Assessing Risk: What You MUST Know

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Risk Assessment Fundamentals

- Risk: the likelihood of harm
- Assessment: Process, not event
- Multi-disciplinary
- Inductive
- Individualized
- Systematic
- Based in risk factors, base rate data
- A weighing of risks/protective factors
- Structured clinical judgment

Dube G, 1997; Simon RI, 2002, 2006; APA, 2003-2005

Major Topics of Attention

- Violence
  - 17-50% of committed inpts assault (Choe et al, 2008)
  - 10-33% of nurses assaulted
  - 1+ physical assault/staff/yr
- Suicide
  - 90% of completers are mentally ill (MI)
  - 30,000+ deaths/year
  - Rare event
  - Not a matter of prediction

A Framework

- Demographic/dispositional factors
- Historical
- Situational/contextual
- Clinical
- Individual/unique
  - Mnemonic: DISCHarge

Demographic/Dispositional

- Violence (in schizophrenia)
  - Male
  - Poor
  - Unskilled
  - Uneducated
  - Unmarried
  - ASPD

APA, 2004

Demographic/Dispositional

- Suicide (general)
  - Male
  - Widowed, divorced, single
  - Elderly, adolescent
  - White
  - Gay, lesbian, bisexual orientation
  - BPD

APA, 2003

Historical

- Violence
  - History
    - Frequency
    - Recency
    - Severity
  - Age of onset; early onset of MI
  - Prior/childhood violence or abuse
  - Arrests, father's arrest/drug use
  - Aggression+anxiety at admission

Historical

- Suicide
  - Recent attempt (of high lethality/secrecy, in 1st yr s/p)
  - Past attempt
  - Abuse (10x)
  - Partner violence
  - Treatment intensity
  - Recent change in Rx setting/intensity
  - Recent discharge
  - Chronic illness (neuro, CA, HIV)
  - Good premorbid/intellectual fn (schiz)

Situational/Contextual

- Violence & Suicide
  - Stressors (family, work)
  - Supports (home, peers)
  - Access to weapons (training?)
  - Access to victims (at work, in a gang)
  - Substances (even on-grounds passes)
  - Context/pattern of prior behavior

Clinical

- Violence
  - MacArthur Violence Risk Study
    - No major mental d/o
    - Psychopathy
    - Violent fantasies
  - Schizophrenia (APA, 2004)
    - Positive symptoms
    - Paranoia
    - Bizarre behaviors
  - Other
    - Substance abuse (current, recent, at last opportunity)
    - Thought Control Override
    - Hostility/anger
    - Anxiety
    - Cogn/neuro impairment

Clinical

- Suicide (APA, 2003)
  - Degree of suicidality/SI
  - Presence of plan
  - Availability of means
  - Lethality
  - Intent
  - Rigid thinking, thought constriction, all-or-nothing
  - Eating d/o, MDD, SA (higher SMR); not MR
  - Inpatient setting without specific risk, but…
    - Extreme agitation or anxiety
    - Rapidly fluctuating course

Individual/Unique

- Violence (name the risk category)
  - Age, personality
  - Prior events
  - Symptoms of illness
  - Triggers
  - Only when drinking

    - Don’t forget protective factors

Individual/Unique

- Suicide (provide the example)
  - Demographic/dispositional
  - Historical
  - Situational/contextual
  - Clinical
  - Individual/unique

    - Don’t forget protective factors

Protective Factors

- Suicide
  - Positive coping skills
  - Positive problem-solving skills
  - Positive social support
  - Positive therapeutic relationship
  - Children/pregnancy
  - Religiosity
  - Reality testing
  - Sense of responsibility for family

APA, 2003

Categorization

- Low, medium, high
- Clinically informed
- With sufficient information
- From sufficient sources
- Judgment call
- Weighing of factors
  - by Relevance
  - Frequency
  - Recency
  - Likelihood
  - Severity

Final Touches

- Documentation
  - Factors (+/-), reasoning
  - Are factors acute, modifiable, treatable?
  - Suggest Rx plan
- Standard of Care
  - Systematic
    - not perfect
    - not exhaustive
  - Foreseeable
    - reasonable anticipation
    - probabilistic, not scientific
- Update the assessment
- Beware checklists & contracts

Assessing Risks II

Unsettled Questions
- Are the mentally ill dangerous?
- Does treatment work?
- What is the best assessment approach?

Case Studies
- Mine
- Yours

Unsettled Questions

- Are the mentally Ill dangerous?
  - Predictors similar to general population (esp. SA)
  - Rare serious injury or death
  - Rare use of weapons
  - Less likely to assault strangers
  - Less likely to assault in public places
  - More likely to assault family
  - Slightly greater risk overall, but not a good policy answer (encourages inappropriate fear, expectation)

Steadman et al, 1998; Torrey et al, 2008; Choe et al, 2008

Does Treatment Work?

- Yes, but…
  - MacArthur: more Rx sessions, less violence
  - Kendra's law commission, 2005
  - Invol outpt commitment (Swanson, 2000)
  - Most predictors are socioeconomic
    - Access to goods and services
    - Housing
    - Poverty
  - Treatment must align with diagnosis

Model Algorithm

Glancy GD & Knott TF

CPA Bulletin 2003; 35(1): 13-18

Criteria: intervention ranked by strength of research

Glancy Model Algorithm

If no functional mental illness

- If +EEG findings: CBM, VPA 1st
- In dementia, brain injury, MR: mood stabilizer 1st, then β-blockers, trazodone, buspirone, atypical anti-psychotics (APs)

If Schizophrenia/Schizoaffective d/o

- conventional APs (with bz only acutely)
- clozapine
- 2d line: adjunct mood stabilizer, β-blockers, buspirone

Glancy Model (cont.)

If Affective d/o

- Depression: SRIs ± buspirone or β-blocker
- Bipolar: Mood stabilizers ± atypical APs

Other (antisocial, borderline pd; IED; ADHD)

- Consider CBT
- Substance abuse Rx
- Use SRIs among 1st meds
- Then: b-blockers, mood stabilizers, buspirone, trazodone

Which Assessment Approach is Best?

- Actuarial vs. clinical
- Actuarial generally outperforms clinical
- But depends on base rate and cut-off points
- Decisions require clinical reasoning
  - Whether to hospitalize
  - …discharge
  - …leverage
  - …support

Mossman, 1994; Hart, 2007; Buchanan, 2008

Instruments

- PCL-R (Hare 1991, 1998)
  - Semi-structured interview (1-2 hrs)
  - Requires psychosocial hx
  - Collateral informants
  - Selfish, unfeeling victimization+unstable, anti-social lifestyle
  - Expert administration and interpretation
- VRAG (Harris et al, 1993)
  - 12 characteristics (e.g., age, marital status, criminal hx)
- HCR-20 (Webster et al 1995, 1997)
  - Historical
    - Previous violence
    - Young age at first violence
    - SA, MI, ASPD
  - Clinical (dynamic, changeable)
    - Lack of insight
    - Active sxs
    - Unresponsive to Rx
  - Risk Mgt
    - Poor plans
    - Lack of support
    - Noncompliance

“I can’t believe Richard gave me homework”

- Anniversary reactions
  - Some imperfect epidemiologic connections
  - Psychoanalytic basis
  - Not a primary predictor in large studies
  - But still part of clinical lore

Case A

- 31 yo WF with hx of PTSD, bpd, ASPD, polysubstance abuse on evaluation for treatment in prison. Multiple past attempts at self-injury, assaults on others. Failure of multiple medication trials, treatment plans. Highly intelligent, has been employed in the community, and has contact with family/children. What are risks of violence/suicide in the hospital? Upon discharge?

Case B

- 45 yo WM with dx of chronic schizophrenia. Treated on last stage of Texas Medication Algorithm Project. Weekly assaults, almost always 4-6 pm, until recent trial of anti-depressant and beginning of music intervention. Now assault-free for 4 months. What is risk of violence in hospital?