CrisisMonitor

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

January 2012 Maastricht

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

Objectives

Pathways to consistent risk management strategies

CrisisMonitor in clinical practice

Research findings (cluster randomized controlled trial)

Risk management steering principles

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

Major challenges:

Combat false positive risk judgments
(Sharkey & Shapira, 2005; O’Rourke & Stiles, 2000; Doyle & Eskin, 2002; Hankey et al., 2000)

Combat false negative risk judgments
(Kapur et al., 2000; Simon & Pesch, 2002)
Instrumental aggression
Affective aggression
Agitation in families
Self harm
Suicide
Self neglect
Intoxication
Fire
Noise
Pollution
Material damage

Critique on clinical decision making

Risk assessment in psychiatric care

Instruments can support clinical decision making

33% clinical judgment

Risk assessment modalities

Long term
- History of violence
- Patient records analysis
- Escalation patterns

Short term
- Mental state
- Level of agitation
- Social context

Indication and frequency?
Symptoms and risk of escalation

**AGGRESSION**
- Agitation + delusion: high risk
- Agitation + high EE: high risk
- Delusion + drugs: high risk

**SUICIDE**
- Depression + impulsivity: high risk
- Depression + hopelessness: high risk
- Postpsychotic depression: high risk
- Suicidal + social isolation: high risk
- Depression + psychosis: high risk

How to access this and why a broad screening?

Preferences of interventions

<table>
<thead>
<tr>
<th>Patients:</th>
<th>Staff:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Close observation</td>
<td>Close observation</td>
</tr>
<tr>
<td>Pro Re Nata medication</td>
<td>Pro Re Nata medication</td>
</tr>
<tr>
<td>Time out</td>
<td>PICU referral</td>
</tr>
</tbody>
</table>

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


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).
Provocative stimuli
High arousal
Loss of Control
Climax arousal
Risk Reduction
Arousal reduction
Crisis
Recovery
Incident evaluation
Verbal threats
Hostile attitude
Physical aggression
Early recognition

SOAS-R

Crisis monitoring and de-escalation

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)

Every sub-scale should be rated regularly by nurses.
Score outcomes are used to identify recovery and relapse patterns of monitored patients in specific domains of functioning.

**Risk profile (example)**

- Experimental units
- Control units
- Risk assessment training
- CrisisMonitor
- "Care as usual"

**Research design CrisisMonitor**

1. **Baseline measurement**
2. **Cluster randomization**
3. **Risk assessment training**
4. **Outcome:**
   - Hours spend in seclusion
   - Violent incidents

**Main findings cluster RCT**

- Hours spend in seclusion
- Violent incidents
Identified risk factors at admission

- Suicidal
- History of self-harm
- Recent aggression incident
- Recent substance abuse
- History of violence
- Medication non-compliance
- Lack of insight
- Psychotic episode

Results: hours spend in seclusion

- Patients exposed to seclusion (18.5%)
- Mean hours secluded patients
  - Control wards: 17 hours
  - Experimental wards: 27 hours

Reduction in hours
- Control wards: 27%
- Experimental wards: 68%

SDAS (Wistedt, et al., 1990)

- Verbal aggression
- Directed verbal aggression
- Agitation
- Negativism
- Anger
- Social disturbing behavior
- Physical violence to staff
- Physical violence to others
- Self Harm
- Psychical violence to objects
- Suicidal thoughts or tendency to suicidal behavior
Results: aggressive incidents

- Reduction in experimental wards: 78%
- Increase in control wards: 12%

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 judgement
- Teams need consistent clinical supervision

THANK YOU!

Questions are guaranteed in life; answers aren’t.

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