CrisisMonitor

Presented by: Remco de Winter, psychiatrist
Head of department of Emergency Psychiatry, Area The Hague Parnassia

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Roland van de Sande, Edwin Hellendoorn, Henk Nijman, Cees van der Staak, E. Noorthoorn, Niels Mulder

Objectives

- Pathways to consistent risk management strategies
- CrisisMonitor in clinical practice
- Research findings (cluster randomized controlled trail)

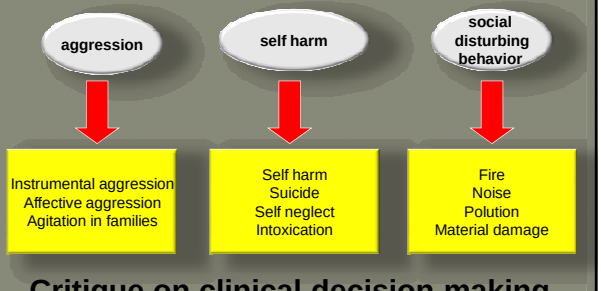
Risk management steering principles

Under- or overestimation of risk can be harmful for patients and staff!

Major challenges:

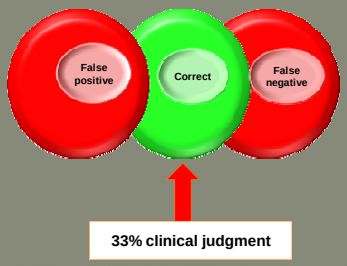
- Combat false positive risk judgments
  (Sharkey & Sharples,2003; O'Rourke & Bailes, 2006; Doyle & Dolan, 2002; Hawley e.a., 2006)
- Combat false negative risk judgments
  (Kapur e.a., 2000; Simon & Petch, 2002).

Danger types



Critique on clinical decision making

Risk assessment in psychiatric care



Instruments can **support** clinical decision making

Risk assessment modalities

Long term	Short term
History of violence	Mental state
Patient records analysis	Level of agitation
Escalation patterns	Social context

Indication and frequency ?

Symptoms and risk of escalation

AGGRESSION

- Agitation + delusion — high risk
- Agitation + high EE — high risk
- Delusion + drugs — high risk

How to acces this and why a broad screening?

SUICIDE

- Depression + impulsivity — high risk
- Depression + hopelessnes — high risk
- Postpsychotic depression — high risk
- Suïcidal + social isolation — high risk
- Depression + psychosis — high risk

Preferences of interventions

- **Patients:**
  - Close observation
  - Pro Re Nata medication
  - Time out
- **Staff:**
  - Close observation
  - Pro Re Nata medication
  - PICU referral

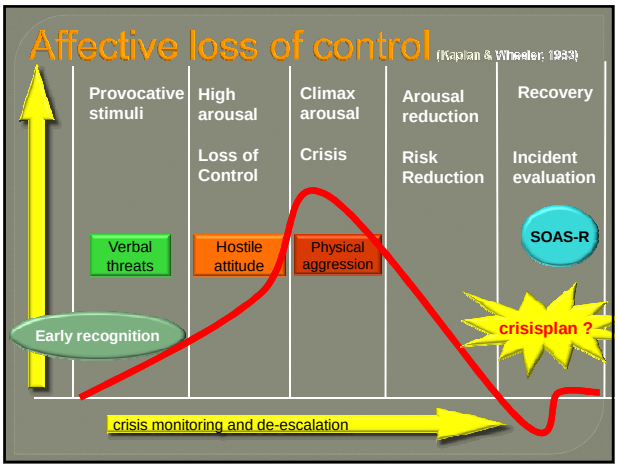
Remarkable finding:
Long history in mental health care is related to mild judgments of coercive interventions

Whittington, R, Bowers, L, Nolan,P, Simpson,A, Neil, L (2009) Approval ratings of inpatient coercive interventions in a national sample of mental health service users and staff in England , *Psychiatric Services*, 60,792-798

Risk management

the use of comprehensive risk assessment materials, followed by a properly developed plan is an absolute pre-requisite for the recognition, prevention and therapeutic management of violence" (UKCC, 2002, p. 22).

Risk assessment *"must be seen as an essential intervention, possibly the single most important intervention, in the therapeutic management of disturbed/violent behaviour"* (NICE, 2004, p. 44).



CrisisMonitor

- Kennedy Axis V (Kennedy, 2003)
- Broset Violence Checklist (Almvik et al,2001)
- Brief Psychiatric Rating Scale (Overall et al,1988)
- Schaal voor Gevaar (Mulder & van Baars,2004)
- Social dysfunction and Aggression Scale (Wistedt et al,1990)

Kennedy axis 5: Problem categorization

Psychological Impairment	Social Skills	Violence	ADL-Occupational	Substance Abuse	Medical Impairment	Ancillary Impairment

Every sub-scale should be rated regularly by nurses

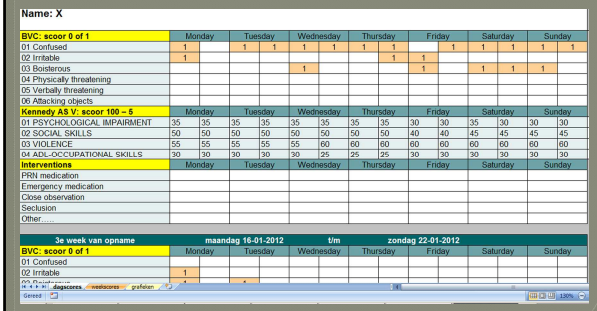
100-95-90-85-80-75-70-65-60-55-50-45-40-35-30-25-20-15-10-0

STRENGTH | RISK

Score outcomes are used to indentify recovery and relapse patterns of monitored patients in specific domains of functioning

Kennedy, J.A (2003) *Mastering the Kennedy Axis V: A New Psychiatric Assessment of Patient Functioning*

Risk profile (example)



Name: X

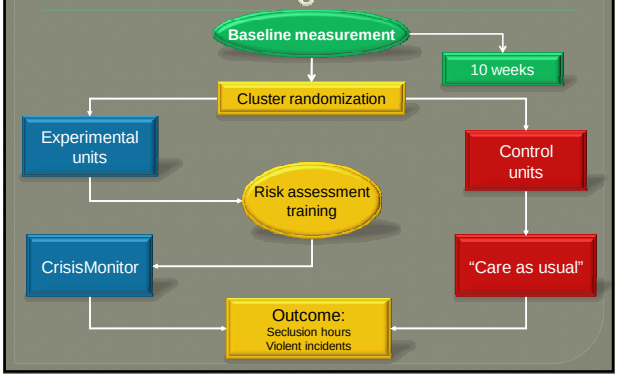
BVC: scoor 0 of 1	Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		Sunday	
01 Confused	1		1	1	1	1	1	1		1	1	1	1	1
02 Irritable	1							1	1					
03 Boisterous					1				1		1	1	1	
04 Physically threatening														
05 Verbally threatening														
06 Attacking objects														

Kennedy AS V. scoor 100 – 5	Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		Sunday	
01 PSYCHOLOGICAL IMPAIRMENT	35	35	35	35	35	35	35	35	30	30	35	30	30	30
02 SOCIAL SKILLS	50	50	50	50	50	50	50	50	40	40	45	45	45	45
03 VIOLENCE	55	55	55	55	55	60	60	60	60	60	60	60	60	60
04 ADL-OCCUPATIONAL SKILLS	30	30	30	30	30	25	25	25	30	30	30	30	30	30

Interventions	Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		Sunday	
PRN medication														
Emergency medication														
Close observation														
Seclusion														
Other.....														

3e week van opname	maandag 16-01-2012				t/m		zondag 22-01-2012							
BVC: scoor 0 of 1	Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		Sunday	
01 Confused														
02 Irritable	1													

Research design CrisisMonitor

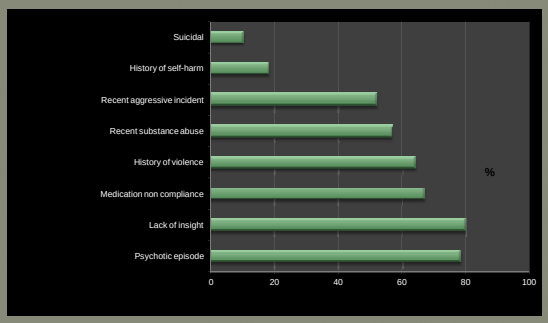


Main findings cluster RCT

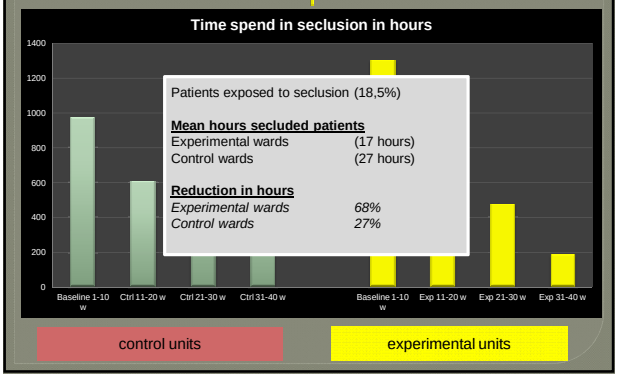
- Hours spend in seclusion
- Violent incidents

Identified risk factors at admission

(Baseline measurement in 4 acute wards N=183)



Results: hours spend in seclusion

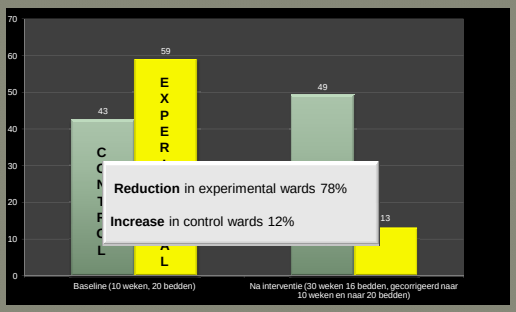


control units | experimental units

SDAS (Wistedt, et al,1990)

1. Verbal aggression
2. Directed verbal aggression
3. Agitation
4. Negativism
5. Anger
6. Social disturbing behavior
7. Physical violence to staff
8. Physical violence to others
9. Self Harm
10. Psychical violence to objects
11. Suicidal thoughts or tendency to suicidal behavior

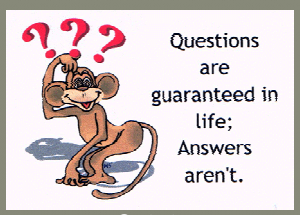
Results: aggressive incidents



Conclusion CrisisMonitor project

- Short term risk assessment can enhance safe practice
- Supports risk taking and risk control in the acute phase
- Should be combined with evidence informed interventions
- Can be helpful for care planning
- Will never totally replace clinical jugdement
- Teams need consistent clinical supervision

THANK YOU!



Contact:
roland.vandesande@hu.nl
r.dewinter@parnassia.nl
e.hellendoorn@parnassiabavogroep.nl