

COMPARISON OF ASSESSMENT AND MANAGEMENT OF SUICIDAL RISK FOR ACUTE PSYCHIATRIC ASSESSMENT BETWEEN TWO STATE SPONSORED HOSPITALS IN ENGLAND AND ITALY

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SUMMARY

The risk of suicide is one of the most important risk factors looked into for acute psychiatric assessments that influences the management plan. The prevalence of suicide is on a rise across European countries; as a consequence, the different countries have created specific guidelines and policies in order to prevent suicides in the acute settings. These guidelines are based on both different cultural aspects as well as the different organization of the mental health system in the different countries. This paper wants to present the comparison between the guidelines of two European countries, England and Italy, in order to evaluate the systems, understand differences and common contact points. The different European countries could learn one from the other and a European shared point of view may be a way forward to create better understanding and preventing the risk of suicide across the population.

Key words: suicide - suicide risk - crisis team – consultation - liaison activity

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BACKGROUND

The awareness and expansion of mental health services has been noticeable across the European nations more so ever in the current century. The people suffering from mental illnesses are on a rise.

According to the WHO, “1 in 4 get mental illness during their lifetime” (Boseley 2001) and “during their entire lifetime, more than 25% of individuals develop one or more mental or behavioural disorders” (Sayers 2001).

As a consequence, the operational policies and relevant guidelines are being regularly revised. One of the key clinical aspects is risk assessment and management for an acute psychiatric patient presenting to A&E department.

Obviously, due to cultural aspects and the organization and policies of the different countries, the guidelines vary not only between the different European countries but even within the same country.

One of the most important factors that is taken into consideration when assessing the clinical risks of a patient is the risk of suicide.

In fact, suicide risk arises across Europe and European regions had a higher rate of suicide than other regions of the world (Jacob 2007). According to this, OMS predicted that in 2020 the incidence of suicide will be around 1.5 million (WHO 2004).

The incidence of suicide is higher in the patients hospitalized and in those discharged, mainly in the first three weeks after the discharge. The wards that are particularly at risk of suicide are the A&E, the oncological, gynaecological and psychiatric wards. As for

the risk factors associated to suicide, males have a higher risk of suicide, mainly those between 15 and 24 years old or over 65 (Percorso aziendale Azienda Ospedaliera di Perugia 2010).

The idea to develop this work was the consequence of a clinical attachment of one of the author (N.V.), resident student in Psychiatry at the University of Perugia, at the General Hospital of Bedford (SEPT, South Essex Partnership University NHS Foundation Trust) in the UK.

During the clinical placement, the author was fascinated by the acute risk assessment conducted by the Crisis Team, mainly in consideration of the differences and the common aspects in comparison to the consultation liaison activity of the Psychiatric Unit at the Santa Maria della Misericordia Hospital, in Perugia, Italy.

Consequently, the aim of our work is to describe the assessing and the managing of the risk of suicide in two different European hospitals and look to the learning outcomes.

METHODS

In order to compare the assessment and management of clinical risk of suicide in England and in Italy, we looked at the Local Trust Policy for Weller Wing, in UK (“Clinical guideline for the assessment and management of clinical risk” - CG28-South Essex Partnership NHS Foundation Trust) and the hospital guideline for prevention of suicide at the Perugia Hospital, in Italy (“Percorso aziendale per la prevenzione del suicidio in ospedale”, Rev. 00, April 2010, Azienda Ospedaliera

“Santa Maria della Misericordia”, Perugia). We also looked at the initial assessment forms used in the two hospitals.

Weller Wing is a mental health unit providing inpatient, outpatient, crisis and psychiatric liaison services in town of Bedford, UK.

The Santa Maria della Misericordia Hospital in Perugia is a multi-speciality hospital, offering psychiatric services in the catchment area of Perugia, Italy.

RESULTS

Assessment of risk of suicide

In England

At the Weller Wing, the activity of assessing and managing suicide is carried out by the CRHT (Crisis Resolution and home treatment team) which acts as a “gatekeeper” for patients presenting predominantly to the Emergency Services such as the Accident and Emergency Department.

In the local trust policy, we could locate “*the Risk Assessment is an essential and on-going aspect of patient care, which must be clearly documented and reviewed*”.

Consequently, the staff, the service users and the relatives and/or carers should develop a “*working therapeutic relationship that enables a full holistic assessment of needs, risks and strengths...in a manner and in an environment that is conducive of the promotion of psychological exchange*”.

The staff-members are asked to complete a systematic assessment of clinical risk together with the patient, in accordance with the SEPT (South Essex Partnership NHS Foundation Trust) clinical guidelines.

In particular, when assessing the risk of suicide, they should include previous attempts, threats, plans, opportunity and access to means and suicidal thoughts together with the other clinical risks, such as; risk of self-harm, of adverse consequences of treatment and physical injury, of absconding from in-patient services, of disengaging or moving out from the catchment area without informing necessary agencies, of violence to others, of other types of risk to other people, of self neglect, of neglect and child protection concerns and associated with intrusive sexual, aggressive or death-related thoughts.

After that “*the suicidal ideation of the patient, tendencies and plans (mainly if including risks to children) need to be discussed fully with the Multi-Disciplinary Team (MDT) involved in the person’s care. Decisions taken surrounding care and treatment in light of these factors must be reviewed regularly and agreed by the MDT involved*”.

In particular, attention should be given to contributory factors that may enhance risk such as; the presence of history of self-harm and suicide, the failure to treat psychiatric disorders adequately, the failure to remove dangerous objects and the failure to adopt or follow safeguarding measures.

The assessing member-staff should underline even the evidence of; transitory behaviour or social restlessness, the poor compliance to treatment and disengagement from psychiatric after-care, the actual or potential substance misuse, the recent severe stress, loss events or threat of loss, the recent discontinuation of medication, change in medication or non-compliance, the physical health risks, the threatening behaviour and delusions/hallucinations of a persecutory nature and risks to children.

The form used for initial assessment contains a specific section for risk assessment where the assessing member-staff should indicate the past and present risks as well as the protective factors and patient/carers views and the information from relatives/carers.

In Italy

According to the clinical guidelines, the prevention of suicide in the Perugia Hospital follows a flow-chart that begins with the assessment of the risk of suicide carried out by the medical staff of the ward in which the patient is hospitalized or of the A&E.

The medical staff should take the history of the patient in a comfortable environment because “*the taking of the history represents the first moment of interaction with the patient and represents an essential tool in identifying the risk factors that should be monitored*”; furthermore, the Italian guidelines provide the medical staff with suggestions about how to communicate with the patient.

The history of the patient should assess; clinical diagnosis, clinical history (both physical and psychiatric disorders, substance misuse and end-stage diseases), psychosocial evaluation (previous self harm, family history of suicide, history of sexual abuse, recent severe stress), risk of suicide (the patient has plans in order to commit suicide, history of past suicide attempts, feelings of guilt or dissatisfaction).

In addition, the medical staff should do a clinical examination of the patient, in particular searching for signs of depression, substance abuse, psychomotor agitation and erratic behaviour.

Finally, the guidelines provide a list of medical and social conditions that are at particular risk for committing suicide.

When the doctors of the medicine ward/A&E has assessed the risk of suicide, they should ask for a psychiatric evaluation which the aims are to give a psychiatric diagnosis and to establish the useful preventive measures, psychiatric medications and the management of the patient.

If a psychiatric hospitalization is needed, the psychiatrist should create the link.

The form used for the psychiatric assessment of the patients contains a specific part in which the psychiatrist should write information about the suicide attempt and suicidal ideation.

Management of the risk of suicide

In England

The management of clinical risk is a multi-disciplinary process that should include the service user and/or their carers and all those concerned should collaborate.

Generally, a plan of care is developed after the risk assessment and should be agreed by the MDT; the plan must be clearly recorded and include evidence of the considerations that have supported decision-making.

After that, due to the fact that the risk assessment process is on-going and not one-off event, it must be reviewed as considered necessary by the clinical team, which may be, for in-patient services, as frequent as daily, “with an evaluation of care being undertaken at least once each week, at the service user’s care review meeting/ward round” and this will be coordinated by the named nurse.

A re-assessment of risk should take place when further information is available and these should be promptly sought in clarifying any areas of ambiguity.

The English guidelines then provide advices for the environment suggesting that “ward environment should be considered when assessing risk, with actions taken to minimise associated risks”.

As for the documentation, the care plan should be documented both in the medical and nursing records, clarifying and assessing the severity, the immediacy, the intensity of the risk and the specific intervention/treatment and management plan that is likely to best minimise the level of risk.

In Italy

After the psychiatric evaluation, “the psychiatric diagnosis, the agreement of the suicidal risk, the preventive measures that should be applied, the medications that should be given to the patient and the follow-up plan should be recorded in the clinical notes and referred to the on-call doctor of the ward”.

In the Italian guidelines, there is a specific part about the preventive measures that should be applied in order to avoid suicide.

In particular; the doctor should ask the relatives to collaborate in observing the patient, the patient should be continuously observed and the way of controlling him should be defined on the basis of the severity of the risk of suicide (if the relatives cannot look after the patient, the doctor could ask for nurse staff help, by the means of the DBS, Dipartimento delle Professioni Sanitarie).

Furthermore, the Italian guidelines advise the doctors about the measures that should be applied in order to provide a safer environment, such as checking the personal stuff of the patient and locking the windows.

Plan and Discharge

In England

During the initial assessment, the assessing member-staff needs to complete the last page of the form where

he is requested to give an initial formulation with the Summary of needs discussed with the patient and the carer; to collect the notes about the patient views and initial goals according to the question “What would you like to achieve?”; on the basis of the previous points, an initial management is given, including level of observations on admission, medication prescribed, psychosocial aspects of management, and a plan is written by the assessing member-staff.

According to the guidelines, “arrangements for assessing and managing risk under the CPA Policy need to be taken into account from the point of admission through the point of discharge. It is vitally important that appropriate steps are taken when discharging or transferring service users to ensure risk is minimised”.

On the basis of the clinical needs of the patient, the staff decide if he/she can be; 1. discharged back to the GP, 2. he/she can be requested to be assessed by the ASPA clinic (Assessment and Single Point of Access, or initial psychiatric assessment), 3. he/she can be discharged to the CMHT, after an arrangement with her/his care coordinator, 4. he/she can be reviewed by the House Treatment Team, 5. if he/she is on crisis, he/she can have mental health act assessment in order to evaluate if the patient should be sectioned and consequently admitted in the psychiatric ward under Section 2 or 3.

In Italy

According to the Italian policy, if a patient attempted suicide or is considered to be at risk of suicide, it is important to elaborate a “safe discharge”. In order to do so, the psychiatrist and the medical staff of the ward/A&E should organise a discharge based on shared opinion. The people involved in doing this are; 1. The psychiatrist, 2. the medical staff of the ward/A&E where the patient is hospitalized at the moment, 3. the carers of the patient, 4. territorial social services and 5. the GP.

Furthermore, a contact person or the referring CMHT should be provided to the patient and to the care-giver.

The discharge plan should be recorded in the form, where the psychiatrist can tick a program at discharge from a multiple choice list, including; 1. no plan at discharge, 2. discharged to the social worker, 3. to the GP, 4. to the CMHT, 5. to Drug and Alcohol service, 6. to a private psychiatrist, 7. to the hospital outpatient clinic, and 8. other which include the admission in the psychiatric ward, under a mandatory (TSO – *Treatmento Sanitario Obbligatorio*) or an informal treatment (TSV – *Treatmento Sanitario Involontario*) or in a medical ward.

Training, implementation and review of the guidelines

In England

In order to assess and manage clinical risk effectively, all the staff needs to attend an induction program and undertake specific training in the Assessment and Management of Clinical Risk. After an initial training, an update every three years is required.

The Clinical Guideline could be found on the Trust Intranet Site and are reviewed at least once in each three year period.

A Trust-wide audit co-ordinated by the Clinical Audit Department will be undertaken a minimum of 3 yearly and both the practice and procedure will be reviewed, while locally managed audits will be undertaken annually.

In Italy

In order to involve all the staff of the “Azienda Ospedaliera S. Maria della Misericordia” and to increase the skills in identifying suicide ideation in patients and to adopt effective prevention measures, the Azienda Ospedaliera will train the staff through specific training programs.

The “Percorso Aziendale” will be reviewed after one year and the useful changes will be added on the basis of specific outcomes; 1. Number of suicides that is the number of suicides registered in the hospital in one year. Of course, the expected standard is no suicide at all; 2. Number of suicide attempts; it is the number of suicide attempts that was done in one year in the hospital and the expected standard is one in a year; 3. Number of psychiatric assessments for suicide risk. This is the count of the psychiatric assessments required in a year at the hospital in order to evaluate the risk of suicide. The outcome is obtained dividing the number of psychiatric assessments for suicide risk for the total number of psychiatric assessments in one year. The expected standard is > 10% than the previous year.

The clinical guideline is available in the Azienda Ospedaliera di Perugia website and it was shared within the regional hospitals.

DISCUSSION

The authors could appreciate that while the most initial assessments in UK are nurses led, they are medically led in Italy.

Indeed, the crisis team which carry out most of the assessments in UK is virtually non-existent currently in Italy.

While the UK policy mentioned more about the Multi-disciplinary team and family involvement, the Italian policy mentioned about robust clinical history taking.

The UK Policy talked about risk assessment as a dynamic process, the Italian had a clear flow chart representation of the pathway.

While the UK policy talked of robust clinical documentation, the Italian counterpart mentioned of specific preventive measures.

The UK has additionally a follow-up service in the form of the Crisis Team. In Italy, the patient can be discharged with an appointment at the Community Mental Service of his/her catchment area for a clinical follow up by a psychiatrist.

Overall we feel that the Italian counterpart can learn from the existence of crisis resolution home treatment teams in UK (although we are aware that the studies have mixed data regarding the clinical outcome) (Jacobs 2011; Carpenter 2013) and explore the need in Italy.

The UK counterpart could learn from the medical led model of the Italian system which partly is already reflected in the expansion of more medically led liaison psychiatric services in UK.

CONCLUSION

The authors conclude that both of the units are following robust measures depending upon the geography, services needs and available resources.

The need is for more collaboration of mental health services across the Europe to learn from established models.

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