HETI
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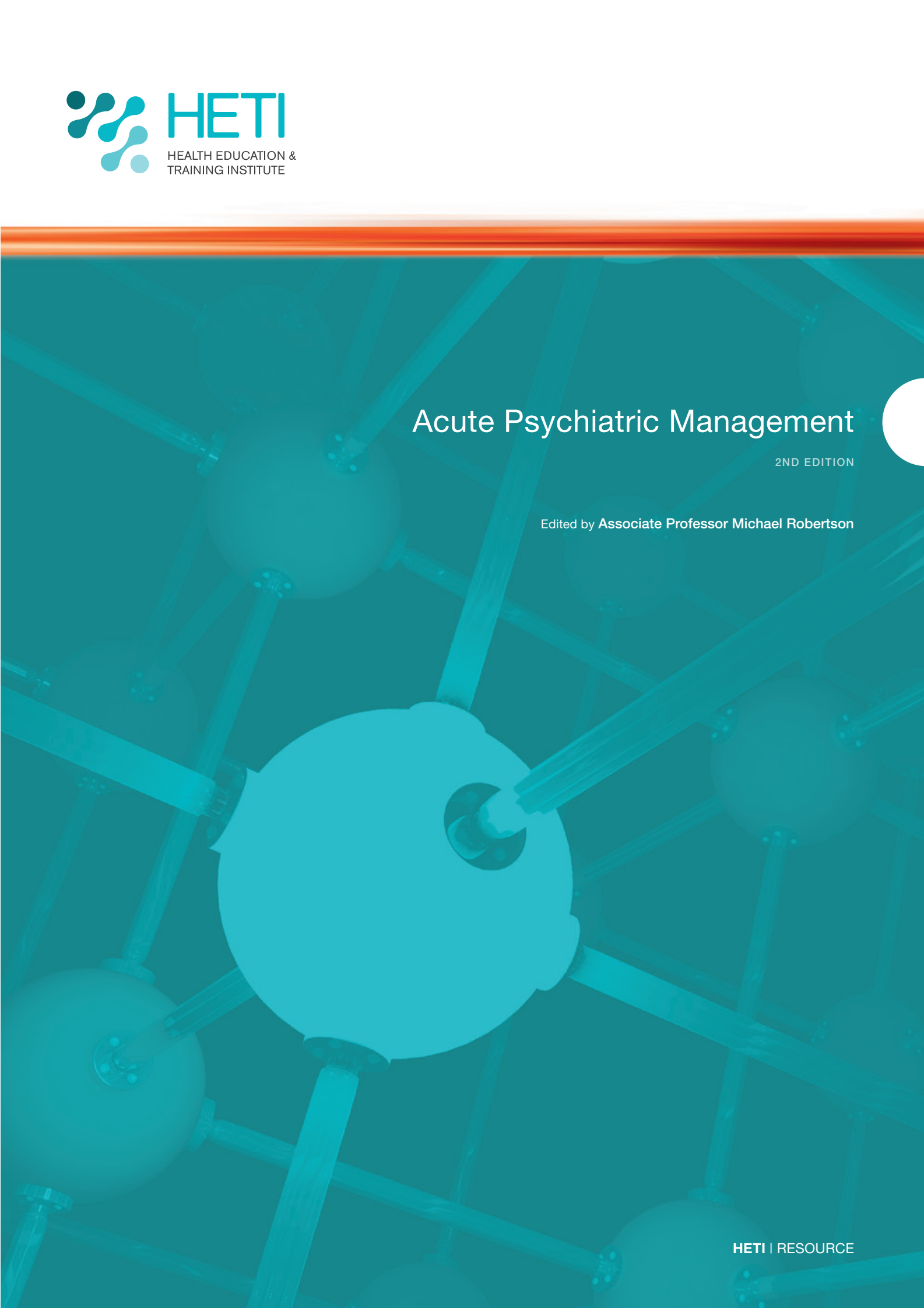
Acute Psychiatric Management

2ND EDITION

Edited by **Associate Professor Michael Robertson**



HETI | RESOURCE

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Contents

Foreword

A clinical encounter with a patient suffering an acute psychiatric episode is likely to occur early in the career of many junior doctors. For many this is their first experience in the emergency department or in out-of-hours practice. This text is a straightforward guide to management options for acute psychiatric conditions. It will certainly help junior doctors prepare for managing what is often a very stressful situation. It is not often that we have a text written specifically with the NSW public health system in mind. The Editorial Group who prepared this text are all prominent psychiatrists working within NSW mental health services, and they have created an excellent resource for all clinicians involved in psychiatry training. I am pleased that the Health Education and Training Institute (HETI) and HETI's Psychiatry State Training Council have been able to support the Editorial Group in this work. HETI has made this text available to all junior doctors and their supervisors via the HETI website, and I hope that it will help junior doctors manage the care of patients with acute psychiatric conditions confidently.

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Introduction

The commencement of psychiatric training is a daunting task for any medical officer. Whilst exposure to mental illness and the institutional systems which operate around it may occur during graduate medical training programs and some junior resident medical officer rotations, nothing prepares the new trainee in psychiatry for their many responsibilities in this early phase of their careers.

Didactic content is provided for psychiatric trainees by the NSW Institute of Psychiatry and local training networks, however information on how to provide safe and effective care to people with mental illnesses is invariably acquired in the course of working in acute mental health settings. With this in mind, the contributors to this resource have attempted to provide accessible overviews of the kind of information which might be needed in the course of working in acute adult mental health settings.

This resource is set out in a series of themes. It does not seek to provide a comprehensive reference, nor does it attempt to summarise text-books or the current literature in psychiatry. Each contributor has written a brief account of different topics of relevance to practice in acute adult psychiatry. The style of writing aims to provide the reader with a grasp of the necessary information, which can be absorbed rapidly by the inexperienced psychiatric trainee. Whilst not a manual of 'how to be a registrar', it aims to provide a ready reference to both common and classic challenges in the setting of acute adult mental health.

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1

1

Assessment

LEARNING OBJECTIVES

- Describe the components of a comprehensive risk assessment
- Identify the variables associated with increase risk of adversity
- Formulate a comprehensive management plan based on assessment of risk

Comprehensive approach to risk assessment

Introduction

The notion of "risk assessment" is usually considered the process of estimating the likelihood of dangerousness, such as completed suicide or harm to others. In the insurance industry, actuarial assessment is a mathematical discipline aimed at computing a probability of adversity, based upon a broad consideration of variables. Such an approach has been applied in criminology in the prediction of recidivism in sexual offences[1]. Actuarial approaches to risk assessment in psychiatry attempt to integrate different situational and clinical factors in different populations at different times[2]. Actuarial approaches have been challenged by their aims to predict, rather than anticipate and prevent dangerousness in psychiatry[3]. The actuarial approach to risk assessment provides little more than passive prediction[4] and is inferior to a standardised clinical assessment[5]. The apparent superiority of clinical judgement appears to relate to its emphasis upon prevention, rather than prediction. The distinction between prevention and prediction is important, in that a recent UK review indicated that whilst around 28% of dangerousness was predictable, 65% was preventable[6]. The clinical approach to risk assessment is also more appropriate in psychiatry, as it links the clinical tasks of gathering data, synthesising data and formulating a plan of action to alter the factors likely leading to a dangerous act on the part of a person suffering mental illness.

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1. Silver E, Chow-Martin L. A multiple models approach to assessing recidivism: Implications for judicial decision making. *Criminal Justice and Behavior.* 2002) 29: 538–568.
2. Monhan J. The prediction of violent behavior: Toward a second generation of theory and policy". *American Journal of Psychiatry.* 1984);141:10-15.
3. Bauer A, Rosca P, Khawalled R, et al. Dangerousness and risk assessment: the state of the art. *Israel Journal of Psychiatry and Related Sciences.* 2003);40:182-90.
4. Hart S. The role of psychopathy in assessing risk for violence: conceptual and methodological issues. *Legal and Criminological Psychology.* 1998);3:121-137.
5. Douglas K, Kropp P. A prevention-based paradigm for violence risk assessment: clinical and research applications. *Criminal Justice and Behaviour.* 2002);29: 617-658.
6. Munro E, Rumgay J. Role of risk assessment in reducing homicides by people with mental illness. *British Journal of Psychiatry.* 2000);176:116-120.

In this chapter, the approach to the assessment of risk moves this process beyond the short-term estimation of harm to a longer term and broader account of adversity facing the patient, considering many different individual, demographic and situational factors. In this approach, the term "risk assessment" refers to the propensity of an episode of mental illness to create adversity in the life of a patient in a broad array of domains.

Physical or emotional harm
• Harm to others
• Suicide or deliberate self-harm
• Sexual assault or exploitation
• Latrogenic insult
• Traumatic stress before and during episode of care
Incomplete recovery
• Symptom persistence
• Treatment non-adherence
• Family or cultural resistance
• Co-morbid psychiatric disorder
• Post-illness impairment of personality
• Brain injury
Chronicity of impairment
• Effect of illness process
• Stigma
• Incapacity to participate in comprehensive treatment
• Problems of access
• Effect of lifestyle
• Family and social determinants
Deterioration physical health
• Latrogenic complications
• Neglect of self care
• Problems of access
Long-term impairment of psychosocial and interpersonal functioning
• Vocational impairment or job loss
• Relationship disruption
• Developmental disruption i.e. of Eriksonian tasks
• Existential aspects of illness experience

Table 1 – The main components to the actuarial approach to risk

The components of the comprehensive approach to risk assessment

The main domains of an actuarial approach to risk are outlined in Table 1. The short-term risk of physical or emotional harm is usually the main focus in the acute phase of care. Incomplete recovery, via the persistence of psychiatric disturbance or the development of co-morbid psychiatric or physical disorder, is the usual focus of the 'post-acute' phase of care. Chronic disability, the effect of stigma and social disadvantage and the impact of illness on long term social, interpersonal and vocational function, as well as the person's experience of selfhood. Many components of the risk

assessment are addressed in more detail in other parts of this monograph. This chapter will focus upon assessment of risk of harm to others, risk of incomplete recovery and chronicity of impairment and longer term functioning.

Assessment of risk to others

Traditionally, there is an expectation of psychiatrists to accurately predict risk. Such an expectation is unrealistic in that the predictive capacity of psychiatrists in regards to future harm perpetrated by their patients has been shown to be low[6,7], with estimates of accuracy varying from 30-60%[8]. The principle failing of psychiatric risk assessment is a tendency to overstate risk[9].

Any assessment of the capacity for dangerousness to self or other integrates multiple dimensions of the patient's situation including situational factors in the patient's illness or immediate ecological setting, the pattern of previous dangerousness and the effectiveness of intervention. The strongest predictor of future 'dangerousness' is past dangerousness, but this in itself is a vacuous statement in the absence of consideration of the situational factors involved[10]. (e.g. A patient who becomes aggressive when the intensity of auditory hallucinations increases.) Thus, statements of potential for future dangerousness, rather than a "crystal ball" prediction are more methodologically sound.

The MacArthur risk assessment study[11], a large scale study of the factors associated with violence (Table 2) identified a number of variables associated with heightened risk of dangerousness –

Variable	Comment
Gender	Men more likely than women to be violent, but the difference was not large. Violence by women more likely to be directed against family members and to occur at home.
Prior violence	All measures of prior violence strongly related to future violence.
Childhood experiences	A history of child abuse or neglect and parental criminality was strongly associated with violent offending.
Neighborhood and race	Some trend of increased risk of aggression towards non-white members of the community, but this diminished when the neighborhood was considered 'disadvantaged'.
Diagnosis	A diagnosis of a major mental disorder – especially a diagnosis of schizophrenia – was associated with a *lower* rate of violence than a diagnosis of a personality or adjustment disorder. A co-morbid diagnosis of substance abuse was strongly predictive of violence.
Psychopathy	Psychopathy was the strongest risk factor identified.
Delusions[12]	The presence of delusions – or the type of delusions or the content of delusions – was not associated with violence. A generally "suspicious" attitude toward others was related to later violence.
Hallucinations	Hallucinations did not elevate the risk of violence. "Command" hallucinations specifically commanding a violent act increased risk, particularly when the voice is recognisable.[13]
Violent thoughts and anger	Thinking or daydreaming about harming others was associated with violence, particularly if the thoughts or daydreams were persistent. High levels of anger correlated with violence.

Table 2 – Summary of the MacArthur study

7. Steadman HJ, Cocozza JJ, 1980. "The prediction of dangerousness- Baxtrom: A case study". In: G. Cooke, ed. *The Role of the Forensic Psychologist.* Springfield, Il.: Thomas. (pp. 204-215).

8. Appelbaum P, Guthiel T. *Clinical Handbook of Psychiatry & the Law.* Philadelphia: Lippincott, Williams & Wilkins. 2007.

9. Levinson R, Ramsay G. Dangerousness, Stress, and Mental Health Evaluations. *Journal of Health and Social Behavior.* 1979);20:178-187.

10. Litwack TR. Assessments of dangerousness: Legal, research, and clinical developments. *Administration and-Policy-in-Mental-Health.* 1994);21:361-377.

11. Monahan J, Steadman H, Silver E, et al. *Rethinking Risk Assessment: The MacArthur Study of Mental Disorder and Violence.* New York: Oxford University Press. 2001.

12. Mullen P. Forensic Mental Health. *British Journal of Psychiatry.* 2000.

13. Junginger J. Command hallucinations and the prediction of dangerousness. *Psychiatric Services*. 1995);46:911-914.

Based upon the literature and clinical experience it is possible to accumulate a series of variables for risk of harm to others, with the expectation that the more modifiable variables will serve as the basis of a management plan.

The approach to the acute assessment of dangerousness requires consideration of both "static" and "dynamic" risk factors. Static risk factors are the components of a particular patient's presentation, which are not amenable to intervention, such as age, gender or aspects of a patient's previous history, such as a past history of violent offending. By contrast, dynamic risk factors are those which are potentially amenable to clinical intervention, such as active psychotic symptoms, problematic living circumstances or substance abuse. In formulating an assessment of the risk of particular patient poses to self or other, consideration of the dynamic factors of risk assessment. Dynamic risk factors may be quite changeable, such as the level of psychotic disturbance or acuity of a crisis in a person's life, or they may be stable such as personality traits or problematic interpersonal relationships (Table 3).

Static	Dynamic Stable	Dynamic Changable
• Age • Gender • Ethnicity • Intellectual disability • Social class • Educational level • Developmental trauma • Criminal history • History of previous dangerousness	• Treatment non-responsiveness • Personality • Interpersonal support network • Impulsivity • Problem solving capacity • Cognitive schema • Attribution style • Attachment style • Immature or primitive psychological defences	• Psychotic symptoms • Mood or anxiety symptoms • Substance use • Acute crisis • Social isolation • Unsatisfactory living situation • Treatment non-adherence

Table 3 – Static and Dynamic Risk Factors

The instrumental value of such an approach is that certain factors amenable to clinical intervention can be identified and implemented, thus potentially reducing risk. Identifying factors historically associated with increased risk of dangerousness in a particular patient serves the basis of a credible risk management plan. For example, a male patient has been previously aggressive in response to command hallucinations, which tend to worsen when there are changes to his living situation and concomitant increase in alcohol use. In this circumstance, the assessing clinician applies the above algorithm and identifies the risk variables of previous aggression, and the relationship of this to increased intensity of psychotic symptoms, alcohol use and disturbed living situation. The risk management plan thus follows along the lines of closer monitoring of psychotic symptoms and further treatment, strategies to avoid or reduce alcohol use and strategies to stabilize the patient's immediate living situation.

Psychometric Measurement of risk

The HCR 20[14] is one of a number of psychometric measures, which assess for the severity of risk, which integrates historical, current clinical and management factors (Figure 2). The HCR-20 has the benefit of being relatively sensitive to change on the clinical and risk-management scales. Other psychometric scales such as the Hare Psychopathy Checklist measure components of potential dangerousness.

[14] Webster C, Douglas K, Eaves D, Hart S, 1997. HCR-20: Assessing risk for violence (version 2). Burnaby, BC: Mental Health, Law, and Policy Institute, Simon Fraser University.