for the last two weeks, as he has been on an amphetamine binge. He is brought into the emergency department by the police who were called to his rooming by his neighbours because of the banging in his room all night. The police report that he had been dismantling his room looking for cameras. He has a history of three suicide attempts, one by hanging and two by overdose. In interview he is guarded, glancing around the room suspiciously, his pupils are dilated and he is grinding his jaw incessantly. Eventually he confides that his neighbours have been after him for some time and he knows they are going to kill him. He confesses that they are speaking to him through the radio telling him to take all of the medication he has stockpiled and that he has been thinking of doing just that rather than allow them to kill him.
Explanation

Here Paul is psychotic, he is intoxicated with amphetamines and lives in a rooming house with little social support. He appears to have either a relapse of his psychotic illness or a drug induced psychosis with command hallucinations telling him to kill himself, with a plan, means and intent. This is on a background of previous serious suicide attempts. It would appear the Paul requires an in-patient admission to come down off the amphetamines and re-establish a medication regime along with referral for case management.

Vignette three (Female, self soothing)

Mary presents to the emergency department with self inflicted lacerations to her forearms, she is 22 and is accompanied by her mother with whom she lives. She has been having a difficult time at work recently and today had an altercation with a co-worker, when she arrived home she felt so angry she went to the bathroom and cut herself. She denies any deliberate self-harm ideation or intent and states that she does this to “feel normal”. Her supportive mother states that she is in counselling and that the incidence of self soothing has decreased since she engaged with the counsellor.

Explanation

In this vignette Mary is in the other category with a probable diagnosis of borderline personality disorder. She has normal intellectual functioning, good social connectedness and counselling as safety factors. These are balanced by returning to an unresolved situation at work and many previous self-harm events. She denies deliberate self-harm ideation and follow up with her counsellor would appear to be the outcome of
choice. In this test vignette, it would be expected that there would be agreement to not admit to hospital.

**Vignette four (Female, impulsive, supported)**

Jenny is a 20 yrs old female presenting with Metropolitan Ambulance Service (MAS), called by her flat mate who arrived home from work to find her unconscious in the lounge with two empty packets of paracetamol beside her. She was found to be toxic and required overnight antidote treatment. She is the youngest in a sibship of three with supportive parents, who are sitting by her bedside. She also has a history of an eating disorder but no previous self-harm. In interview she says that she took the overdose because of stress at work, financial issues and the recent break down of a two year relationship. She is tearful and says that she has not been sleeping. She states that she took the overdose impulsively after a call from her ex-boyfriend in which he emphatically refused to resume the relationship. She took the overdose because she wanted to die and stated that she knew that it was lethal. Although denying any on-going deliberate self-harm plan she states that she has been thinking that it would be good to not wake up. Her parents want to take her home so they can care for her

**Explanation**

Jenny would fall into the other diagnostic category, she appears to be suffering from an adjustment disorder, she was not intoxicated and appears to have clear intellectual functioning. She is working, shares a house, and has very supportive parents who want to take her home. Her situational factors include some background work and
financial difficulties but the unresolved grief over the relationship is her biggest risk factor as she has no history of self-harm.

Vignette five (Male, ID, depressed)

Aaron’s elderly mother bought him into ED; he is 35 yrs of age and lives with her. He has Down syndrome and had been attending a sheltered workshop up until the death of his father eight months ago. Since that time his mother reports that he has become increasingly reclusive, refusing to leave the house, at times she cannot get him out of bed. His GP has diagnosed depression and prescribed Efexor but Aaron has refused to take it. Recently his mother has noticed Aaron is talking to himself when no one is around and today found him hitting his head against the brick wall causing extensive lacerations and bruising. Aaron told her that he was doing this because his father was telling him to kill himself. He has never done anything like this before. His mother is tearful, and is asking for help, but she does not want him to be admitted as he has never been away from her. Aaron is sullen and doesn’t want to talk but reluctantly tells you that he can hear his father in his head telling him that he is bad and that is why he went away.

Explanation

Aaron has a mood disorder with psychotic features, intellectual disability and command hallucinations. His suicide attempt was of low lethality and he has an extremely supportive family environment, the ability of his mother to care for him appears to be the pivotal point towards admission.
Vignette six (Male, depressed, intoxicated, supported)

Geoffrey is a married man of 47 with three children aged 24, 21 & 18. He lives with his wife and the two youngest children. He worked as a middle manager for a firm for many years but was retrenched 18 months ago. Since that time he has been trying unsuccessfully to find employment and is currently being supported by his wife who works for a cleaning firm. He has found this difficult and has taken to drinking daily. He has no formal psychiatric history but has been being treated for depression by his GP with whom he has a good relationship, and has been on Zoloft 100mg daily for the last three weeks, and Temazepam 10-20mg nocte. Tonight the family was invited to a friend’s house for dinner but Geoffrey had started drinking early and was in no condition to accompany them. The family left him at home and went to dinner. When they arrived home later in the evening Geoffrey was found in his car at the back of the house, with a hose running into the back window and the motor running. He was unconscious and required resuscitation by Metropolitan Ambulance Service and in the Emergency Department. He had written a suicide note stating his regret for his behaviour recently and for taking his life and talking of his love for his family. When you interview him the next morning he admits to feeling down recently and agrees that he hasn’t been sleeping well, drinking much more than is usual for him and not taking much pleasure in life. He states he is embarrassed about the previous night’s events and denies any deliberate self-harm ideation either prior to the events of the night before or any on-going thoughts of suicide, scoffing at the idea that he would take his own life and attributes the attempt to being intoxicated. He agrees that he needs to cut down on his alcohol intake as it is
having an adverse effect on his life and his relationships within his family. His wife is very supportive of him, as are his children.

**Explanation**

Geoffrey would meet criteria for depression, he was intoxicated at the time of the attempt. His situational factors (unemployment, loss of status) remain unchanged, and it was a potentially lethal attempt. Balancing this he has good social connectedness and no history of self-harm and agrees he needs to address his drinking.

**Vignette seven (Female, borderline, intoxicated, in crisis)**

Gayle is a 39 yr old married mother of four children aged between five and eleven. She reports having a history of childhood sexual abuse, but managed to finish secondary school and worked as a personal assistant until the birth of her first child. All was well until the birth of her last child after which she was diagnosed with post partum depression and had a private admission, since that time her life has been a roller coaster with alcohol and drug abuse, episodes of self-harm, many private admissions under different private psychiatrists and some public involuntary admissions, usually after being recommended in the private hospital for disruptive behaviour. She has attempted suicide in the past by overdosing and cutting her wrists, these are distinct from the times that she reports that she cuts herself to self soothe. She has been tried on many medications both antidepressant and antipsychotic as well anxiolitic and anticraving medication, all to no avail. Things have come to a head recently with a notification being made to DHS about her ability to care for the children and her husband has given her an ultimatum to clean up her act or he will take the children and leave her. This has led to
even more out of control behaviour and threats to end her life. MAS were called by her eldest child, who arrived home from school unexpectedly to find her mother in the garage with a noose around her neck, standing on a chair. On arrival at ED her BAL was 0.24. Once sober she downplays the attempt saying that she knew that her daughter would find her. She denies this was a suicide attempt or that she is currently deliberate self-harm

**Explanation**

Gayle would qualify for the other category probably attracting a diagnosis of borderline personality disorder. She was drunk at the time of the attempt and despite her reassurances was found accidentally. She has a history of suicide attempts as well as self-harm but this method was novel for her. Her social connectedness is under threat at the moment and it would appear that her main support is under threat.

**Vignette eight (Male, homeless, depressed, intoxicated)**

Dillon is 32 and states that he is homeless, he is unemployed and is an intravenous drug user, and his substances of choice are stimulants. He has a history of itinerancy and has had no contact with his family of origin for many years. He has had sporadic contact with mental health services over the years attracting diagnoses as diverse as schizoaffective disorder, depression, explosive personality disorder and antisocial personality disorder. He has had a few short admissions and was case managed for a period of three months some years ago. He has had no contact for the last two years. He states that he has attempted suicide in the past “a couple of times” by cutting his wrists and by heroin overdose. He presents as thin and extensively tattooed with a shaved head and red-rimmed eyes. While his pupils are normal he is grinding his
teeth and is unable to settle. Upon questioning he admits that he hasn’t slept for four nights and is coming off an “ice” binge. His girlfriend called the police to remove him from her house yet again because of his violence. He had stabbed himself in the thigh with a pocket knife when she called the police. He states that he feels agitated and depressed and that he wants to throw himself off a bridge as he has no friends, no future, and no girlfriend.

Explanation

Dillon states that he is depressed and has been given that diagnosis in the past, he is suffering from the effects of stimulant use. He states that he has a plan to suicide by jumping off a bridge, he has no social connectedness and his situation is worse at the moment as his girlfriend has had him removed. His self-harming is, however, of low lethality.

Vignette nine (Male, psychotic, in crisis, supported)

Alan has been brought in by his new case manager who has just met him taking over from his long term case manager who has retired. She is concerned because Alan had been stockpiling his medication (Quetiapine 600mg bd) he says in order to overdose on it. He is 36 years of age on a disability support pension and has lived in a supported residential service (SRS) for the last eight years, he has been diagnosed with schizophrenia since the age of 19 and has persistent delusions that the CIA are tracking him and conspiring to make his life “a living hell”. He attempted suicide by overdose eight years ago after moving from his parent’s home to the SRS. He has a history of non-compliance with his medications as he does not believe he needs them as he is not unwell,
he has never attempted self-harm in the past. Alan denies that he was going to take the medication but the manager of the SRS has said that he has been talking recently about being sick of his life and the fact that he will never marry or have children, and she has noticed that he has become wary of strangers and she has found him keeping guard at the door of late.

Explanation

Alan has a psychotic illness that appears to be in relapse due to his lack of medication. His intellectual functioning is unaffected and he appears to have a reasonably supportive accommodation. His reported pessimistic assessment of his future is troubling as is his history of a suicide attempt.

Stage 2 – Judgement-Quantification Stage

In this stage of the instrument development the vignettes above were sent to a panel of experts to determine content validity. Having established the domain to be studied, this phase ensured that the instrument was covering that domain. The experts were chosen from clinicians in Australia that specialise in the area of suicidology. According to Lynn (1986) the minimum number of experts required for validity would be ten. In order to ensure that number in returns, twenty experts were asked to participate. These were selected by approaching Australian clinicians who had published in the area. Eleven of the experts agreed to participate. These experts were then asked to rate the vignettes according to the index of content validity (CVI) this involves determination against a 4 option rating scale (1 = not relevant; 2 = unable to assess relevance without item revision or item is in need of such revision that it would no longer be relevant; 3 =
relevant but needs minor alteration; 4 = relevant and succinct) (Lynn 1986 p. 384). This process resulted in some minor changes but the eleven experts that replied were in agreement that the domain had been explored.

**Measures**

The primary outcome measures for this study are:

1. Spread, defined as the proportion of responses for each vignette in each of the dispositional categories

2. Concordance, defined as the percentage of responses for each vignette in the modal category

3. Agreement, proportion of responses in the modal category adjusted for chance.

**Data collection**

The tool was distributed by the Australian College of Mental Health Nurses (n= approx 2000) to all of its members with email access. They were sent an explanation of the research along with a link to the tool. A reminder email was sent 2 weeks into the 4 week collection period. At the conclusion of the collection period the response rate was 155 completed surveys. In order to boost this response rate the survey was distributed to registrants at The 10th Victorian Collaborative Psychiatric Nursing Conference on the 13th and 14th August 2009 in Melbourne. The survey was handed to participants as they registered. Participants were given the option of placing the completed surveys in a box provided or to utilise an attached reply paid envelope. Mention was made in the key note address encouraging participants to complete and return the survey.
The participants were asked to complete the demographic questions about themselves, their levels of education, training and current position and appointment level. They were also asked to rate each of the vignettes for intent, lethality and disposition to three outcomes (immediate admission to specialist mental health hospital, community follow up by specialist clinicians within 24 hours or follow up by General Practitioner within 7 days).

Only participants not currently working in mental health nursing were excluded. Consent to participate in the study was implied by return of the survey. The researchers did not have the names of any participants and could not link responses to study participants ensuring the study was totally anonymous.

**Problems**

There were two main problems encountered by respondents, the first appeared to be browser compatibility when the link in the email did not work, however this appeared to be overcome when respondents pasted the link into their browser. The second issue was with the unique key used to return to the survey once it had been commenced, it appears that the problem was with respondents mistaking O (capital o) with 0 (zero), this was addressed by the survey developers using phonetic text.

**Quantitative Analysis**

Data were entered into a spreadsheet to facilitate data analysis using the statistical package for the social sciences (SPSS version 12.0). Initial analyses included basic descriptors of the population such as frequencies, percentages and measures of central tendency. This described the population under investigation, their gender, geographical
distribution, qualifications and experience.

Similar analyses were undertaken on the vignette questionnaires with the data being aggregated and reported as frequencies and percentages for the decisions made. This was to explore for concordance and disagreement and patterns within this.

As most of the data on the vignettes was categorical in nature, the data were then examined utilising cross tabulation, binary logistic regression, Pearson’s chi square, Kruskall Wallis and Fisher exact testing to identify associations with modal responses and demographics. These tests examined the spread, concordance and agreement. A nonparametric Friedman test was run to explore for differences in disposition.

Rather than the five point Likert type scale that is traditionally used, this study opted for a four point scale, removing the neutral midpoint to force a decision.

To measure agreement a 95% confidence interval for each vignette was calculated as fifty percent agreement is no more agreement that would be expect by chance, if nurses choices were completely unrelated, so it was not considered evidence of any genuine agreement.

The comments made by participants were subjected to a thematic analysis (Ritchie and Spencer 1994). This is stepwise process where the text based data is systematically explored using a process of familiarization and sorting according to key descriptors by scenario. The data were then examined to identify a thematic framework. Charting of decisions for the specific scenarios by decision type and decision outcome was then performed.
Qualitative Analysis of Reasons for Decisions

For this study the framework method of qualitative data analysis as described by Ritchie and Spencer (1994) was utilised. They describe five stages involved in an analysis.

- Familiarisation which involves immersion in the data which involves reading and rereading the material noting down key themes that emerge.
- Identifying a thematic framework is the identification of key themes. Issues and concepts. At this stage this index is largely descriptive and consists of emergent themes
- Indexing is applying the framework systematically to the data in its textual form.
- Charting the data involves developing headings and sub-headings that arise from the thematic framework and placing the material under the relevant headings.
- Mapping and interpretation is the pulling together the key characteristics of the data to “map and interpret the data set as a whole” (p. 186).

Data Preparation

The electronic survey had the facility for respondents to qualify their answers to any of the questions with a prompt asking why? They were then encouraged to expand on the reasons for their decision making. While this facility was not open to those responding to the paper based survey, some did take the time to expand in the limited space available to them. The data were downloaded into a spreadsheet, and hand written responses were transcribed into the relevant columns. The entered data were perused and cleaned. Cleaning involved the removal of extraneous entries such as hyphens before an entry that would render the entry unreadable.
Familiarisation

The initial step in analysing qualitative data according to Ritchie, Spencer and O’Connor (2003) is to identify initial themes and concepts, this involves first familiarisation of the data. The response of interest in this exercise was the intervention and the reasoning given for taking that particular intervention. Each vignette was taken in turn, initially the responses were grouped according to their intention (to admit or not) and the reasons given were scrutinised. In order to give some transparency and replicability to the process each respondent’s main themes were then distilled and labelled, the data were already de-identified and respondents were simply called R1 – R210.

Thematic framework

Below is a sample of the extracted themes for Vignette five (Male, ID, depressed), these are the respondents who chose to admit along with their reference (R8 – R23) and the themes that emerged from the reasons given for their decision.

Themes associated with the decision to admit

R4 – acute illness needs treatment, risk to others

R8 – depression needs treatment, mother unable to cope

R19 – treatment, mother at risk

R20 – treatment, risk to self

R23 – longitudinal assessment, treatment, mother unable to treat
This was done for every respondent who chose to give reason for their decision. The themes that emerged were then scrutinised in order to create a thematic chart with subthemes being grouped under a unifying title or domain. In the vignette above six domains were identified.

1/ Assessment and treatment

Under this domain the themes identified were admission for longitudinal assessment, to initiate treatment in someone unwilling, to involve specialist services.

2/ Perceived risk

This domain took in all of the reason for admission that related to risk, this included risk to self (of self-harm) risk to his elderly mother, risk of deterioration due to non-compliance with treatment

3/ Mother unable to cope

While it could be argued that this theme could fall into the perceived risk domain it was decided to single this out as it seemed to be a key pivotal factor in the decision to admit or not. The respondent’s perception of the mother as a protective factor or not proved decisive throughout.

4/ Undecided

These were the respondents who, while making a definitive decision to admit in the intervention box then qualified that decision, predominantly with the patient’s mother being able to cope.
5/ Community treatment

Themes grouped here included assessment and treatment by the community team who were achieving much of what was grouped under the initial treatment domain but achieving it in the community. They were initiating and supervising treatment, supporting and educating the mother, and referring to specialist services.

6/ Hospital too stressful

This was cited a number of times as under the guise of parting the patient from his mother would be too stressful for the patient or his mother, also mentioned was the process of hospitalisation being stressful.

Thematic charting

Having identified the domains, the next step was to return to the data and assign each theme to a domain, counting how many times each appears under the dispositional decision. Themes and domains straddled this decision, particularly when it came to treatment as a domain. Similar reasons were given when quite different decisions were made. When it came to perceptions of risk or the aversive nature of a hospital admission it was clear with no crossover.

Once the domains were assigned and counted a thematic chart was constructed to incorporate the domains and the main themes there under. Here the domains and themes are clearly articulated and then tied back to verbatim quotes from the respondents in order to illustrate the themes.
Table 11

*Thematic chart for Vignette 5 (Male, ID, depressed)*

<table>
<thead>
<tr>
<th>Domain</th>
<th>1/Assessment and treatment</th>
<th>2/Perceived risk</th>
<th>3/mother unable to cope</th>
<th>4/undecided</th>
<th>5/community treatment</th>
<th>6/hospital too stressful</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theme</td>
<td>Longitudinal assessment/ treatment/ referral to specialist services</td>
<td>Risk to mother/risk to self</td>
<td>mother's ability to cope</td>
<td>CATT/mother supportive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admit</td>
<td>Number 23</td>
<td>17</td>
<td>9</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reasons</td>
<td>Although it is unclear about the intent of the behaviour the patient is obviously disturbed. There is a diagnosis of depression that is untreated and evidence of auditory hallucinations. It needs to be established if this is a psychotic depression or a symptom of another disorder. Although mum is against admission there is a history that the patient is reluctant to take medication. (R23)</td>
<td>probable psychosis, elderly mother at risk and not able to keep him safe or get him to take him to take his medicatio ns (R19)</td>
<td>it is unlikely that his mother can ensure his safety due to her age - may even be herself at risk if she tries to intervene (R49)</td>
<td>it is unlikely that his mother can ensure his safety due to her age - may even be herself at risk if she tries to intervene (R49)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comm</td>
<td>Number 9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treat</td>
<td>Reasons</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Wouldn't cope well in hospital setting. Needs prompt follow-up/intervention to treat for psychosis initially, then grief counselling (R80)</td>
<td></td>
<td></td>
<td></td>
<td>Mother does not want admission</td>
<td>Taking him away from mum would be very distressing for both of them and I would be surprised if mum wouldn't watch him like a hawk for a while given he has never done anything like this before (R53)</td>
</tr>
<tr>
<td></td>
<td>He and his mother need community intervention and he needs grief counselling and possibly review of medication by psychiatrist. (R135)</td>
<td></td>
<td></td>
<td></td>
<td>community treatment and behaviourai intervention would be more beneficial in the long term. (R59)</td>
<td></td>
</tr>
</tbody>
</table>
Mapping

This process was then carried out for each vignette and reported back in the form of a thematic chart for each vignette. They are presented in Appendix 1. This mixed methods approach has provided some explanation for the variation in disposition that was uncovered by the quantitative analysis.
CHAPTER 4

Results

Introduction

This chapter will present the analysis of the data collected. Strengths and weaknesses of the method are first examined to explain the response rates. The data collected are then explored quantitatively, first presenting the frequencies to describe the demographics of the sample, along with any data transformations that were performed. The demographics are then methodically compared with decisions made.

Response rates

The electronic survey package received 202 commenced surveys, the survey distribution at the collaborative conference yielded a further 59 surveys. Of the collected surveys 56 were entered into the electronic survey and three were discarded as the respondents were Division 2 nurses and not eligible to participate (this gives a margin of error range from 6.5% to 8.5%).

The data were downloaded into a Microsoft Excel (2007) spreadsheet and checked visually. When a respondent opened a survey they were given a unique key in order to access the survey at a later time to complete the survey. When the respondent turned a page the survey saved itself, therefore many of the surveys were incomplete, of these 147 of respondents had completed the first vignette and were retained for the analysis, with the 56 that were entered this gives a final sample of 210. Where the respondent had not answered a question the electronic survey defaulted to 999.
Quantitative Analysis

Data preparation

Some data entered required re-entering, for example when respondents were asked “How long since you have worked in acute psychiatry?” some respondents had entered the year they last worked in acute psychiatry. This was addressed by replacing the year with the number of years since practicing e.g. 2005 = 5, 2009 = 0. This step was necessary in order to have comparable data. This spreadsheet was then entered into SPSS and the variables coded as per the codebook.

Participants

A frequency table from SPSS then revealed the figures presented in Table 5.

Demographics

The demographic data showed 66/210 (31.4%) respondents were male and 144/210 (68.6%) were female; the average age was 46 years (SD of 9.39 years). Participants had been in the field for an average of 18 years (SD 0f 10 years) and averaged 38 hours per working week.

Demographic of practice

Frequencies revealed only one respondent that identified their population as remote, for this reason it was decided to combine rural and remote giving 53 cases (25.2%) rural/remote and 154 (74.4%) as urban from the 207 valid cases.
Table 5

Valid vs. missing responses

<table>
<thead>
<tr>
<th>Vignette</th>
<th>Description</th>
<th>Valid</th>
<th>Missing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vignette 1</td>
<td>(Depressed retired male)</td>
<td>206</td>
<td>4</td>
</tr>
<tr>
<td>Vignette 2</td>
<td>(Male, homeless, intoxicated)</td>
<td>166</td>
<td>44</td>
</tr>
<tr>
<td>Vignette 3</td>
<td>(Female, self soothing)</td>
<td>158</td>
<td>52</td>
</tr>
<tr>
<td>Vignette 4</td>
<td>(Female, impulsive, supported)</td>
<td>146</td>
<td>64</td>
</tr>
<tr>
<td>Vignette 5</td>
<td>(Male, ID, depressed)</td>
<td>135</td>
<td>75</td>
</tr>
<tr>
<td>Vignette 6</td>
<td>(Male, depressed, intoxicated, supported)</td>
<td>133</td>
<td>77</td>
</tr>
<tr>
<td>Vignette 7</td>
<td>(Female, borderline, intoxicated, in crisis)</td>
<td>124</td>
<td>86</td>
</tr>
<tr>
<td>Vignette 8</td>
<td>(Male, homeless, depressed, intoxicated)</td>
<td>126</td>
<td>83</td>
</tr>
<tr>
<td>Vignette 9</td>
<td>(Male, psychotic, in crisis, supported)</td>
<td>124</td>
<td>86</td>
</tr>
</tbody>
</table>

**Role**

Under the role demographic the numbers were again unbalanced with 151 or 72.6% of the valid cases being clinically based, because of this the other categories were combined to give two categories being clinical and non-clinical containing 151 (72.6%) and 57 (27.4%) respectively. The non-clinical category combined management, education and research roles.

**Field**

The field of practice was another variable that showed skewed data. In this case 152/208 (72.4%) respondents practiced in the adult field while 56/208 (27.6%) practiced in other fields of mental health nursing such as management and academia. They were combined giving the two categories of adult and other.
**Qualification**

Within the qualification field data were coded according to the level of qualification with certificate or Graduate Diploma being 1 N = 158 (75.2%), Masters 2 N = 49 (23.3%) and PhD 3 N = 3 (1.4%). This was then collapsed with 2 & 3 being combined giving RPN 158 (75.2%) and higher 52 (24.8%).

**Perception of lethality**

A new variable was created and called perception of lethality, this took the question of whether the attempt was lethal or not and recoded it from the original four point scale (strongly agree, agree, disagree, strongly disagree) into agree or disagree.

**Perception of deliberate self-harm**

A new variable was created and called perception of deliberate self-harm, this took the question “I think the patient believed their actions would result in death” and recoded it from the original four point scale (strongly agree, agree, disagree, strongly disagree) into agree or disagree.

**Disposition**

When the data within the disposition field were examined it appeared that in all vignettes with the exception of vignette three (Female, self soothing), the number of responses that selected referral to GP or private practitioner within seven days was small. For this reason this variable was collapsed into two categories: admission or no admission, with the exception of vignette three where the two categories were community follow up with 24 hours or selected referral to GP or private practitioner within 7 days.
Table 6

*Frequency of role*

<table>
<thead>
<tr>
<th>Role</th>
<th>Number</th>
<th>Valid %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management</td>
<td>22</td>
<td>10.6</td>
</tr>
<tr>
<td>Clinical</td>
<td>151</td>
<td>72.6</td>
</tr>
<tr>
<td>Education</td>
<td>29</td>
<td>13.9</td>
</tr>
<tr>
<td>Research</td>
<td>6</td>
<td>2.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>208</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Within the study design two vignettes were crafted to maximise and minimise risk factors in order to check that there is consistency at the extremes. Vignette two was one where the risk were maximised and 95.8% (95% confidence intervals (CI) 91.6% - 98.3%) of respondents elected to admit to hospital. Vignette three was one where risks were minimalised and 100% of respondents agreed not to admit to hospital. Of interest in this result is that, of the two community treatment options respondents could not agree on which was appropriate with indications being towards community team referral, although the 50% mark is within the range (35.8% - 51.8%). The remaining seven vignettes split the respondents as to dispositional decision. The closest to consistency was vignette seven where 63.7% of respondents agreed to admit with a range of 55.3% - 72.6% followed by vignette six with 60.2% admitting (51.3% - 68.5%). Vignette nine was the only one aside from vignette 3 with any agreement on community treatment with 62.1% selecting that option (52.9% - 70.6%)
**Risk aversiveness**

A new variable was created and called risk aversive, this variable is the number of times a clinician either admitted or in the case of vignette three (Female, self soothing) referred for community team follow up. This shows that only one clinician admitted on one occasion whereas three admitted every vignette. This variable was designed to investigate the predisposition of the clinician towards conservative decisions. The three respondents that admitted every vignette displayed a conservative stance when it comes to risk as opposed to the respondent who only admitted the test vignette.
Table 7

*Spread of disposition*

<table>
<thead>
<tr>
<th>Vignette</th>
<th>Decision outcome</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>N</td>
</tr>
<tr>
<td>One</td>
<td>206</td>
<td>90 (43.7%)</td>
</tr>
<tr>
<td>Two</td>
<td>166</td>
<td>7 (4.2%)</td>
</tr>
<tr>
<td>Three</td>
<td>158</td>
<td>69 (43.7%)</td>
</tr>
<tr>
<td>Four</td>
<td>146</td>
<td>85 (58.2%)</td>
</tr>
<tr>
<td>Five</td>
<td>135</td>
<td>75 (55.6%)</td>
</tr>
<tr>
<td>Six</td>
<td>133</td>
<td>53 (39.8%)</td>
</tr>
<tr>
<td>Seven</td>
<td>126</td>
<td>45 (36.3%)</td>
</tr>
<tr>
<td>Eight</td>
<td>126</td>
<td>54 (42.9%)</td>
</tr>
<tr>
<td>Nine</td>
<td>124</td>
<td>77 (62.1%)</td>
</tr>
</tbody>
</table>
Table 8

*Frequency of admission*

<table>
<thead>
<tr>
<th>Number of admissions</th>
<th>Clinicians who admitted that number of times</th>
<th>Valid %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>2</td>
<td>5</td>
<td>2.4</td>
</tr>
<tr>
<td>3</td>
<td>23</td>
<td>11.0</td>
</tr>
<tr>
<td>4</td>
<td>21</td>
<td>10.0</td>
</tr>
<tr>
<td>5</td>
<td>22</td>
<td>11.9</td>
</tr>
<tr>
<td>6</td>
<td>18</td>
<td>8.6</td>
</tr>
<tr>
<td>7</td>
<td>18</td>
<td>8.6</td>
</tr>
<tr>
<td>8</td>
<td>7</td>
<td>3.3</td>
</tr>
<tr>
<td>9</td>
<td>3</td>
<td>1.4</td>
</tr>
<tr>
<td>Missing</td>
<td>121</td>
<td>42.4</td>
</tr>
<tr>
<td>Total</td>
<td>210</td>
<td>100.0</td>
</tr>
</tbody>
</table>

This variable was then broken down further. When the vignettes were crafted they were based on three diagnostic categories being depression, psychosis and other taking in adjustment disorder and personality disorder. Hence vignettes one, six and eight represented patients with symptoms suggestive of depression, two, five and nine showed symptoms indicative of a psychosis and three, four and seven fell into the other category. Three new variables were created that counted the number of times the more conservative option was chosen under each of the diagnostic groupings.
A nonparametric Friedman test was then run to explore for differences in disposition between these groupings, no statistical significance was found with the mean ranks being 2.00 for depression, 2.05 for psychosis and 1.95 for other.

**Factors explaining variation in disposition decision**

Factors influencing disposition were then explored across the categorical variables. For these variables the dispositional decision for each vignette as coded above was explored separately using crosstabs and binary logistic regression.

**Acute experience**

The first categorical variable explored was those with experience in acute psychiatry against disposition. On all vignettes except number seven there was agreement between the groups and roughly the same decision was being made. In vignette seven however, there was a marked variation with those having acute experience being much more likely to admit the person. 61/88 (69.3%) of those with community experience admitted the person while only 18/36 (50%) of those without community experience were so inclined. Having community experience was a significant predictor of admission (OR 2.26, 95% CI 1.02 – 5.00 p=.05).

**Years of acute experience**

As there was statistical significance in vignette seven for those having acute experience the number of years was tested against decision to admit in a logistic regression. In vignette seven where the decision to admit was statistically significant above it appears that the decision is the same no matter how much experience the clinician has (p=.91). However, in vignette nine it appears that the more experience that
a clinician was the less likely they would be to admit (p=.03) and each additional year of experience decreased the odds of admitting by a factor of 0.89.

**Role**

The next variable explored was the current role of the respondent which has been collapsed into clinical and non-clinical roles against their dispositional decision. Again in the majority or the vignettes the two groups were similar both in percentages and direction, there were, however no significant results.

**Demographic of population**

The demographic of the population in which the respondents work, be it either rural/remote or urban was explored for disposition. Again in the majority of vignettes the decisions were similar. In vignette six, 16/29 (55.2%) of rural/remote respondents wanted to treat in the community as opposed to 36/102 (35.3%) of urban respondents, regression revealed a p value of 0.06. In vignette one, 15/52 (28.8%) of respondents from rural/remote areas wanted to treat in the community where as 74/151 (49%) of urban practitioners were of that opinion. The demographic of the population in practice was a significant predictor of decision to treat in the community (OR 2.37, 95% CI 1.20 – 4.68, p = .02).

Vignette nine showed an even greater variation with 23/27 (85.2%) of rural/remote practitioners wanting to treat in the community as opposed to 53/95 (55.8%) of urban practitioners. Again working in a rural/remote community was a significant predictor of the decision to treat in the community (OR 0.22 95% CI 0.07 – 0.68 p = .01)
**Field of Practice**

This variable reflects the specialist field in which the respondent works. As explained above, this was highly skewed and so was collapsed into two fields being adult and other. This was explored using cross tabulation and binary logistic regression, for all vignettes with the exception of vignette seven the decisions of each group were similar, none were significant.

**Qualifications**

As explained this was another variable where it was necessary to collapse into two fields, basic qualification and higher degrees. Vignette one revealed a difference between the groups with 36/51 (70.6%) of those with higher qualifications wanting to admit against 80/155 (51.6%) of those with basic qualifications (OR 2.25, 95% CI 1.14 – 4.44, p = .02). In vignette three those with higher qualifications were more likely to take the least risk averse path of referring for public community treatment 26/38 (68.4%) as against 63/120 (52.5%) (p= .09). In vignette four there was disagreement between the groups with RPN’s wanting to treat in the community 70/112 (62.5%) while those with higher degrees disagreed 15/34 (44.1%) p=.06. Vignettes five and six saw those with higher qualifications split exactly 50/50 while the RPN group was wanting to community treat five 60/105 (57.1%) and admit six 65/103 (63.1%). There was agreement on seven, eight and nine.

**Gender**

The effect of gender on decision to admit was explored and males were marginally more risk averse than females.
Table 9

Decision to admit by gender

<table>
<thead>
<tr>
<th>Vignette</th>
<th>Description</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vignette 1</td>
<td>(Depressed retired male)</td>
<td>37/66 (56.1%)</td>
<td>79/140 (56.4%)</td>
</tr>
<tr>
<td>Vignette 2</td>
<td>(Male, homeless, intoxicated)</td>
<td>49/51 (96.1%)</td>
<td>110/115 (95.7%)</td>
</tr>
<tr>
<td>Vignette 3</td>
<td>(Female, self soothing)</td>
<td>29/47 (61.7%)</td>
<td>60/111 (54.1%)</td>
</tr>
<tr>
<td>Vignette 4</td>
<td>(Female, impulsive, supported)</td>
<td>19/44 (43.2%)</td>
<td>42/102 (41.2%)</td>
</tr>
<tr>
<td>Vignette 5</td>
<td>(Male, ID, depressed)</td>
<td>16/41 (39.0%)</td>
<td>44/94 (46.8%)</td>
</tr>
<tr>
<td>Vignette 6</td>
<td>(Male, depressed, intoxicated, supported)</td>
<td>27/41 (65.9%)</td>
<td>53/92 (57.6%)</td>
</tr>
<tr>
<td>Vignette 7</td>
<td>(Female, borderline, intoxicated, in crisis)</td>
<td>27/38 (71.1%)</td>
<td>52/86 (60.5%)</td>
</tr>
<tr>
<td>Vignette 8</td>
<td>(Male, homeless, depressed, intoxicated)</td>
<td>26/40 (65.0%)</td>
<td>46/86 (53.5%)</td>
</tr>
<tr>
<td>Vignette 9</td>
<td>(Male, psychotic, in crisis, supported)</td>
<td>17/40 (42.5%)</td>
<td>30/84 (35.7%)</td>
</tr>
<tr>
<td>Average</td>
<td></td>
<td>60.06%</td>
<td>55.72%</td>
</tr>
</tbody>
</table>

Factors explaining variation in perception of deliberate self-harm

Perceptions of deliberate self-harm

In this study we asked respondents for their perceptions of whether the person portrayed in a series of seven vignettes intended to kill themselves. To measure agreement a 95% confidence interval for each vignette was calculated as fifty percent agreement is no more agreement that would be expect by chance, if nurses choices were completely unrelated, so it was not considered evidence of any genuine agreement.

Vignette three (0% - 3.5%) showed the most pronounced agreement as would be expected as this was one where there was little doubt that the patient was not deliberate self-harm. Vignettes four (88.8% - 97.2%) and six (93.5% - 99.5%) were not quite as emphatic in the opposite direction but showing agreement that the patient was deliberate
self-harm. Vignette one (66% - 78.5%) and seven (66.4% - 82.3%) show agreement on deliberate self-harm both being well above the 50% mark and vignettes eight (14.5% - 29.4%) and two (16.3% - 29%), well below that mark reveal agreement as to the patient not being deliberate self-harm. Vignette nine (50.1% - 67.9%) showed marginal agreement but was as close to the null point of 50% as to show disagreement. Only in vignette five (46% - 63.3%) was the null point included in the confidence intervals showing no agreement.

**Acute experience**

Those with experience in acute psychiatry were investigated as to their perceptions of deliberate self-harm. There was no statistical difference across the vignettes, the only differences of note were in vignette seven where those with acute experience were more likely to believe the person intended to kill themselves 69/88 (78.4%) as opposed to 24/36 (66.7%) p= .18 and vignette Eight where the opposite was noted with acute experience seemingly leading towards a belief that the actions were without deliberate self-harm intent 16/89 (18%) versus 11/38 (28.9%) p= .17.

**Years of acute experience**

The number of years worked in an acute setting had no effect on perceptions of deliberate self-harm.

**Role**

The respondent’s clinical role was investigated for effect on perceptions of deliberate self-harm and the results were not significant.
Table 10

Perceptions of deliberate self-harm

<table>
<thead>
<tr>
<th>Vignette</th>
<th>Yes</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>One</td>
<td>151/208 (72.6%)</td>
<td>36.8% - 50.7%</td>
</tr>
<tr>
<td>Two</td>
<td>39/176 (22.2%)</td>
<td>1.7% - 8.4%</td>
</tr>
<tr>
<td>Three</td>
<td>1/159 (0.6%)</td>
<td>35.8% - 51.8%</td>
</tr>
<tr>
<td>Four</td>
<td>140/149 (94.0%)</td>
<td>49.7% - 66.3%</td>
</tr>
<tr>
<td>Five</td>
<td>75/137 (54.7%)</td>
<td>46.8% - 64.1%</td>
</tr>
<tr>
<td>Six</td>
<td>128/131 (97.7%)</td>
<td>31.5% - 48.7%</td>
</tr>
<tr>
<td>Seven</td>
<td>93/124 (75.0%)</td>
<td>27.4% - 44.7%</td>
</tr>
<tr>
<td>Eight</td>
<td>27/127 (21.3%)</td>
<td>34.1% - 52%</td>
</tr>
<tr>
<td>Nine</td>
<td>74/125 (59.2%)</td>
<td>52.9% - 70.6%</td>
</tr>
</tbody>
</table>

Demographic of population

The demographic of the population in which the respondents work, be it either rural/remote or urban was explored for perceptions of deliberate self-harm. The most significant finding was in vignette One where 44/52 (84.6%) clinicians from rural/remote populations believed the person was suicidal compared to 104/153 (68%) of urban clinicians (p=.03). This was reversed in vignette eight with only 2/29 (6.9%) rural/remote clinicians believing the person suicidal and 24/96 (25%) urban clinicians (p=.051).
**Field**

The clinical field within which the respondent practiced was explored and displayed a high degree of agreement across all vignettes.

**Gender**

The effect of gender on the perceptions of deliberate self-harm revealed reasonable agreement across most vignettes with the exception being vignette one where 108/142 (76.1%) of females believed the person to be deliberate self-harm as opposed to 43/66 (65.2%) of males (p=.11) and vignette four where the division was 100/104 (96.2%) of females and 40/45 (88.9%) of males (p=.11). Going against this trend was the only statistically significant result which was in vignette eight where 14/40 (35%) males believed the person to have attempted to kill themselves as against 13/87 (14.9%) females (p=.02).

**Qualifications**

The variable qualification was tested against perceptions of deliberate self-harm and in all except one vignette there was a high degree of agreement.

**Factors explaining variation in perceived lethality**

Once the field perceptions of lethality (item 1 “I think the actions were potentially lethal) were collapsed into disagree and agree this was explored in order to find demographic variables that may explain any variation.

**Acute**

In vignette one 63/64 (98.4%) of those without acute experience believed the actions were potentially lethal whereas 127/143 (88.8%) of those with acute experience
agreed with them (p = 0.05). The difference in vignette two was larger with 37/46 (80.4%) of those with no acute experience believing the actions potentially lethal as opposed to only 71/122 (58.2%) of those with acute experience giving a p value of 0.01 while these were the only statistically significant results it should be noted that in every vignette those with acute experience were less likely to believe the actions were potentially lethal.

**Years of acute experience**

In none of the vignettes did this ever approach significance and there was no consistency.

**Role**

There was no significance in perceptions of lethality whether the clinician worked in a non-clinical or clinical role.

**Demographic of population**

For vignette eight, 4/28 (14.3%) of those working in a rural/remote demographic believed the actions were potentially lethal while 39/96 (40.6%) of those in an urban demographic did (p = 0.02). Other vignettes were not significant and no pattern emerged.

**Field**

No vignettes approached significance when looking at field of practice and perceptions of lethality.

**Gender**

Males and females largely agreed as to whether the presentation was deliberate self-harm or not in all vignettes.
Qualifications

Within vignette one those with higher qualifications were less likely to believe the actions were lethal (43/51 (84.3%)) than RPN’s (147/156 (94.2%)) with a p value of 0.04. Vignette five garnered the opposite result with 15/30 (50%) of those with higher qualification believing lethality as opposed to 31/105 (29.5%) of RPN’s (p = 0.04). Vignette eight was also significant with 30/99 (30.3%) of RPN’s believing the actions potentially lethal compared to 14/27 (51.9%) p = 0.05.

Factors explaining variation in perceptions of patient’s belief in lethality

Once the field perceptions of the patient’s belief in the lethality of the attempt (item 1 “I think the patient believed their actions would result in death”) were collapsed into disagrees and agrees this was explored in order to find demographic variables that may explain any variation.

Acute

No vignettes approached significance when comparing acute experience and the perceptions of a patient’s belief in lethality.

Role

No vignettes approached significance when comparing the clinician’s role and the perceptions of a patient’s belief in lethality.

Demographic of population

While there was some variation when looking at the effect of the demographic in which the clinician worked against their perception of the patient’s belief in lethality, no vignette came close to significance.
**Field**

The field in which the clinician practices was explored. Only vignette eight approached significance with 88/98 (89.8%) of clinicians practicing in the field of adult mental health disagreed that the patient believed the attempt would be lethal while 22/29 (75.9%) of those practicing in other fields disagreed (p = 0.06).

**Gender**

The gender of the clinician proved to provide some differences in opinion the greatest being in vignette two where 28/51 (54.9%) of male respondents disagreed that the patient believed their actions to be lethal whereas 82/114 (71.9%) of females disagreed (p = 0.04), another significant finding was in vignette eight where females again disagreed with 79/87 (90.8%) of them disagreeing that the patient believed their actions would be lethal compared to 31/40 (77.5%) of males (p = 0.05).

**Qualifications**

In vignette seven those with higher qualifications were more likely to be sceptical about the patient’s belief in the lethality of the attempt with 13/25 (52%) disagreeing compared to 30/98 (30.6%) of those with graduate diploma or certificate (p = 0.05).

**Factors explaining variation in risk aversiveness**

A new variable was created and called risk aversive; this variable is the number of times a clinician either admitted or in the case of vignette three referred for community team follow up. This is designed to test for how comfortable the clinician was with risk, for example in vignette three the patient was well linked with a private practitioner, and referral to a community team could be seen as a conservative option. In order to test this
numeric variable against demographic data, a univariate analysis of variance was run in SPSS with "risk aversive" as the dependent variable.

_Acute_

Showed a p value of 0.33 with those with acute experience admitting on average 4.91 (SD 1.84) times and those without 5.25 (SD 1.59).

_Role_

This was the only variable that showed statistical significance with a p value of 0.02. This indicated that those currently working in a clinical role were more likely to take the more conservative option (mean 4.40 SD 1.77) compared to those currently working in a non-clinical role (mean 5.22 SD 1.73).

_Demographic of population_

This variable returned a p value of 0.31, urban practitioners tended to the more conservative option (mean 5.1 SD 1.82) compared to their rural counterparts (mean 4.69 SD 1.81).

_Field_

A p value of 0.833 seems to indicate that the field of practice does not influence risk aversiveness (adult mean 4.99 SD 1.78, other mean 5.07 SD 1.78).

_Gender_

While males inclined towards the more conservative option (mean 5.21 SD 1.88) over females (mean 4.92 SD 1.72) this was not statistically significant (p = 0.40).
CHAPTER 5

Discussion

Introduction

The purpose of this chapter is to examine the research findings. The discussion includes a critique of the conceptual model that underpins the research design and examines the strengths and limitations of the methods used. An extensive search of current literature did not identify research that examines inconsistency in disposition for clients presenting with suicide risk. For this reason, the recommendations include directions for further research, specifically designed to improve the understanding of mental health nurses’ decision-making processes.

The strengths and limitations of using vignettes in this study were explored in the study design section of the thesis. Vignettes appear to have fulfilled the task of replicating situations that would be encountered in practice. Comments from respondents indicated that the vignettes used were construed by the participants to be realistic representations of presenting cases. Feedback from one respondent after the study had been completed was that she found the exercise to be useful in and of itself as a reflective practice tool.

The electronic survey distribution yielded limited success with 10% return rate (202 of 2000 mail outs). Anecdotal reports to the student researcher related issues of browser compatibility and a problem with the unique key. The other problem was one of time, in order to read and give considered responses to all the vignettes required approximately an hour.
The paper questionnaire that was utilised at the conference overcame these problems and generated a more satisfactory response rate being a sample of convenience. However this came at the cost of the richness of explanation that came with the electronic responses.

The demographic data of the sample proved to be similar to the national mental health nursing workforce. The demographic data of the sample showed 66/210 (31.4%) respondents were male compared to a national average of 31.3%. The average age of the participants was 46 years with a SD of 9.39 years whereas the average age of the national mental health nursing workforce was 46.4 years (National Health Workforce Advisory Committee, 2008). Participants averaged 38 hours per working week again comparable to the 36.9 hours per week averaged by the national workforce. While this study could not by design be able to be generalised to the whole population of mental health nurses, having the sample representative in terms of age and gender means that at least the sample mirrors the population under examination.

**Variation in dispositional decisions**

The first aim of the study was to investigate variation in disposition, following deliberate self-harm risk assessment among Australian mental health nurses, using a set of seven vignettes. The results showed a high level of variation in dispositional outcomes among participants for all seven scenarios. This result occurred despite agreement on the deliberate self-harm of the subject. This finding was best demonstrated in vignette four (an impulsive, supported female) where 94% (140/149) of respondents believed the subject to be deliberate self-harm but only 58.2% (85/149) of respondents opted for admission as a disposition. This result would seem to suggest that there is a decision
making tree wherein participants assess deliberate self-harm intent at roughly the same level but then diverge in decision around the assessment of risk and the management of that risk. Repper (1999) discussed the mutability of deliberate self-harm intent and the fact that this varies according to environmental influences. The agreement found within the participants’ assessment of deliberate self-harm intent may reflect the assessment of the same cross sectional view within the vignette. Even so, this consistency bears out Reppers’ (1999) contention that global assessment is as reliable a gauge of deliberate self-harm intent as formal scales. She had observed that formal scales are seldom used to gauge deliberate self-harm intent but that their use would not improve accuracy in assessment. The variation in dispositional outcome observed in this study appears in the assessment of the risk and safety factors that were present rather than the deliberate self-harm intent. This finding is contrary to the findings of Wagner, Wong and Jobes (2002) where vignettes were distributed to experts and clinicians to establish whether deliberate self-harm presentations were construed as suicide attempts. Agreement was found only on the extremes, very low agreement was otherwise established.

**Influence of demographic factors on dispositional decisions**

The second aim of the study was to explore participants’ demographic factors and how these may or may not affect dispositional decision making for deliberate self-harm risk assessment. None of the factors explored were found to significantly influence the decision outcome of disposition. There was a significant difference in disposition in one vignette that is having acute community experience was associated with a decision to admit the subject of vignette seven, but this did not occur in any other vignette. Similarly in vignette one, practicing in a rural/remote setting would appear to predispose the
respondent to treat in the community. Yet, in this vignette those practicing in rural/remote settings were much more likely to believe the subject was deliberate self-harm. This result may be due to their practice having been shaped by the geographic areas that they cover and the scarcity of inpatient resources in those areas, thereby circumscribing the range of interventions available. There could also be a sense that removing people from their rural communities is traumatic and should therefore be avoided where possible.

**Clinicians reason for dispositional decisions**

The third aim was to understand the clinicians’ reasonings that lead to their dispositional decisions. As the thematic charts showed, respondents each place different weightings to risk and safety factors. In vignette six, one respondent wanted to admit to hospital because of “Too many risk factors. Gender, age, means, alcohol misuse, presence of hopelessness and worthlessness. (R31)” risk was weighted more heavily than safety. In the same vignette another respondent considered safety factors “The intent and therefore the risk is very high but the attachment to family is also very strong - If several members of the family are mobilised, they could effectively maintain constant presence and help him minimise alcohol, process the foundations of his crisis and his almost-suicide. (R100)” Risk is acknowledged, but protective factors have been taken into account in deciding disposition. At times it appeared that respondents took admission as the default and were more at pains to explain their reasoning behind not admitting. In vignette three where no-one wanted to admit, still the decision was justified as “Little is ever achieved by admission other than to cause anguish to the person and their partner/carer/parent. (R43)”.
Principal Findings

Clinicians’ perceptions of the patients’ deliberate self-harm showed good agreement. For example, the first of the test vignettes (a homeless intoxicated young male) achieved almost complete agreement that the patient was not deliberate self-harm: only one respondent out of 159 disagreed. To assess the precision of the estimates of agreement, 95% confidence intervals were calculated for the proportion of participants that rated the patient as deliberate self-harm for each vignette. In only three vignettes did the 95% confidence intervals contain 0.5, which corresponds to only chance agreement. This means that for six of the nine vignettes, there was better than chance agreement among participants as to the deliberate self-harm of the patient. This result is surprising, because the assessment of deliberate self-harm ideation is noted by Rosenman (1998) to be difficult. He describes the mutability of deliberate self-harm ideation and the multiple variables at play. In the current study, consistency about the level of deliberate self-harm for each client portrayed in the vignettes, was seen among a diverse population of clinicians with varied experience, working in different services and performing different clinical roles. A finding such as this may indicate there is a sound agreed understanding of deliberate self-harm intent.

There was little agreement on the dispositional outcome, that is, whether to admit to hospital or treat in the community. In the first of the test vignettes, vignette two, 95.8% (159/166) of respondents opted for hospitalisation, a very high level of agreement. This was despite 77.8% (137/176) of the respondents not believing that he was deliberate self-harm. This result supports the use of variables included within the model. In this vignette the subject was a homeless, stimulant-using male with poor social connectedness
and intellectual functioning. These later factors were posited as the most important
within this model of dispositional decision making. The second of the test vignettes was
a self-harming female who lacerated her wrists but denied deliberate self-harm ideation
and is well supported by her family. Here a concordance rate of 99.4% (158/159) was
achieved for non-hospitalisation. Of the remaining two dispositional options, referral to
private practitioner or referral to the community outreach team, 56.3% (89/158) opted to
refer to the community treatment team. This was despite only one respondent believing
the person to be suicidal and the protective aspects of good relationships with her
counsellor and mother. This may be an instance of a conservative decision considering
corporate needs as articulated by Callaly et al (2005) but anecdotal evidence would
suggest that in practice it would be difficult to articulate a role for a community team in
this scenario, and the busy workloads of these teams would make it unlikely that this
referral would be accepted. Undrill (2007) echoes these points when he argues that often
a decision to admit is made to manage the clinician’s anxiety rather than the patient’s
risk. He calls this approach secondary risk management, which in essence is the
clinician’s own fear of litigation if the person subsequently dies. He makes the point that
managing secondary risk may have an adverse effect on the therapeutic relationship
because of the coercive treatment that is implied.

The response rate for vignette seven (a woman with a borderline personality
structure, intoxicated and in crisis) was the most divergent with the majority (79/126 or
63.7%) of respondents admitting this patient. The reasons given for the decision were
quite emphatic in both cases (admit or community treat) with themes of escalating
lethality of attempt and the magnitude of the crisis justifying admission, while others
reluctantly offering community team support or stating “Possibly a waste of effort, but necessary to cover all parties Gayle's quality of life, or duration” (R4). This quote encapsulates the ambivalence that this vignette generated. It is often people who have attracted the diagnosis of borderline personality disorder that produce this type of polarisation within psychiatry because of the perceived intractability of the condition and the impotence felt by staff. This may also be at work in the split decisions made for vignette three and discussed previously, given the shared diagnostic category, albeit with more support and containment.

In vignette six there was a clear preference for admission, this middle aged man was unemployed and intoxicated with a possibly lethal attempt. Balancing this he is denying on-going deliberate self-harm ideation and is well supported by his family. This vignette attracted the second highest level of agreement on deliberate self-harm intent with a concordance rate of 97.7% of respondents believing that he meant to kill himself. Comments on disposition tended to weigh up his denials of ongoing deliberate self-harm against the supportiveness of his family and the safety thus provided. At the extremes, some believed the attempt to be wholly impulsive and alcohol fuelled with the crisis now passed and referral to his GP adequate, (“Transient deliberate self-harm ideation in context of intoxication. Supportive family and GP. No previous attempts or psych history. Insight into need to decrease drinking. Accepting of help (R114)”). Others did not believe his denials and believed the risk issues were too high to treat him in the community (“Too many risk factors. Gender, age, means, alcohol misuse, presence of hopelessness and worthlessness. (R31)”).
Variability in disposition has not been previously documented in published literature. The exploration of respondent’s demographic details against their dispositional decision showed that no consistent pattern emerged to explain the observed variation(s). Statistically significant findings emerged within the demographic data, but these were not consistent for all vignettes. The amount of acute experience showed that the more experience respondents had, the less likely they would be to admit in vignette nine, but only in that vignette. Where the respondents work also showed a significant difference in vignette nine, with rural/remote practitioners wanting to treat in the community as opposed to urban practitioners. This may reflect the availability of resources to the practitioners, although this trend was only noted in vignettes one, six and nine and not in the other vignettes. Lastly, whilst not statistically significant, gender variance showed males to be marginally more risk averse than females, echoing the findings of Mihai et al (2009).

When comparing whether the person intended to end their life and dispositional decision there is no consistency. Deliberate self-harm intent does not appear to be a clear indicator for admission according to this study. In vignette six, 97.7% of respondents agreed that the person intended to kill themselves but only 60.2% thought that hospitalisation was appropriate, in vignette eight only 21.3% believed the person to be deliberate self-harm but 57.1% hospitalised. Even with clear agreement on disposition as in vignette two where 95.8% of respondents opted for admission only 22.2% believed the person intended to kill themselves.

The Engleman et al model (p. 22) posits that the decision to admit to hospital depends initially on an overall risk rating. This comprises factors such as clinician
experience and risk among other things. This study does not support this finding with clinician factors providing no clear indicator as to dispositional decision making. Danger to self is only one of many variables influencing the decision. This may, however, be indicative of the small sample size. Rabinowitz et al (1995) found that with more experience clinicians were less likely to admit, a phenomenon not found in this study. A recent meta-analysis by Large et al has questioned the validity of risk assessment. They found that “no factor or combination of factors was strongly associated with suicide in the year after discharge” (Large et al., 2011). They conclude that 60% of those who commit suicide are actually categorised as low risk. This finding has sparked debate about the place of risk assessment given its poor predictive power. Mulder, in his editorial, states that risk assessments are used to minimise clinician anxiety and may lead to unintended negative consequences (Mulder, 2011). He states “Risk assessments of suicide are vulnerable professional decisions in the face of uncertainty” (p. 606). Each clinician will have a different tolerance for that anxiety and this may also go some way to explaining the variability found in this study.

**Conceptual model**

The hypothesis underlying this study is that clinicians bring to each assessment their own biases, constructs and mind sets, that colour their view of the patient and the risks associated with that patient. Keeping that in mind, literature was read in order to gain similar patient themes that were important in risk assessment. A model was developed weighing each of five factors gleaned as important from the literature. These factors were diagnosis, situational crisis, previous suicide attempts, intellectual
functioning and social connectedness. This model was then used to design vignettes for this study that balanced risk and safety factors.

When developing this model, the content validity was tested according to the method proposed by Lynn (1986), with experts being used to test that the vignettes truly represented the field of presentations with deliberate self-harm ideation. The very concept of content validity has been the subject of dialogue recently (Beckstead, 2009). Arguments are posited that this is a valueless step, best tested with statistics after application. The countering argument to this is that content is best tested prior to the application of the instrument rather than waste money trialling a flawed instrument that does not truly test the area under investigation (Squires, 2009).

This study expected to find agreement between respondents on two vignettes if the model was a true representation of the way risk is viewed by clinicians. In vignette two, a young male, socially disconnected, drug affected, experiencing psychosis and command hallucinations, would fit within the conceptual model as postulated if their dispositional status was that they were admitted to hospital. The majority 77.8% (137/176) of respondents did not believe that he was deliberate self-harm but 95.8% (159/166) believed he should be admitted to hospital. In vignette three, a young woman presented with self inflicted lacerations to her arms in the absence of deliberate self-harm ideation with normal intellectual functioning, good social connectedness and personal and professional supports. Only one of 159 respondents (0.06%) believed her to be deliberate self-harm and not one respondent elected to admit her to hospital. The remaining vignettes were designed to balance these factors according to the model developed and the results show that, even when some agreement is shown the range of
the confidence intervals includes 0.5. This would accord with the findings of Rabinowitz et al (1995) that concordance may be found at the extremes but rarely otherwise.

This finding appears to provide preliminary data to support the model developed that weighted intellectual functioning and social connectedness over diagnosis, situational crisis and previous suicide attempts as a guide to dispositional decisions.

**Limitations and strengths of the study**

The purpose of this study was to describe and test for consistency in dispositional decision making within particular community teams, for whom deliberate self-harm presentations form the greater part of their day-to-day practice and where levels of expertise would be expected to have been high. The aim was to test the proposition that there was consistency in dispositional decision making. The questionnaire was distributed nationally to the Australian College of Mental Health Nurses. This population includes Mental Health Nurses working in diverse practice settings and with varying levels of expertise in acute or crisis settings. This diversity meant that there was no universal understanding about risk assessment or management as would be expected to be found in clinicians who work together in a team environment within a shared organisational culture. The application of this study to such a group might have produced very different findings with higher levels of conformity across all levels within teams due to the osmosis of ideas. This may be the result of the development of individual practice through mentoring, coaching or perceived value in colleagues’ work practice, as well as the sequelae to common organisational policy and practice frameworks.
The use of electronic distribution methods may have introduced an unintended selection bias because of the time it took to complete the questionnaire. A sampling bias effect may have been as only those committed enough to complete the full questionnaire would allocate an hour as needed. This is evidenced by the drop in numbers over the vignettes one to nine.

The model and vignettes appear to have been successful in replicating a range of presentations to test for dispositional decisions and to serve as a reflective practice tool. The two control vignettes generated the expected disposition while the other seven were contentious and generated vigorous debate with strident support given for decisions either way.

While not the primary focus of this paper the level of agreement on deliberate self-harm intent was unexpected and perhaps reflects on the accurate representation of the vignettes.

**Implications of the findings**

The findings of this study suggest that patient disposition outcomes may be influenced by factors brought by clinicians to the interaction with the patient. These variables appear to be poorly understood by the participants, with similar justifications given for different interventions. This might suggest that there is an important role for reflective practice and clinical supervision. Reflective practice has been shown to be of benefit in the examination and conceptualisation of complex clinical issues (Cooke & Matarasso 2005). Researchers state that reflective practice provides “opportunities to
explore experiences within a context and interpretive paradigm that facilitates new understandings” (Cooke & Matarasso 2005 p. 244).

Proctor (1986) quoted in Brunero & Stein-Parbury, (2008) identified clinical supervision as being composed of three aspects, these being the formative, normative and restorative phases. These aspects of supervision may enable clinicians to explore underlying beliefs, including their own and, in a group context, the beliefs of others. This could help clinicians develop an understanding of dispositional principles (the formative function) and through peer review or group supervision, possibly develop a shared belief of these principles (the normative function) or at least understand how others beliefs about disposition. A further benefit of clinical supervision is the restorative function wherein the stress of this difficult function of risk assessment and management may be shared and supported throughout the group.

**Suggestions for further research**

The model and the vignettes have revealed *consistency* in perceptions of deliberate self-harm and *inconsistency* in disposition. Application of the model and vignettes to a team could be used as a tool to foster awareness and insight into of the decision making process behind dispositional decision making. This may help teams to strive towards a more informed response in these situations to the advantage of the patient. If this study was then carried out in conjunction with a trial of clinical supervision it would enable a pre and post study of the effects on the dispositional decisions within the team. This will enhance the understanding of the multifactorial process of these decisions.
This study is the first identified in the published literature to explore variation in mental health nurse’s dispositional decision-making (treatment in the community as opposed to an in-patient setting) as its primary focus. It found that, with the exception of the extremes, no consistency existed in dispositional decision making for deliberate self-harm presentations. It also highlighted that clinician factors influence outcomes.

Wyder (2004) showed that the majority deliberate self-harm presentations are impulsive and alcohol fuelled. Large et al (2011) have demonstrated that risk assessment cannot be relied upon to predict risk with any consistency, and Mulder (2011) has highlighted the issue that good clinical practice should be informed by risk assessment, rather than driven by it. This study has shown some conformity in the assessment of deliberate self-harm intent but wide individual differences in the weighing of risk and safety factors. These differences point to the subjective nature of dispositional decisions and highlight the need for robust clinical reviews. Within this study no patterns emerged to explain this difference, importantly length of service, higher qualifications, area of practice did not affect the dispositional decision. Because of this it is not possible to recommend mentorship or targeted training for any group of clinicians. Hence, the recommendation for more transparent clinical reviews, reflective practice and both individual and peer supervision.

Decisional differences underscore the need for supervision and reflective practice, a process that has been described as “positively transforming in that outcomes are advanced self-awareness, meaningful professional practice, improved client care, and therapeutic relationships” (Cooke & Matarasso 2005 p. 247). The constant review of
practice by both the clinician and the team ensures that complacency has no place in practice.
REFERENCES


The Victoria Mental Health Act, (1986).


APPENDIX A

Paper questionnaire
Project: Suicide risk assessment: A survey of Australian mental health nurses' decision making

Funding: The University of Melbourne

Researchers: Dr. Marie Gerdtz (Supervisor), Grant Phillips (Masters Candidate)

Introduction:

This study aims to survey Australian mental health nurses in order to describe how they initially assess and decide to manage people who are at risk for suicide who present to the emergency department. The primary decision outcome of interest in this study is the transfer of the consumer to definitive care and the rationales for this.

The study has been approved by the Human Research Ethics Committee at the University of Melbourne as part of a Masters by Research project. (Ethics I.D. 0829522.2)

What will I be asked to do?

This survey asks some demographic questions and contains a series of 9 scenarios of people presenting to the Emergency Department with deliberate self-harm ideation. You will be asked to answer questions on your views of the presentation and what you believe would be an appropriate outcome for the person. You will also be asked some demographic information about yourself although this will in no way identify you.

There are no “correct” answers for these scenarios. We are interested in measuring the extent to which a group of nurses agree on the motivations behind the presentations and the outcomes for each. The survey should take approximately 20 minutes to complete and will be returned in the reply paid envelope provided.

How will my confidentiality be protected?
All of the data we collect from you will be treated in a confidential manner. Raw data will be kept at the University of Melbourne for five years from the time the study is completed. The data will be entered onto a data base for analysis and will be stored on a password protected file. The only people who will have access to the data will be the researchers. All of the data that is collected for the study will be analysed and reported in summary form.

How will I receive feedback?

We intend to report back to the Australian College of Mental Health Nursing with a one page summary of findings. We will also publish the outcomes in a professional journal.

Where can I get further information?

If you have any questions about the project please contact Marie Gerdtz on 03 83440780 or email gerdtzmf@unimelb.edu.au. or Grant Phillips g.phillips4@pgrad.unimelb.edu.au. Should you have any concerns about the conduct of the project, you are welcome to contact the Executive Officer, Human Research Ethics, The University of Melbourne, on ph: 03 8344 2073, or fax: 9347 6739.

How do I agree to participate?

If you would like to participate please complete the survey and return it in the reply paid envelope provided. If you have already participated in the electronic mail out it is not necessary to complete this survey.

Thank you for your participation
Demographic questionnaire

1. Are you
   - Male
   - Female

2. What is your age? ______________________

3. What are your qualifications
   _______________________________________________________________________

4. In what Australian state or Territory do you practise?

   - SA
   - WA
   - VIC
   - QLD
   - NT
   - TAS
   - ACT
   - NSW

5. Which would best describe the population in which you practice?

   - Urban
   - Rural

6. How long have you been working in Mental Health? ____________(years)

7. Describe as your main field of practise? (eg. Management, clinical etc)
   _______________________________________________________________________
   _______________________________________________________________________
   _______________________________________________________________________

8. How many hours per week do you work? _______________
9. In what field do you practice?

- Child & Adolescent
- Adult Psychiatry
- Psychogeriatrics
- Other

If other please elaborate _________________________________________________

10. The organisation that employs you is owned?

- Publicly
- Privately

11. Have you ever worked in an acute community team?

- Yes
- No

12. If so, how long ago? ___________(years)

13. For what duration? ___________(years)

14. Briefly outline the resources available in your local area i.e. inpatient beds, community teams.
Vignette 1

Trevor is brought in from the scene of a single vehicle accident where his late model Volvo hit a tree at high speed. Fortunately for him air bags deployed and probably saved his life. His blood alcohol is 0.12 and he is sullen and non-communicative. His wife arrives in a distraught state showing obvious concern for him, she confides that he has been talking about how worthless his life is recently and has discussed a suicide pact with her which she laughed off. Trevor is a 68 year old man who lives at home with his wife, he has 2 adult children, he retired 3 years earlier as a senior partner in a law firm and his wife reports that he has not adjusted to retirement. Whilst they have travelled and renovated the house he has not developed any interests outside the home and his alcohol consumption has been steadily increasing he says to manage his insomnia. For the past six months he has been becoming increasingly reclusive, not keeping in touch with friends and not interested in going out, his wife says that he has been losing weight recently. When he finally agrees to engage he states that the accident was just that and denies it was a suicide attempt although he admits to have been fantasizing about death. He states that he has seen his GP and has been on Zoloft for about 2 months and reports feeling better than he did.

For the above vignette please answer the following questions.

1. Did this person intend to kill themselves?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</table>

   I am confident in my decision.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

2. I think the actions were potentially lethal.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Strongly Disagree</td>
<td>Disagree</td>
<td>Agree</td>
<td>Strongly Agree</td>
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</tbody>
</table>

3. I think the patient believed their actions would result in death.

<table>
<thead>
<tr>
<th>I strongly disagree</th>
<th>I disagree</th>
<th>I agree</th>
<th>I strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

4. What do you believe would be the most appropriate acute intervention for this person?

<table>
<thead>
<tr>
<th>Immediate Admission</th>
<th>Community team follow up</th>
<th>GP or private practitioner</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I am confident in my decision.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
</tr>
<tr>
<td>□</td>
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</tbody>
</table>

5. How much at risk do you believe the person to be within the next 48 hours?

<table>
<thead>
<tr>
<th>High</th>
<th>Medium</th>
<th>Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

Do you have any other comments to make about this case?
Vignette 2

Paul is a 28 years old gent who has a diagnosis of paranoid schizophrenia. He hasn’t been taking his medication, which is Olanzapine 10mg mane and 20mg nocte for the last two weeks, as he has been on an amphetamine binge. He is brought into the emergency department by the police who were called to his rooming by his neighbours because of the banging in his room all night. The police report that he had been dismantling his room looking for cameras. He has a history of three suicide attempts, one by hanging and two by overdose in similar circumstances the last 5 years ago. In interview he is guarded, glancing around the room suspiciously, his pupils are dilated and he is grinding his jaw incessantly. Throughout the difficult engagement he displays marked psychomotor agitation. Eventually he confides that his neighbours have been after him for some time and he knows they are going to kill him. He confesses that they are speaking to him through the radio telling him to take all of the medication he has in his room and that he feels increasingly unable to fight them.

For the above vignette please answer the following questions.

1. Did this person intend to kill themselves?

[ ] YES  [ ] NO

I am confident in my decision.

[ ] Strongly Disagree  [ ] Disagree  [ ] Agree  [ ] Strongly Agree

2. I think the actions were potentially lethal.

[ ] Strongly Disagree  [ ] Disagree  [ ] Agree  [ ] Strongly Agree
3. I think the patient believed their actions would result in death.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
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4. What do you believe would be the most appropriate acute intervention for this person?

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5. How much at risk do you believe the person to be within the next 48 hours?

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Do you have any other comments to make about this case?
Vignette 3

Mary presents to the emergency department with self inflicted lacerations to her forearms, she is 22 and is accompanied by her mother with whom she lives. She has been having a difficult time at work recently and today had an altercation with a co-worker, when she arrived home she felt so angry she went to the bathroom and cut herself. Mary has been cutting herself since the age of 12 at times of stress, she has also attempted suicide by overdose twice. Her mother has raised her as a single mother and never knew her father. She denies any deliberate self-harm ideation or intent and states that she does this to “feel normal”. Her supportive mother states that she is in counselling and that the incidence of this self soothing (a term suggested by her counsellor) behaviour has decreased since she engaged with the counsellor.

For the above vignette please answer the following questions.

1. Did this person intend to kill themselves?

[ ] YES  [ ] NO

2. I think the actions were potentially lethal.

[ ] Strongly Disagree  [ ] Disagree  [ ] Agree  [ ] Strongly Agree

I am confident in my decision.

[ ] Strongly Disagree  [ ] Disagree  [ ] Agree  [ ] Strongly Agree

2. I think the actions were potentially lethal.

[ ] Strongly Disagree  [ ] Disagree  [ ] Agree  [ ] Strongly Agree
3. I think the patient believed their actions would result in death.

<table>
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<tr>
<th>Disagree</th>
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Do you have any other comments to make about this case?
Vignette 4

Jenny is a 20 yrs old female presenting with Metropolitan Ambulance Service (MAS), called by her flatmate who arrived home from work to find her unconscious in the lounge with 2 empty packets of paracetamol beside her. She was found to be toxic and required overnight paracetamol antidote treatment. She is the youngest in a sibship of 3 with supportive parents, who are sitting by her bedside. She also has a history of an eating disorder but no previous self-harm. In interview she says that she took the overdose because of stress at work, financial issues and the recent break down of a 2-year relationship. She is tearful and says that she has not been sleeping. She states that she took the overdose impulsively after a call from her ex-boyfriend in which he emphatically refused to resume the relationship. She took the overdose because she wanted to die and stated that she knew that it was lethal. Although denying any on-going deliberate self-harm plan she states that she has been thinking that it would be good to not wake up. Her parents want to take her home so they can care for her.

For the above vignette please answer the following questions.

1. Did this person intend to kill themselves?

| YES | NO |

| Strongly Disagree | Disagree | Agree | Strongly Agree |

| I am confident in my decision. | ☐ | ☐ | ☐ | ☐ |

| Strongly Disagree | Disagree | Agree | Strongly Agree |

| 2. I think the actions were potentially lethal. | ☐ | ☐ | ☐ | ☐ |
3. I think the patient believed their actions would result in death.

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4. What do you believe would be the most appropriate acute intervention for this person?

- Immediate Admission
- Community team follow up
- Within 24 hours
- GP or private practitioner
- Within 7 days

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Do you have any other comments to make about this case?
Vignette 5

Aaron’s elderly mother bought him into ED; he is 35 yrs of age and lives with her. He has Down syndrome and had been attending an adult training and support workshop up until the death of his father eight months ago. Since that time his mother reports that he has become increasingly reclusive, refusing to leave the house, at times she cannot get him out of bed. His GP has diagnosed depression and prescribed Efexor but Aaron has refused to take it. Recently his mother has noticed Aaron is talking to himself when no one is around and today found him hitting his head against the brick wall causing extensive lacerations and bruising. Aaron told her that he was doing this because his father was telling him to kill himself. He has never done anything like this before. His mother is tearful, and is asking for help, but she is adamant that she does not want him to be admitted as he has never been away from her. Aaron is sullen and doesn’t want to talk but reluctantly tells you that he can hear his father in his head telling him that he is bad and that is why he went away. His father is telling him that he needs to kill himself.

For the above vignette please answer the following questions.

1. Did this person intend to kill themselves?

▢ ▢

YES NO

Strongly Disagree Disagree Agree Strongly Agree

I am confident in my decision.

▢ ▢ ▢ ▢

2. I think the actions were potentially lethal.

▢ ▢ ▢ ▢
### 3. I think the patient believed their actions would result in death.

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### 4. What do you believe would be the most appropriate acute intervention for this person?

- Immediate Admission
- Community team follow up
- Within 24 hours
- GP or private practitioner
- Within 7 days

### I am confident in my decision.

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Do you have any other comments to make about this case?
Vignette 6

Geoffrey is a married man of 47 with 3 children aged 24, 21 & 18. He lives with his wife and the 2 youngest children. He worked as a middle manager for a firm for many years but was retrenched 18 months ago. Since that time he has been trying unsuccessfully to find employment and is currently being supported by his wife who works for a cleaning firm. He has found this difficult and has taken to drinking daily. He has no formal psychiatric history but is being treated for depression by his GP with whom he has a good relationship, and has been on Zoloft 100mg daily for the last 3 weeks, and Temazepam 10-20mg nocte. Tonight the family was invited to a friend’s house for dinner but Geoffrey had started drinking early and was in no condition to accompany them. The family left him at home and went to dinner. When they arrived home later in the evening Geoffrey was found in his car at the back of the house, with a hose running into the back window and the motor running. He was unconscious and required resuscitation by Metropolitan Ambulance Service and in the Emergency Department. He had written a suicide note stating his regret for his behaviour recently and for taking his life and talking of his love for his family. When you interview him the next morning he admits to feeling down recently and agrees that he hasn’t been sleeping well, drinking much more than is usual for him and not taking much pleasure in life. He states he is embarrassed about the previous night’s events and denies any deliberate self-harm ideation either prior to the events of the night before or any on-going thoughts of suicide, scoffing at the idea that he would take his own life and attributes the attempt to being intoxicated. He agrees that he needs to cut down on his alcohol intake as it is having an adverse effect on his life and his relationships within his family. His wife is very supportive of him, as are his children.

For the above vignette please answer the following questions.

1. Did this person intend to kill themselves?

   □ □
   YES NO

   I am confident in my decision. □ □ □ □
2. I think the actions were potentially lethal.

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3. I think the patient believed their actions would result in death.

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I am confident in my decision.

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Vignette 7

Gayle is a 39 yr old married mother of 4 children aged between 11 and 5. She reports having a history of childhood sexual abuse, but managed to finish secondary school and worked as a personal assistant until the birth of her first child. During this time she self harmed at times of stress and had an overdose when a relationship ended. After the birth of her last child she was diagnosed with post partum depression and had a private psychiatric admission, since that time her life has been a roller coaster with escalating alcohol and drug abuse, episodes of self-harm, many private admissions under different private psychiatrists and some public involuntary admissions, usually after being recommended under the Mental Health Act in the private hospital for disruptive behaviour. She has attempted suicide in the past by overdosing and cutting her wrists, which she distinguishes from the times that she deliberately self-harms in order to self soothe. She has been tried on many medications both antidepressant and antipsychotic as well anxiolytic and anticraving medication, without benefit. Things have come to a head recently with a notification being made to DHS about her ability to care for the children and her husband has given her an ultimatum to clean up her act or he will take the children and leave her. This has led to even more out of control behaviour and threats to end her life. MAS were called by her eldest child, who arrived home from school unexpectedly to find her mother in the garage with a noose around her neck, standing on a chair. On arrival at ED her BAL was 0.24. Once sober she downplays the attempt saying that she knew that her daughter would find her. She denies this was a suicide attempt or that she is currently deliberate self-harm.

For the above vignette please answer the following questions.

1. Did this person intend to kill themselves?

[ ] [ ]

YES NO

Strongly Disagree Disagree Agree Strongly Agree

I am confident in my decision. [ ] [ ] [ ] [ ]
### DISPOSITIONAL DECISION MAKING

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2. I think the actions were potentially lethal.  

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3. I think the patient believed their actions would result in death.  

4. What do you believe would be the most appropriate acute intervention for this person?  

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5. How much at risk do you believe the person to be within the next 48 hours?  

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Vignette 8

Dillon is 32 and states that he is homeless, he is unemployed and is an intravenous drug user, and his substances of choice are stimulants. He has a history of itinerancy and has had no contact with his family of origin for many years. He has had sporadic contact with mental health services over the years attracting diagnoses as diverse as schizoaffective disorder, depression, explosive personality disorder and antisocial personality disorder. He has had a few short admissions and was case managed for a period of three months some years ago. He has had no contact for the last two years. He states that he has attempted suicide in the past “a couple of times” by cutting his wrists and by heroin overdose. He presents as thin and extensively tattooed with a shaved head and red-rimmed eyes. Whilst his pupils are normal he is grinding his teeth and is unable to settle. Upon questioning he admits that he hasn’t slept for four nights and is coming off an “ice” binge. His girlfriend called the police to remove him from her house yet again because of his violence. He had stabbed himself in the thigh with a pocket knife when she called the police. He states that he feels agitated and depressed and that he wants to throw himself off a bridge as he has no friends, no future, and no girlfriend.

For the above vignette please answer the following questions.

1. Did this person intend to kill themselves?

   - [ ] YES
   - [ ] NO

2. I think the actions were potentially lethal.

   - [ ] Strongly Disagree
   - [ ] Disagree
   - [ ] Agree
   - [ ] Strongly Agree

I am confident in my decision.

   - [ ] Strongly Disagree
   - [ ] Disagree
   - [ ] Agree
   - [ ] Strongly Agree

2. I think the actions were potentially lethal.

   - [ ] Strongly Disagree
   - [ ] Disagree
   - [ ] Agree
   - [ ] Strongly Agree
### DISPOSITIONAL DECISION MAKING

#### 3. I think the patient believed their actions would result in death.

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#### 4. What do you believe would be the most appropriate acute intervention for this person?

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  - Within 24 hours
- GP or private practitioner
  - Within 7 days

#### I am confident in my decision.

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**Do you have any other comments to make about this case?**
Vignette 9

Alan has been brought in by his new case manager who has just met him taking over from his long term case manager who has retired. She is concerned because Alan had been stockpiling his medication (Quetiapine 600mg bd) he says in order to overdose on it. He is 36 years of age on a disability support pension and has lived in a supported residential service (SRS) for the last 8 years, he has been diagnosed with schizophrenia since the age of 19 and has persistent delusions that the CIA are tracking him and conspiring to make his life “a living hell”. He attempted suicide by overdose 8 years ago after moving from his parent’s home to the SRS. He has a history of non-compliance with his medications as he does not believe he needs them as he is not unwell. Alan denies that he was going to take the medication but the manager of the SRS has said that he has been talking recently about being sick of his life and the fact that he will never marry or have children, and she has noticed that he has become wary of strangers and she has found him keeping guard at the door of late.

For the above vignette please answer the following questions.

1. Did this person intend to kill themselves?

☐ YES ☐ NO

2. I think the actions were potentially lethal.

☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree

I am confident in my decision.

☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree

2. I think the actions were potentially lethal.

☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree
3. I think the patient believed their actions would result in death.

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Do you have any other comments to make about this case?
## APPENDIX B

### Thematic Charts

#### Thematic chart for Vignette 1 (Depressed retired male)

<table>
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<tr>
<th>Domain</th>
<th>Theme</th>
<th>Admit</th>
<th>Community treatment</th>
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<tr>
<td>Physical health</td>
<td>Alcohol (sober up, withdrawal) exclude organic causes</td>
<td>30</td>
<td>I would admit him while undergoing full medical tests to rule out medical causes. Also admission will help to see how insightful he is when sober and to measure risk (R54)</td>
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<tr>
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<td>To a general hospital as has been involved in a major accident and remains intoxicated. Would review next morning and prepare for alcohol withdrawal. Assessment of actual mental state is impaired by alcohol and review after time to sober up is required to fully assess risk to self (R2)</td>
</tr>
<tr>
<td>Perceived risk</td>
<td>Deliberate self-harm, high lethality attempt, high risk demographic, Patient poorly engaged, not enough community support to provide safety</td>
<td>60</td>
<td>Because this man needs assessment as high risk for suicide, needs period of time for assessment and safety (R104)</td>
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<td></td>
<td>Pt is at high risk of repeating attempt due to some planning for suicide plus current attempt, losses in his life, difficult to engage (R129)</td>
</tr>
<tr>
<td>Assessment</td>
<td>Assessment,</td>
<td>65</td>
<td>Clearly the treatment with Zoloft needs review and a</td>
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<td>Patient has been involved in serious accident, appears to be</td>
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<td>and treatment</td>
<td>Observation, Treatment review</td>
<td>short admission to ensure his safety and get him detoxed from ETOH and on suitable medication is indicated. I would be anxious to leave him to go 24 hours for follow up. (R42) I would admit this gentleman for comprehensive observation, treatment and management. He has been on Zoloft for 12/12 with some improvement, but over the past 6/12 this does not appear to have been effective. Trevor needs close observations re his suicide risk. (R24)</td>
<td>under the influence of alcohol. He has a safe place to stay with wife-would benefit from another review in next 24 hours Patient has a good rapport with GP-appropriate to encourage referral to psychiatrist via GP. Patient not actively deliberate self-harm but still has symptoms of depression which require further intervention. (R14) Has available willing support from wife &amp; strong family links. Requires assertive follow up and close monitoring because despite denial of suicide attempt, is exhibiting significant depressive symptoms. (R37)</td>
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<tr>
<td>4/ undecided</td>
<td>Hospital vs. least restrictive environment</td>
<td>This person requires close follow up, at least until effects of alcohol have worn off to perform a risk assessment. It is likely he would require ongoing close supervision in view of recent history of severe depressive illness. If this is not possible in the community setting then hospitalisation would have to be considered. (R89)</td>
<td>I think admission should be offered but not enforced, because that is not an EVIDENCE BASED intervention- unless it is clearly established it was an attempt, then this changes the risk summation. (R33)</td>
</tr>
<tr>
<td>5/ Environment and engagement</td>
<td>Admission too traumatic</td>
<td></td>
<td>Trevor would be best followed up in the community as it would be the least restrictive environment. He has no previous history and I think admitting him would reinforce his feelings of worthlessness. His wife is very concerned and supportive. Trevor and his wife would probably benefit from some short term case management looking at things such as medication review, alcohol use and mental state, self-esteem, how Trevor could use his skills to benefit community organisations etc. (R47)</td>
</tr>
</tbody>
</table>
### Thematic chart for Vignette 2 (Male, homeless, intoxicated)

<table>
<thead>
<tr>
<th>Domain</th>
<th>Theme</th>
<th>Admit</th>
<th>Reasons</th>
<th>Community treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>I/treatment</td>
<td>Immediate treatment, no community supports, not competent,</td>
<td>92</td>
<td>Paul is not competent to make decisions for himself and needs to be kept safe until his psychosis is treated (R20)</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Need to get his medications re-introduced and at a therapeutic level (R64)</td>
<td>This decision would depend to some degree on Paul's preference and to a greater degree on his engagement with mental health staff and the subsiding of agitation. If he preferred hospital admission as a safer solution to his current plight, then that would be an entirely reasonable option. But if he were reluctant to be admitted and willing to engage with CATT, then this option is worth exploring. He would require substantial and close attention initially, to engage him effectively in-treatment even while at ED and on return to his community. It is not clear if there are any people in his life that might assist with community support in the immediate time.</td>
</tr>
</tbody>
</table>
The CATT intervention would include re-establishing treatment, investigating the habitability of his room, removing excess medications from his room, mediating interactions with neighbours, investigating precipitants of the recent decision to cease meds...etc. Even before leaving ED he would benefit from basic needs met - fluids, food, sleep (R100)

2 / withdrawal
Needs to come down, needs detox, needs to withdraw 27

dry out from amphetamine use re-commence anti-psychotic meds safe place for him to be (R15)

Detox, stabilization with re introduction of medication (R131)

does require hospital to control agitation? drug induced, or drug withdrawal or paranoid illness. (R69)

3/ Risk
Deliberate self-harm, depressed, impulsive, risk to self and neighbours, command hallucinations, 66

Vulnerable, risk to self and others, psychotic (R13)

The poor bloke is at high risk of being driven to self harm by his symptoms, especially the command hallucinations. (R35)

Considering 3 previous attempts and other history, he is a danger for himself (R106)

Thematic chart for Vignette 3 (Female, self soothing)

<table>
<thead>
<tr>
<th>Domain</th>
<th>Theme</th>
<th>Community Team</th>
<th>Private counsellor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/ nothing to gain or do more</td>
<td>admission unhelpful, would encourage behaviour, issues chronic</td>
<td>10</td>
<td>Crisis follow-up only needed Inpatient admission may make the problem behaviours worse</td>
</tr>
<tr>
<td>Damage</td>
<td>(R13) Little is ever achieved by admission other than to cause anguish to the person and their partner/carer/parent.</td>
<td>(R26) I would suggest diagnosis would suggest the hospital admission is not appropriate course of action - clinically not indicated nor best practice (R62)</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>/2/ Short term Support</td>
<td>(R43) I would suggest diagnosis would suggest the hospital admission is not appropriate course of action - clinically not indicated nor best practice (R62)</td>
<td>Mary and her mother require support, monitoring and education (R98)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Brief follow-up for now, with the goal of handing ongoing support back to her counsellor sooner rather than later. (R35)</td>
<td>Unpredictable, history of emotional vulnerability, poor coping mechanism, angry. Engaging within a few days is within the 98/31 protocol of medium risk after discharge from hospital, perhaps then back to councillor when no foreseeable risk or low risk handover to be managed by counsellor, (R40)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mary and her mother require support, monitoring and education (R98)</td>
<td>Support current therapeutic relationship. Advise therapist of today’s presentation. Involve Mary, her mother and therapist in discharge plan with emergency options/supports if situation deteriorates again. (R70)</td>
<td></td>
</tr>
<tr>
<td>3/ No risk, well connected and supported</td>
<td>Good supports in place, well connected with private counsellor, not deliberate self-harm, low risk, consistency of care,</td>
<td>6 Mary knows her history and so does the mother. Mary is relieved of her burden for the moment as she has expressed herself by cutting. She requires understanding, support and reassurance. (R29)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>She has engaged with counsellor and the advice would be to follow up this person in the community (R131)</td>
<td>Moderately Low risk of suicide. Well established pattern of behaviour, already has therapist in place. Has supportive mother, can re-present ED if things escalate before seeing therapist (R20)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Supportive and understanding mother already engaged with counsellor not deliberate self-harm (R15)</td>
<td>Well engaged with counsellor, supportive mother. Consistent care from counsellor more beneficial than having to repeat story to new clinicians. (R79)</td>
<td></td>
</tr>
<tr>
<td>Domain</td>
<td>Theme</td>
<td>Admit No.</td>
<td>Reasons</td>
</tr>
<tr>
<td>----------------------</td>
<td>------------------------------------------------------------------------</td>
<td>-----------</td>
<td>---------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>1</td>
<td>Perceived risk</td>
<td>25</td>
<td>Although she has supportive parents there could be difficulty in their understanding of the potential risks. The patient is clearly clinically depressed; the stressors, leading to her attempt, remain unchanged; she remains of the view that death was a preferred option for her. (R31)</td>
</tr>
<tr>
<td>2</td>
<td>Assessment and treatment</td>
<td>12</td>
<td>A thorough assessment, crisis plan and risk assessment needs to be completed. There should be a medication review and linking in with a community mental health clinician if not already in place as well as a counsellor/psychologist who specialises in eating disorders and mental health issues. Jenny needs to have long-term community supports and this can be started while an inpatient. She may also need a referral to financial services and to a career counsellor. (R125)</td>
</tr>
<tr>
<td>3/ undecided</td>
<td></td>
<td>3</td>
<td>I am entirely uncertain whether she is a current risk or not so I feel an admission is needed to be sure. (R115)</td>
</tr>
<tr>
<td>4/ Perception of protective factors</td>
<td>Parents supportive/ Community team to build</td>
<td>44</td>
<td>Her parents want to take her home and it is better for her to be treated at home rather than hospital</td>
</tr>
</tbody>
</table>
if appropriate, however, requires intervention and further assessment once she has had time to process what has occurred and help her deal with current stressors (R11)

Has parental support environmental issues depressive symptoms are reactional linking to appropriate support services could be done in the community (R52)

5/ Nothing to be gained
Hospital will not change the circumstances/ be too stressful

4
This girl has very supportive parents who are willing to look after her rather than the stress of an inpatient admission. (R30)

Admission would be an excessive step, with unknown consequences in terms of stigma effects, a young woman exposure to disturbed behaviour of others (R100)

6/ not deliberate self-harm
Not deliberate self-harm/crisis over/ No plan

18
she denies on-going intentionality or plan -her action was impulsive at the time and contextually at a time under higher stress than post treatment. (R61)

Thematic chart for Vignette 5 (Male, ID, depressed)

<table>
<thead>
<tr>
<th>Domain</th>
<th>Theme</th>
<th>Admit</th>
<th>Community treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment and treatment</td>
<td>Longitudinal assessment/treatment/referral to specialist services</td>
<td>23</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Although it is unclear about the intent of the behaviour the patient is obviously disturbed. There is a diagnosis of depression that is</td>
<td></td>
<td>Wouldn't cope well in hospital setting. Needs prompt follow-up/intervention to treat for psychosis initially, then grief counselling (R80)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>He and his mother need</td>
</tr>
</tbody>
</table>
untreated and evidence of auditory hallucinations. It needs to be established if this is a psychotic depression or a symptom of another disorder. Although mum is against admission there is a history that the patient is reluctant to take medication. (R23)

community intervention and he needs grief counselling and possibly review of medication by psychiatrist. (R135)

| Perceived risk | Risk to mother/risk to self | 17 | probable psychosis, elderly mother at risk and not able to keep him safe or get him to take him to take his medications (R19)
| | risk to self, will continue to respond and react to auditory hallucinations (R101) |

| mother unable to cope | 9 | He is a danger for himself and his elderly mother will not be able to cope with him herself (R106)
| | it is unlikely that his mother can ensure his safety due to her age - may even be herself at risk if she tries to intervene (R49) |

| undecided | Depends on mother’s ability to cope | 7 | If mother was able to show effective strategies to protect Aaron without causing herself injury or distress. Otherwise admission would be recommended. (R9) |

| community treatment | Community team assessment and treatment/ mother supportive/ referral to specialist services | 23 | supportive mother medication supervision (R159)
| | Mother does not want admission community treatment and behavioural intervention would be more beneficial in the long term. (R59) |
6 / hospital too stressful

14

Taking him away from mum would be very distressing for both of them and I would be surprised if mum wouldn't watch him like a hawk for a while given he has 'never done anything like this before' (R53)

Increased stress if removed from mother. (R105)

Thematic chart for Vignette 6 (Male, depressed, intoxicated, supported)

<table>
<thead>
<tr>
<th>Domain</th>
<th>Theme</th>
<th>Admit No.</th>
<th>Reasons</th>
<th>Community treatment No.</th>
<th>Reasons</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Perceived risk</td>
<td>Still deliberate self-harm, covering up true symptoms, minimising intent</td>
<td>23</td>
<td>Patient now not disclosing, denying and covering up extent of his depression and deliberate self-harm (R19)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Too many risk factors. Gender, age, means, alcohol misuse, presence of hopelessness and worthlessness. (R31)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2</td>
<td>The intent and therefore the risk is v high but the attachment to family is also v strong - If several members of the family are mobilised, they could effective maintain constant presence and help him minimise alcohol, process the foundations of his crisis and his almost-suicide. (R100)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. alcohol issues</td>
<td>Withdrawal, needs linking with addiction services</td>
<td>8</td>
<td>Safe environment observation and engagement medication review involvement with alcohol and other drugs service for potential joint management (R38)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Assessment and treatment</td>
<td>Assessment, Observation, Treatment review</td>
<td>15</td>
<td>to treat his depression (R210)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Monitoring of mental state, stabilisation of medication and referral to support services (R129)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Environment and engagement</td>
<td>Supportive family, good relationship with GP, community team to liaise</td>
<td>27</td>
<td>Geoffrey's family will be present and observe him until the community team arrives. They can see him in his regular context. As long as Geoffrey is not drunk he is unlikely to try</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Thematic chart for Vignette 7 (Female, borderline, intoxicated, in crisis)

<table>
<thead>
<tr>
<th>Domain</th>
<th>Theme</th>
<th>Admit</th>
<th>Reasons</th>
<th>Community treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Admit qualifications</td>
<td>Negotiated admission, limited time, reluctant admission, cooling off period, link to services, time out</td>
<td>15</td>
<td>This patient is currently in crisis and I believe a short admission could contain the situation (R77)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>She needs time out from the stress of home and to have some psychotherapy (R135)</td>
<td></td>
</tr>
<tr>
<td>2 Perceived risk</td>
<td>Different method, escalating behaviour, serious attempt, deliberate self-harm, hopeless, out of control, impulsive, poor self worth, in crisis</td>
<td>29</td>
<td>High lethality suicide attempt in complex and difficult situational crisis, thus admission despite significant pathological personality traits (R34)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>despite history of self harm and previous attempts, lethality has escalated (R62)</td>
<td></td>
</tr>
<tr>
<td>3/ risk to family</td>
<td>Protection of children, no family support, need to support family</td>
<td>20</td>
<td>the husband and children cannot have responsibility for Gayle in her current mental state. they will be traumatised in need of care themselves. Gayle’s</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>At this stage probably would not benefit from admission. Could be assisted at home and important to be done within the family. Needs to continue with her family role</td>
<td></td>
</tr>
</tbody>
</table>
self harming and deliberate self-harm is out of control. (R19)

| 4/ not deliberate self-harm | 1 | Although attempt does not appear to have high lethality the behaviour is highly disturbing and there is a massive risk to children with the behaviour. There is no support at home from any adults. (R23) | 3 | Denies deliberate self-harm or that this event was an attempt. (R149) She has admitted it was not a serious attempt when sober. (R29) |

| 5/ Alcohol issues | Needs to detox, has to stop drinking, needs connection with alcohol and drugs services | 5 | A period of drying out and detoxing (R64) She doesn't seem to have any self control, the children are at risk, she needs help with her alcohol addiction and support around withdrawals and a review of medications and supports. (R125) | 2 | Gayle needs care but I don't think inpatient care is warranted. She needs a counsellor to help her sort out some of the problems she is facing at the moment. In particular, she needs drug and alcohol counselling (R124) |

| 6/ nothing to be gained | Not helpful in the past, she needs to take responsibility, disempowering | 12 | This lady needs to take responsibility for her own actions, acute intervention in the past has not proven beneficial. (R20) Possibly a waste of effort, but necessary to cover all parties Gayle's quality of life, or duration. (R4) |

**Thematic chart for Vignette 8 (Male, homeless, depressed, intoxicated)**

<table>
<thead>
<tr>
<th>Domain</th>
<th>Theme</th>
<th>Admit</th>
<th>Community treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong></td>
<td>Admit</td>
<td>No.</td>
<td>Reasons</td>
</tr>
<tr>
<td></td>
<td>Longitudinal assessment and treatment, depression, in</td>
<td>20</td>
<td>He needs treatment and containment while drying out. Perhaps rehab would be more suitable, but an</td>
</tr>
<tr>
<td>qualifications</td>
<td>crisis</td>
<td>acute admission ward would do well in the short term. (R4) May need admission to mitigate risk while still intoxicated. Reinstate MHS follow up. Clarify diagnosis and management plan. Reassess risk and mental state (R58)</td>
<td>depression but not sure that he would accept help as it would be more appropriate for him to have help for his drug use and then be referred when he has decided to do something about it to help with his depression (R54)</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>2</td>
<td>Perceived risk</td>
<td>Threat to self and others, plan and intent, impulsive, impaired judgement</td>
<td>Dillon is seriously disordered and likely to hurt someone in his current state. (R19) May be a risk of harm to self or to girl friend. (R101)</td>
</tr>
<tr>
<td>3/ drug issues</td>
<td>Detoxification, needs to dry out, needs referral to drug services</td>
<td>I do not think the bed would be available. He requires immediate admission to Detox. A 7 day stay where, if he were not in denial, he may be able to arrange long term Rehabilitation. If a bed is available he would see a psychiatrist and the services could aid his immediate circumstance of lack of sleep. He could then be, if Dillon were interested, introduced to concepts of self-helping like Narcotics Anonymous. (R29)</td>
<td>Detox admission may be helpful if willing otherwise community management and treatment of his substance misuse and emotional dysregulation (R97)</td>
</tr>
<tr>
<td>4/ Homeless</td>
<td>Nowhere to visit, needs referral or link to services (social work, alcohol and drug, general practitioner)</td>
<td>No supports ongoing deliberate self-harm needs assistance with withdrawal, housing connection (R60) Crisis brief admission, until situation with girlfriend has calmed down or alternative accommodation can be accessed. Drug withdrawal regime can be started and he can be offered substance abuse</td>
<td>He has long term psychiatric issues and he is still coming down from an ice binge. He is probably not registered with a GP and is unlikely to seek treatment due to his homelessness (R27) Some level of short term support, however, alcohol and drug intervention would be more appropriate. Need to engage him to prevent further, serious crisis (R86)</td>
</tr>
<tr>
<td>Domain</td>
<td>Theme</td>
<td>No.</td>
<td>Reasons</td>
</tr>
<tr>
<td>--------</td>
<td>-------</td>
<td>-----</td>
<td>---------</td>
</tr>
<tr>
<td>1</td>
<td>Admission qualifications</td>
<td>17</td>
<td>safety appropriate medication at the appropriate time if he has been stockpiling he may not have been taking the correct amount thereby increasing his level of depression (R15) The re-stabilisation of Alan on his medication or changing his anti-psychotic medication to an injectable form while Alan is an inpatient might be useful, or perhaps trying Alan on Clozapine if this has not been tried previously. (R31)</td>
</tr>
<tr>
<td>6/ Hospitalisation may make things worse</td>
<td>No acute mental illness, nothing to gain from admission</td>
<td>5</td>
<td>no attempt at suicide, does have some issues of concern (R85) Does not require acute mental health services. Should be advised to attend GP to consider anger management counselling if he wishes to address his issues. (R144) I can’t see that anything would be of benefit, but an attempt must be made. (R140)</td>
</tr>
<tr>
<td>5/ No mental health issues</td>
<td>No acute mental illness, nothing to gain from admission</td>
<td>3</td>
<td>No mental illness. Admission would result in an escalation of behaviour to delay discharge (R198)</td>
</tr>
</tbody>
</table>

Thematic chart for Vignette 9 (Male, psychotic, in crisis, supported)

<table>
<thead>
<tr>
<th>Domain</th>
<th>Theme</th>
<th>No.</th>
<th>Reasons</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Admission qualifications</td>
<td>17</td>
<td>safety appropriate medication at the appropriate time if he has been stockpiling he may not have been taking the correct amount thereby increasing his level of depression (R15) The re-stabilisation of Alan on his medication or changing his anti-psychotic medication to an injectable form while Alan is an inpatient might be useful, or perhaps trying Alan on Clozapine if this has not been tried previously. (R31)</td>
</tr>
<tr>
<td></td>
<td>Community treatment</td>
<td>19</td>
<td>He could do with a review and more intensive follow up (R54) needs to be monitored and medication supervised to reduce risk and abate symptoms (R85) GP's are not mental health specialists - this person needs speciat mental health care not just more medications from a GP (R45)</td>
</tr>
<tr>
<td>Perceived risk</td>
<td>Deliberate self-harm, in crisis, similar to the last time he attempted, has a suicide plan</td>
<td>acutely unwell, non-compliant meds stated deliberate self-harm ideation and hopelessness (R20) Evidence that he is increasingly psychotic, so is a danger to himself. Needs intensive treatment because he has no insight into his illness (R62)</td>
<td>strong risk factors for a serious attempt on his life (R178)</td>
</tr>
<tr>
<td>----------------</td>
<td>------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------</td>
</tr>
<tr>
<td>2/ undecided</td>
<td>admission may be warranted if via engagement with him a reliable account of intent to die was assessed. He may well be treatable where he is thought obviously with the removal of means of suicide and ongoing engagement and observation where he is (R26) Depends....maybe admission. Can the case manager take the medication away? Can the case manager depend on the SRS manager to assist in monitoring? Can Alan agree to follow up tomorrow? (R58)</td>
<td>need to remove stockpile of medication review medication to increase compliance admit if staff in unit unable to provide enough supervision needs to build rapport with new case manager (R60) If he is able to be convinced to give his stockpiled medication to his new caseworker and agree to be medication compliant (with the SRS worker supervising administration of prescribed dose) then maybe this would be the least restrictive option of ensuring he does not follow through with his overdose plan. If he is unable to agree to this course of action then admission would be necessary. Intense visitation by his new community caseworker would allow monitoring and also be an opportunity to build rapport and trust. (R43)</td>
<td>2/ need to remove stockpile of medication review medication to increase compliance admit if staff in unit unable to provide enough supervision needs to build rapport with new case manager (R60) If he is able to be convinced to give his stockpiled medication to his new caseworker and agree to be medication compliant (with the SRS worker supervising administration of prescribed dose) then maybe this would be the least restrictive option of ensuring he does not follow through with his overdose plan. If he is unable to agree to this course of action then admission would be necessary. Intense visitation by his new community caseworker would allow monitoring and also be an opportunity to build rapport and trust. (R43)</td>
</tr>
<tr>
<td>4/ supported home environment</td>
<td>Home environment is safe/supportive, admission would be too traumatic, remove method/stockpile</td>
<td>Alan has good support around him and the method of choice can be removed. He has been case managed for some time and is used to the service and likely to be compliant with</td>
<td>33 Alan has good support around him and the method of choice can be removed. He has been case managed for some time and is used to the service and likely to be compliant with</td>
</tr>
<tr>
<td>5/ not deliberate self-harm</td>
<td>Not deliberate self-harm, not unwell</td>
<td>1</td>
<td>While he is not acutely unwell, he is showing signs of relapse. The change of his case manager is setting in motion a similar pathway to his previous suicide attempt 8 yrs ago. On the other hand he is living in supported accommodation and does have a key worker - albeit unfamiliar with him. (R10)</td>
</tr>
<tr>
<td>---------------------------</td>
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<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3</td>
<td>No actual expression of deliberate self-harm ideation. No attempt to have taken an overdose, no specific plan to take an overdose. (R30) least restrictive option living in supported accommodation arrangement could be made to ensure compliance with medication no current risks identified psychotic symptoms likely to subside with medication compliance chronic schizophrenia usually managed well in community (R40)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>I do not think he is acutely deliberate self-harm. He needs to be recommenced on his medication. Monitored more regularly at his supported accommodation until he stabilises (R150)</td>
</tr>
</tbody>
</table>

- Dispositional Decision Making
- Medication being dispensed by an community acute team. (R19)
- Has supports at accommodation and community support. Medication can be removed minimising risk. (R63)
- Alan is a prime candidate for intensive case management, rather than CATT. He may benefit even in the short term from an intensive and supportive approach that communicates hope and builds one or two relationships. (R100)
APPENDIX C

Mental State Examination

General appearance and behaviour – these are the signs that are noted in psychiatry, how is the person dressed, has their grooming been attended to, are they relaxed or agitated/restless, how well do they engage in the interview, body language and eye contact.

Speech – this is described under rate, how fast the person talks, rhythm and volume.

Affect and mood – there is some disagreement among clinicians around these terms but generally it is agreed that the mood describes the enduring underlying internal emotional state such as depression while the affect is the external manifestation of the mood. The affect may be mood congruent or not.

Thought – thought is discussed under three headings:

Stream – the amount of thoughts

Structure – is there a logical coherence to the thoughts as articulated or is there one of a number of patterns of disorganisation that are collectively termed formal thought disorder.

Content – the content of thought is explored in order to uncover disorders of belief such as delusions (as contrasted against overvalued ideas), obsessions and phobias. Also
explored under thought content are the risk to self and others. When exploring risk the usual format is to explore any ideation, but then to enquire if the person has planned the event, has the intent to carry it out and has the means to see the act through.

Perception – this refers to sensory disturbance and can affect all five senses, but predominantly hearing, with the presence of auditory hallucinations.

Cognition – this explores the cognitive functioning of the person, the level of their conscious state, orientation, memory, attention span, concentration and executive functioning. It is here that the structured mini mental state (Folstein, Folstein, McHugh, & Fanjiang, 2001) may be used as an objective measure of cognition, it also where issues of intoxication and brain injury will be explored. It is also here that the persons’ ability to understand and give informed consent to any treatments or interventions offered is assessed.

Insight – the understanding that the person has of the presenting problem and the meaning that they attribute to it. This also refers to the persons’ adherence to any treatment regimes or referral options.

Judgement – the capacity of the person to process information and make sound rational judgements.