

**Accuracy of suicide risk assessment
formulation: The relationship between values,
attitudes and communication**

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Background and argument

- A dearth of evidence to indicate any relationship between style of nursing assessment and clinical outcomes
- I argue that there is a relationship between clinicians values, attitudes, knowledge; and
- Clinicians' values, attitudes, knowledge and frame of practice can produce service user behaviours and content of risk assessments

The study

- Multi-site ethnographic study that examined suicide care practices.
- Study across 4 wards in 2 cities.
- Interviews, observations and data mining of files

Suicide and risk assessment

- Assessment frame of reference is often *within* a person
- Focus on pathology and risk
- What is place of clinician attitudes and values in assessing?
- What is the place of formalising risk assessment structures?

The relationship between values, attitudes, and knowledge

- *Lets get real*
- MH nurses' values, knowledge and attitudes
- Unclear how these translate as behaviours

The production of values and behaviours in acute wards

- Values attitude and knowledge are produced by dominant culture, *unless* there is a clear framework of understanding
- Practices are reflective of this dominant values, and may contradict personal values

Practices reflective of dominant values and understandings

- Minimalist engagement
- Don't encourage communication of suicidal thoughts, except for risk (dependency understanding)
- Re-pathologising
- “Men don't cry”
- Dichotomous understandings of risk and control
- Risk assessment needs to be minimal/”people tell the truth” “people manipulate”

Service user behaviours that stem from this

- Not engaging
- Giving up
- Need for other behaviours to get their needs met
- Sense of humiliation

Risk assessment that stems from this

- False negatives
- False positives
- Indifferent answers

Practices reflective of humanistic view of suicidality

- Understanding of complexity of suicidal feelings
- Belief in causation
- Values partnership and support rather than treatment
- Co-production of risk understandings

Service user behaviours stemming from this model

- “Can be honest because I am understood”
- “ Not punished for saying I am going to kill myself”
- “...can get what I need by asking not acting...”
- Mutuality of respect, and of formulation of risk

Risk assessment that stems from this model

- Conversational, narrative,
- Timely,
- Updated
- Negotiated
- ?Less false positives and negatives?

Learnings

- Models of understanding are vital; otherwise dominant values and attitudes (and behaviours) prevail
- The translate into behaviours of clinicians AND service users
- Risk assessments directly impacted
- Could it be that *risk assessments based on “faulty” values and attitudes are worse than no risk assessment*