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Suicide and Intimate Partner Violence Risk Assessment and Decision-making

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Abstract

This research explores the question: "How do social workers and multidisciplinary mental health professionals perceive and understand risk and how does this inform decision-making and service provision?" In-depth face-to-face interviews were conducted with health and mental health workers employed at a major health service based in Melbourne, Australia. Participants were employed in hospitals, community health centres, and residential care facilities including specialist mental health services. Theoretic thematic analysis was used to identify seven dominant themes reported by study participants. These were: (1) establishing risk ownership; (2) a hierarchy of fears; (3) self-doubt and self-blame; (4) organisational incident reviews; (5) blame from client, family and society; (6) the protective shield; and (7) evaluating safety and meaning. The study findings have implications for further research and social work education on risk assessment, decision-making and appropriate social work responses.

Keywords: *Intimate partner violence; Suicide; Risk assessment and management; Emotions; Decision-making*

Introduction

International research findings indicate a co-occurrence between intimate partner violence (IPV) and psychiatric disorders generally (Oram et al., 2016), as well as to specific mental health issues such as eating disorders (Bundock et al., 2013) and suicide and depression (Devries et al., 2013). It is concerning that studies of IPV and mental health risk assessment in Australia (McCulloch et al., 2016; State of Victoria, 2016) the United States (Cattaneo & Chapman, 2011) and Ireland (Higgins et al., 2016) highlight inadequacies and inconsistencies in risk-assessment practices and role expectations. It is presently unclear how social workers and mental health professionals conceptualise risk and how this impacts on their decision-making, and if this varies across different vulnerable populations where these professionals may have a central role in identifying and managing risk. First, we explore the literature on perceptions of risk, risk assessment and risk management. Second is a detailed description of the research methodology, followed by the presentation of main findings according to the seven main themes that emerged from the qualitative data analysis. This is followed by a discussion of key findings including ethical issues of consumer empowerment and self-determination.

What is risk?

The term risk takes on different meanings in different fields that social work draws upon. In psychological risk models, emphasis is often placed on the perceiver of risk (Lupton, 2013). Risk is conceptualised as the interaction between an objective threat and an individual's perception of said threat (Chen, 2015). Sociological risk theories extend on this and assert that risk may be understood as both a product and a condition of a collective cultural group. For example, Douglas (1992) asserted that risk was a conceptual tool produced by a social world that is preoccupied with assigning blame in the event of harm. Economic risk theories tend to represent risk as the probability and severity of possible events (Douglas, 1990; Ryan, et al., 2010).

Risk assessment and management

Risk assessment is considered to be an important element of practice in public mental health services whereby resource allocation is commonly based on perceptions of risk related to exposure to danger to self or others. However, mental health service managers and practitioners agree that the evidence underpinning risk assessment is not robust (Clancy et al., 2014; Grotto et al., 2014; Wand et al., 2015). Risk assessment practices vary, with managers favouring assessment tools over professional judgement, preferring evidence to clinician intuition (Clancy et al., 2014). Managers and practitioners report concerns of being "found negligent" or "blamed" following an adverse event. Fears of blame include complaints from consumers or family members, internal organisational blame, and legal blame, including the Coroner's Court processes and outcomes (Manuel & Crowe, 2014). Practitioners use a variety of strategies to manage this perceived threat of blame including referring a decision to the psychiatrist-in-charge, preferring written to verbal communication and creating an audit trail. This fear of blame and worker-focused protective strategies at times detracts from consumer empowerment by focusing on organisational defence or worker self-protection (Manuel & Crowe, 2014).

Women who experience IPV are far more likely to experience health and mental health issues (Ellsberg et al., 2008; Kimber et al., 2018). Consequently, mental health professionals are likely to be providing services to a significant proportion of people experiencing IPV. There is considerable inconsistency in how social workers and other professionals' perceptions of risk informs decision making in IPV services with some practitioners reporting that the level of risk has virtually no impact on their practice while, for others, it is the key driver underpinning decision-making (Cattaneo & Chapman, 2011; State of Victoria, 2016). General health professionals, including social workers, have reported barriers to conducting IPV risk assessments that include: feeling inadequately trained; concerns about re-traumatising the victim by asking difficult questions; a lack of time; feeling that the service system is poorly equipped to respond when family violence is disclosed; and not perceiving family violence risk assessment as within their role (State of Victoria, 2016). Specialist professionals, such as mental health social workers, tend not to view family violence risk assessment as falling within their role (McCulloch et al., 2016).

Method

Research question

This research explores the question: "How do social workers and multidisciplinary mental health professionals perceive and understand risk and how does this inform decision-making and service provision?"

Setting

The study was located in a major health service in Melbourne, Australia. Study participants were drawn from a number of sites, including three hospitals, community health centres, and residential care facilities.

Procedure

Ethics approval was granted by the university and health service where this study was conducted (no. 47755). A purposive, maximum variation sampling strategy was used – this aimed to achieve representation across disciplines, practice contexts and diverse levels of experience (van Hoeven et al., 2015). An email was distributed by a professional staff member within the health service who had access to staff email distribution listings. This was sent to all staff members employed in hospitals, community health centres, and residential care facilities including specialist mental health services either in a mental health specific role or in a social work role at the health service inviting expressions of interest for face-to-face, in-depth interviews. If the staff member was interested in participating, they were asked to contact the researcher directly. In this way the area service management did not know who had agreed to participate and confidentiality was maintained. The exact number of invitations is not known, so it is not possible to report on the overall response rate. A total of 20 in-depth qualitative interviews were conducted with social workers not in specific mental health roles ($n = 7$), nurses (n = 6), and social workers in specific mental health roles ($n = 5$).

Prior to the interview, participants were sent a letter detailing the aim of the research, the topics for discussion and a consent form to be completed and returned prior to the interview. The letter included consideration of the sensitivity of the topic area with the possibility of triggering during the interviews. Information on the voluntary nature of participation was provided, as well as advice that the interview could be stopped at any time and unprocessed data withdrawn. Details of support services were also provided.

Interviews

Participants were reminded that they could stop the interview at any time prior to the commencement, during and on completion of, the interview. Participants also received follow-up communication after the interview for further support from the interviewer and also a reminder of support services available. The interviewer was an experienced social worker in mental health and interpersonal violence. De-briefing, mentoring, support and follow-up advice were provided to the interviewer by a member of the research team who is an accredited mental health social worker as well as additional support provided by the research supervisors who were external to the health service.

Participants were asked open-ended, qualitative questions on how they conducted risk assessments, the accuracy of these assessments and the evidence-base underpinning these risk assessments. Participants were then presented with the findings of two meta-analyses on suicide risk assessment by Large and colleagues (2011, 2016). These study findings indicate that most suicides occur in those categorised as "low risk" and that most deaths by suicide occur in the 12 months post-discharge. These studies were chosen as they are frequently cited in research on suicide risk assessment (Kessler et al., 2019; Mulder et. al., 2016; Wand et al., 2015). Participants were then asked for their opinion on these study findings and how they related to their own practice of risk assessment.

Data analysis and reporting

Qualitative interview data were transcribed verbatim and analysed using theoretical thematic analysis (Bradshaw et al., 2017; Graneheim et al., 2017). Theoretical thematic analysis was chosen as it allows for greater depth of analysis than do inductive approaches (Braun & Clarke, 2006). Codes were applied to the data to develop categories that were then grouped together according to main themes (Carey, 2013; Sandelowski, 2000). A code-book was developed and applied to all of the interview transcripts. Codes were then refined and grouped into sub-categories, then categories, until finally, themes had been produced that accounted for the meaning held in the data (Lichtman, 2014).

Individual quotes reported were de-identified with the code MH (for mental health specific workers) and SW for social workers not in specific mental health roles followed by a number allocated to each respondent.

Limitations

This is a small exploratory study and findings cannot be generalised to other populations.

Results

Seven themes emerged from the interviews: (1) establishing risk ownership; (2) a hierarchy of fears; (3) self-doubt and self-blame; (4) organisational incident reviews; (5) blame from client, family and society; (6) the protective shield; and (7) evaluating safety and meaning.

Theme 1: Establishing risk ownership

Interview respondents identified different types of risks and decision-making responsibilities. Mental health professionals took responsibility for the management of suicide risk, while social workers not in specific mental health roles took ownership for the management of family violence risk: "Suicide and self-harm risks are kind of our bread and butter…Family violence…that makes me uncomfortable" (MH1); and "I feel like mental health and suicide in particular, are a more specialised area. I don't think we're given the training to help out in those situations.…Whereas family violence, it's basically social work, that's it" (SW2).

There appeared to be an inherent understanding of this role delineation as both staff groups would refer to the other to manage a risk:

> If there's any level of suicidality…I would always be referring them onto the mental health team because managing that level of risk isn't just our responsibility. (SW17)
>
> I don't think most mental health nurses focus on family violence much at all…You might lean on a social worker. (MH13)

Furthermore, such role delineation influenced the risks respondents perceived as illustrated in the following response:

> I guess, for me, because the suicide risk is more – I mean it might not be the case but it feels more risky…I mean I guess you still worry about it [family violence] but maybe because you don't expect it to be quite so final as well. You know, [compared with] if somebody chooses to take their own life. (MH3)

This quote highlights the discomfort experienced when having to assess and prioritise suicide and intimate partner risk.

Observations tended to be different for the two staff groups. Below, a social worker reflects on a difficult situation when they were unable to help a woman escape an abusive relationship:

> Then you think, oh this person is at risk of being killed. That evokes fear in me, because I'm frightened for that person and the consequence…but just to recognise that sometimes for different reasons, people aren't at a stage that they're ready to make changes…then just to keep offering that support, or try to make small safety measures when you can. Just to try and help them feel like there's little gains, even if the overall situation is really bleak. (SW3)

Social workers who worked with family violence risk tended to view the management of family violence risk as ultimately belonging to the woman whose life was at risk.

It was not clear who had ultimate responsibility for risk management and working out who this risk belonged to appeared to be a constant struggle:

> It means someone might say I'm not sure how I'll go with that. So, you come to a plan about how they would manage something, and then you breathe out and you let them go home. Instead of putting them in hospital...but something goes horribly wrong, that's when I've got to go to court and tell people how I came to that decision, and how I've reconciled that with a dead body... You've got this concept of personal growth on one side, and a dead body on the other. (MH1)

Theme 2: A hierarchy of fears

Descriptions were highly emotive. *Fear* and *anxiety* were the typically emotive terms respondents used to describe their experience of risk decision-making – other terms used by respondents included *powerlessness*, *distress*, *anger*, *shame*, *attacked*, *victimised*, *demoralised*, *triggered* and *traumatised*. Respondent comments highlighted that a myriad of processes could be catalysed by an adverse event, including coronial investigations and inquests, organisational reviews, and complaints from consumers or family members. These were often experienced by clinicians as being "mechanisms of blame." The potential for one's actions to be criticised in the Coroner's Court emerged as the most commonly feared outcome: "What will the coroner say if something happens here?... We call it coronoia, like paranoia about the coroner...if this goes horribly wrong, is my arse grass?" (MH1)

Concerningly, these fears served as a distancing process with workers prioritising perceptions of professional and personal risk over client risk. Respondents feared that a coronial inquest could result in very serious outcomes for them personally, such as job loss: "Nurses...they're worried about their job...if the person dies and it goes to coroners…I don't know of many nurses that have gone there and lost their jobs, but it's drummed in to us at University" (MH13).

Outcomes that respondents feared suggested poor knowledge of Coroner's Court powers and processes. Most respondents reported that they had not attended the Coroner's Court themselves. Reports from those who had attended the Coroner's Court, however, validated some of the fears held by those who had not, as attending was reported to be a difficult experience: "It doesn't feel nice though when the family's sitting here, and they're looking for someone to blame. The questions are quite pointed, especially if they've brought a lawyer who then puts you under the grill" (MH1).

Experiences of attending the Coroner's Court were shared between colleagues: "It was the public hostility that the lawyer had built into their role, that they can just go after you…their experience of going to Coroner's Court is very traumatic for them and it affects their working life going forward" (MH5). It appeared that the Coroner's Court was experienced as an adversarial legal process, creating a feeling of being "under the grill" and leading to second-hand reports of "public hostility" which spread throughout the health service. Importantly, the Coroner's Court was a feared outcome, consideration of which centred around the emotional state of fear: "It's a fear isn't it, yes, it's a little goblin sitting over here, one of the many things that can come and hurt you, if you make a wrong decision" (MH1).

Theme 3: Did I do something wrong?: Self-doubt and self-blame

A death, especially a suicide, was a common catalyst for self-doubt and self-blame. Self-blame was an emotive process, often beginning with guilt:

> We will never know whether; if we had done that, they would have been held better to the point where they wouldn't have passed away... It is also true that this poor man is gone, and his family have to live with that, and we have to live with that failure in front of us. (MH5)

A sense of guilt is evident in the above quote in the framing of suicide as a "failure" on the part of the health service. However, distinguishing self-blame from grief also contained an element of fear and anxiety:

> But when there is a death, there is an anxiety because on one hand there's always that question raking over your mind; Did I miss something? Did we do everything we could? Have we missed something? So, self-doubt comes in and the potential to blame yourself. (MH4)

Asking questions such as "did I miss something?" served as a form of internal audit; a helpful tool to prepare for the myriad of external audits that generally followed a death:

> You can't help but think, Did I do something wrong? I think it's human nature, when we have completed suicides...we know we've done everything we can, but it affects the whole team, and that's what's hard...When one of the clinicians has a death...our first thoughts as individual clinicians is, Oh my God, I hope they crossed all their T's and dotted all their I's. Because there's a process that goes on after it, and it's really stressful, and it puts the whole team at risk. There's usually some sort of outcome... you know, our legal department's decided, "We did everything we could", or our Legal Department's decided that, "This clinician did not do this, this, this, and this." (MH12)

As well as being a reflection of staff members' grief, consideration of whether one may be to blame served a forensic function. Interwoven with a fear that one would be blamed, the process of self-blame involved gathering evidence for and against one's own culpability.

Theme 4: "What were you thinking?" Organisational incident reviews

A key finding from the interviews was that the majority of respondents made strong expressions of emotion in both verbal and non-verbal forms. Respondents commonly recounted stories of loss of a consumer from suicide, and less commonly, disclosed personal suicide bereavements. Three respondents became tearful during the interview; two while recounting a death and one while describing a felt sense of pressure and unachievable expectations in their role. Exposure to suicide deaths was described as traumatising: "I think it's a trauma when there has been a suicide, it's a trauma for the staff and I think there is that individual response too" (MH4).

Respondents noted that, following an adverse event, a range of organisational review processes would be instigated such as file reviews and incident reviews. These processes were another source of fear: "I am afraid of being criticised or being judged…Like if something was wrong, there are many procedures within the service itself. There are internal investigations" (MH9).

Organisational review processes could feel as though they were implicitly attributing blame:

> Well no-one would come out and say this is all your fault, but they would say hey, your notes are really not up to standard here. Because they go from the notes, and say "What were you thinking? What were you doing that day at work?" It's easy to get blamed or questions will be asked if you don't have everything perfect…because they do reviews and do incidents and things like this. (MH13)

Many respondents did not feel confident that they would be supported organisationally following a death, noting a tendency for organisational review processes to focus on seemingly insignificant details:

> The risk committee will come back and they'll do an investigation. They'll go, "You didn't fill out this form correctly, when you did that risk assessment, you left off the time or the date or you didn't sign it off properly." It's minuscule… (MH1)

Theme 5: "The family can turn on us": Blame from consumers, families and society

Respondents identified that consumers, family members, and the broader society provided another form of blame: "The family can often turn on health professionals and blame us, particularly if something was to happen" (SW6)

As opposed to other forms of blame which presented as distinct fears, blame from family members appeared to be more of an irritation. There was typically less emotive language used to describe this form of blame: "…the family members, the community, the GP, everyone, because the first person families blame if something happens is the clinician that sees their client once a fortnight, and you know, it's all the clinician's fault" (MH12).

However, on occasion, respondents reported that family members and consumers used formal mechanisms, such as media or internal complaints, to express their dissatisfaction. When formalised, descriptions of blame from consumers and family members involved emotive language:

> We have clients…treated under a Community Treatment Order. They contacted media and they said that they've been forced to take treatment…that media report made an influence. At the next Tribunal, both the Tribunal and the consulting psychiatrist were really nervous to keep him continued with the Treatment Order. They were very concerned…He became a voluntary client. (MH9)

Theme 6: "Cover, cover, cover yourself": The protective shield

In this context of feeling anxious, fearful, or threatened, respondents sought protection. Several strategies emerged which respondents relied upon to feel protected. These were: strict adherence to policy and processes; risk assessment; risk management being very thorough; and risk sharing. These strategies have been grouped as "the protective shield." These strategies were employed in response to difficult emotions, typically fear or anxiety, and the primary function they served was emotion regulation for the worker. Strict adherence to processes and procedures was a source of comfort for many:

> If you have quite structured processes then I think it certainly does give me that reassurance otherwise it would be quite unsettling. I'm very thorough and I'm not someone to not follow through with processes or procedures…this is probably translating to my level of anxiety…but I know that if I follow the pathway, then I can be reassured that that's done. It's not something that I can be worried about. (SW17)

In this quote, the respondent's strict adherence to policy and procedure appeared to help alleviate "anxiety" and prevent excessive worrying. While the actions are undertaken as a part of clinical care, this suggests policies and procedures serve as an emotion regulation tool for the respondent.

The next strategy was risk assessment. As with other strategies used in the protective shield, the emotion regulation function of risk assessment was evident:

> If you know that everyone's doing the same thing it's much more protective. It's so comforting having an assessment tool…if that was taken away…that would just terrify me because I think I'd just be so risk-averse and just be like "no one's safe" because it would make me feel better. (SW7)

Here it is evident the purpose attributed to risk assessment is to appease the social worker's discomfort, with minimal attention given to the goal of ascertaining the person's level of risk. The true purpose is evident as the respondent elaborates on their risk assessment process:

> You pretty much just went down the line to make sure they scored low…so you can kind of not involve anyone else and confidently say that you think that they're okay based on this arbitrary tool, which you can never predict anyway, but like it was just for your own notes. (SW7)

This extract reinforces the true purpose of risk assessment as seen by the respondent who described it as serving a valuable emotion regulation purpose, despite feeling it lacked validity and was ultimately "just for your own notes."

Risk management functioned in a similar way, with decisions being responsive to emotions:

> You carry a lot of anxiety around people's safety…nine times out of 10, you put someone in an ambulance and send them to ED…in the end, it's like, I'm doing this so I can get home, and I don't get that discussion in the morning, "remember that person you sent home last night?" (MH1)

This stark extract highlights that risk management decisions were, at times, primarily about emotion regulation for the health professional. As well as being primarily about emotion regulation, many of these strategies were resource intensive by requiring considerable staffing resources. The following comment highlights risk-averse strategies of thorough documentation and sharing risk between team members:

> Being frightened of things like coroner's….we're taught at university how important documentation is and cover, cover, cover, cover yourself…I will get a colleague to read over my documentation sometimes or I will read it out loud…Or I'll get my team leader or manager, just making sure that I've documented that I've had those discussions with someone higher…that helps share the blame. (MH10)

Thorough documentation can be a useful clinical tool for reminding a clinician of important therapeutic issues that have been covered. In this case it is evident that the purpose of thorough documentation is not to enhance therapeutic care but rather it is to protect the clinician from a perceived legal risk "cover, cover, cover, cover yourself." Thorough documentation appears to be resource intensive involving very close attention from the worker with input from their colleagues.

Theme 7: Evaluating safety and meaning

All respondents to varying degrees were concerned with some or all of the outcomes described in the "hierarchy of fears" theme and engaged in protection seeking behaviour described in the "protective shield" theme. Considerable variation occurred in the extent to which respondents felt burdened by operating in this context of fear and in how meaningful they found evaluation of their work. For example, some respondents perceived organisational review processes as tools that helped health professionals and organisations to learn from mistakes:

> I don't think if there is an adverse outcome, or a near miss, that we can just say as an organisation, oh well, that just happened, and so we just let that one go. We actually do need to look back, and I think we owe it to the people that use our health service. We do owe it to them to look back and to sort of critically analyse: What happened? Where were the gaps? What worked well?…and then put some learnings and some structures in place, to try and prevent it from happening again. (SW3)

The process of looking back on past mistakes is described as productive and healthy. This suggests the respondent views their work as meaningful and virtuous "we owe it to the people." The "my work is meaningful" belief is evident in this account.

The following response highlights how some colleagues have felt unsupported by the organisation following adverse events:

> Staff members have been...their positions have been terminated...For acting outside of the policies and procedures. I think it says to some people that you're not supported... I don't know the ins and outs of those individual circumstances. And I imagine if these people have been terminated, they've done the wrong thing. (MH10)

In this response, the "I am safe" belief is evident. The respondent considers the views held by colleagues that the organisation will allocate blame after an adverse event are erroneous and that this will only occur if "they've done the wrong thing". This affords the respondent a sense of control: do not do the wrong thing and the negative outcome of termination will not affect them.

Responses aligned with either the "I am not safe" or "my work has lost meaning" beliefs, were consistently anchored in a dissatisfaction with risk assessment or risk management:

> I contemplate it all the time because I went to university and learned all about risk and how important it was for other people to establish your risk of if you're going to harm yourself... sometimes it makes me really, really angry that the risk assessment stops you from doing some really good work... I just think the whole system's broken myself. It shouldn't be up to me to keep you alive. I can help you and hold your hand...but that's where it ends. (MH12)

This account provides an example of the "my work has lost meaning" belief "the whole system's broken." The loss of meaning is firmly tied to the risk management paradigm, "risk assessment stops you from doing some really good work." In contrast, respondents who reached alternate conclusions did not reference the risk management paradigm and valued organisational practices such as reviewing adverse events to learn from mistakes, an endeavour which can be viewed as a mechanism of the risk management paradigm:

> The volume of risk assessment...it does interfere with the normal work we're doing. You kind of have to ask people, do they feel safe? Do you have any thoughts to harm yourself? Or harm other people? Every single day, twice a day...We're trying to say good night, and oh, since you're awake, can I ask you if you want to kill yourself? (MH13)

Discussion

This research found that social workers and multidisciplinary mental health professionals' perceptions and understandings of risk have a strong influence on subsequent decision-making and service provision. Of particular concern is that these decisions are often based upon fear of personal and professional repercussions rather than consumers' best interests. This raises significant concerns for ethical practice and consumer empowerment and self-determination. These findings support previous research that indicates risk assessment is considered to be an important element of practice (Clancy et al., 2014; Grotto et al., 2014; Wand et al., 2015). Perceptions of risk are important in resource allocation and have a major influence on worker and organisational responses (Clancy et al., 2014).

Risk assessment practices are found to be varied in mental health and general health services with a higher priority placed on risk assessment in mental health services than in IPV services (Clancy et al., 2014; Cattaneo & Chapman, 2011; Grotto et al., 2014; State of Victoria, 2016). Fear of being found negligent and blame were found to be main drivers in mental health risk assessments and decision-making and practices. This can detract from a consumer-centred approach by shifting the focus to worker self-protection and organisational defence (Manuel & Crowe, 2014). Consistent with prior research our study also found that there were major differences in role expectation and risk assessment according to service context (McCulloch et al., 2016; State of Victoria, 2016). The current study findings highlight the centrality of notions of "risk ownership" and emotions, specifically anxiety and fear. Risk assessment appeared to serve an emotion regulation function in relation to the seven specific themes identified. These emotions lead to processes which are, arguably, excessively thorough. As such, perceived risk is costly. Concerns with legal risk exist and resources are allocated to this but our findings suggest clinicians and managers may have a poor understanding of this risk type. The main concern highlighted is that, in all of the heightened emotion and focus on rational evidence-based assessment processes, the needs and fears of the person seeking assistance can be over-ridden or not fully identified, acknowledged and responded to appropriately.

Conclusion

The findings of this qualitative exploratory study provide increased knowledge for understanding how social workers and multidisciplinary mental health professionals perceive risk, how perceived risk shapes decision making and differences in decision-making processes. These findings highlight the tensions between risk-averse organisational cultures and practices and ethical concerns of consumer empowerment and self-determination that ultimately include some degree of risk-taking. These findings have implications for further research and social work education on risk assessment, decision-making and appropriate social work responses. This includes appropriate knowledge and skill development in both mental health and intimate partner violence that is focused on ethical considerations and includes medico-legal aspects. Further education and research on "risk ownership" and assessment and decision-making processes that prioritise consumer needs and fears while also addressing the fears and needs of workers and organisations is required.

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