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

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)

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


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?