Ethical Risk Management and Decision Making

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Goals

a) What measures and algorithms can be used to assess risk

b) What populations those tools are useful for

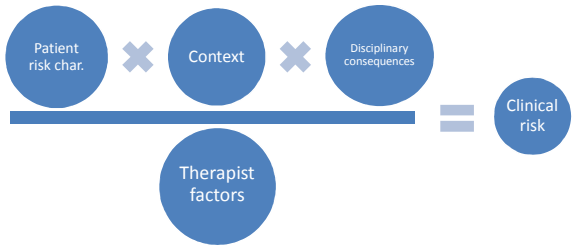
c) How to apply those tools in real-life situations

d) How those tools inform ethical decision making

Outline

- Operational definitions
- Evidence-based practice in risk assessment and management
- Empirically derived risk factors
- Methods of implementing EBP in RA/RM

Risk Calculation



Operational Definitions

- Risk
  - The likelihood of an event happening with potentially harmful or beneficial outcomes for self and others
  - e.g., suicide, self-harm, aggression/violence, and neglect

Morgan (2000)

Operational Definitions

- Risk assessment
  - A gathering of information and analysis of the potential outcomes of identified behaviors
  - Identifying specific risk factors of relevance to an individual, as well as their context
  - Requires linking historical information to current circumstances, to anticipate possible future change

Morgan (2000)

Feedback

What methods of risk assessment are you familiar with, and what is required for you to use?

Operational Definitions

- Risk management
  - A statement of plans and allocation of responsibilities for translating collective decisions into actions
  - Should name all the people involved in the treatment and support, including the client and appropriate informal carers
  - Should also clearly identify the dates for reviewing the assessment and management plans

Morgan (2000)

Assessment & Management

- Should **not** be seen as distinct activities, but instead as part of an overall process
- One leads into and informs the other (similar to case formulation and treatment planning)

Feedback

How do you plan risk management?

Ethical or Legal Duties in RA/RM

- Client – help them avoid harmful consequences (suicide, violence)
- Staff – protecting them from violence perpetrated by those utilizing services
- Public – protecting them from violence perpetrated by service utilizers

Hart et al. (2011)

Operational Definitions

- Evidence-based practice
  - "…the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients."
- This is an increasingly important aspect of behavioral health care

Sackett et al. (1996)

Ethics & EBP

- Practicing ethically means making the best possible decisions in terms of assessment, treatment, and decision-making
- Using EBP means using the best possible science to guide assessment, treatment, and decision-making
- Practicing ethically, in today's world, means to practice using evidence-based methods

Why is EBP in RA/RM Important?

- Clients present with multiple challenges, including high rates of
  - Violence
  - Self-harm
  - Homelessness
  - Suicide attempts
  - Risk of victimization

Why is EBP in RA/RM Important?

- Using valid and reliable means of assessing risk is beneficial to both clients and clinicians
- Protects clients by ensuring most accurate methods of negating risk
- Protects clinicians by mitigating a failure to adequately assess and manage risk

EBP in RA/RM

- Enormous growth in RA/RM research over past 20 years
- Today, clinicians do not (and should not) have to rely on personal experience and intuition
- Instead, numerous problem-, setting-, and population-specific procedures are available

Types of RA/RM

- Discretionary
  - Unstructured professional judgment
  - Anamnestic risk assessment
  - Structured professional judgment*
- Non-discretionary
  - Actuarial use of psychological tests
  - Actuarial risk assessment instruments*

* evidence-based methods

Hart et al. (2011)

Feedback

Which of these kinds have *you* employed during your career?

EBP RA/RM Features

- Conducted by a professional who can talk competently about accuracy indices
- Employs an acceptable assessment approach
- Does not rely heavily on psychological testing
- Examines both individual and environmental or contextual factors

EBP RA/RM Features

- Identifies empirically established risk and protective factors
- Offers relative estimates of risk
- Acknowledges limitations of ability
- Identifies interventions and conditions which may increase or decrease risk

Structured Professional Judgment

- In SPJ (aka guided clinical judgment), decision-making is assisted by guidelines that have been developed to reflect the "state of the discipline" with respect to scientific knowledge and professional practice
- In other words, this is an ethical, evidence-based way to make decisions

Hart et al. (2011)

SPJ as EBP

- Go beyond mere prediction (actuarial) methods to focus on prevention
- Conceptualize risk in terms of nature, severity, imminence, frequency, duration, and likelihood
- Assists the development of RM plans based on an understanding of the causes of past harm

Elements of SPJ

1. Consideration of empirically derived historical (static, largely unchangeable) risk factors relevant to the outcome in question
2. Systematic consideration of relevant dynamic (changeable) risk factors

Elements of SPJ

3. Methodical anamnestic analysis of past episodes of concern (e.g. past episodes of self-harm of violence)
4. Final risk judgment that, although structured by consideration of empirical risk factors, is arrived at by using clinical judgment rather than by an actuarial formula

Benefits of SPJ

- Ensures that clinicians assessing risk will
  - Ask the right questions
  - Efficiently analyze historical information
  - Produce judgments that are transparent
  - Minimize the effect of cognitive biases
- Improves cross-disciplinary communication between individual clinicians and services

Benefits of SPJ

- Can help in a number of other key ways
  - Isolate key factors to form risk management plans
  - Sharpen predictions
  - Discern change in individual clients (and groups) over time and according to circumstance
  - The design of new facilities and programs
  - Guide how clinicians discuss risk issues with clients

SPJ in Action

1. Systematic analysis of historical factors
2. Systematic analysis of dynamic factors
3. Creation of explanatory model
4. Development of risk management plan

QUIZ TIME!

- **Structured professional judgment:**
  1) is based on the clinician's intuition
  2) increases the transparency of the decision-making process
  3) takes into account fluctuations in the patient's circumstances
  4) is a mathematically based approach
  5) takes account of static, stable, dynamic and future risk factors.

QUIZ TIME!

- **Structured professional judgment:**
  1) is based on the clinician's intuition **F**
  2) increases the transparency of the decision-making process **T**
  3) takes into account fluctuations in the patient's circumstances **T**
  4) is a mathematically based approach **F**
  5) takes account of static, stable, dynamic and future risk factors **T**

Risk Factors for Harm to Self or Others

Screening

- The SPJ approach relies heavily on knowing which factors are predictive of risk
- These factors are broadly divided into two categories
  - Static (cannot or are not likely to change)
  - Dynamic (amenable to change)

Otto (2000)

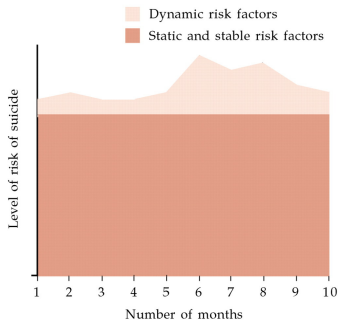


Fig. 1 Chronic high risk due to static and stable risk factors.

Bouch J , Marshall J J APT 2005;11:84-91

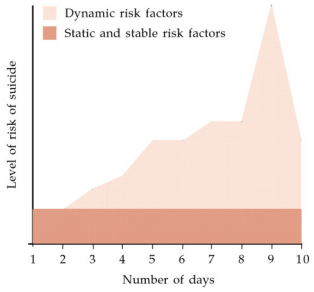


Fig. 2 Rapid onset and resolution of dynamic risk factors.

Bouch J , Marshall J J APT 2005;11:84-91

Empirical Risk Factors for Violence

- Individual / personal factors
- Gender
  - Males are at a higher risk in the general population, this does not appear to be the case for psychiatric patients
  - Males be engaging in *more* violent behavior, not *more frequent*

Empirical Risk Factors for Violence

- Age
  - Higher rates among younger populations, massive decrease after age 40
  - May *not* be the case during acute, highly symptomatic times, though
- SES
  - Lower SES is related to an increased risk, regardless of race/ethnicity

Empirical Risk Factors for Violence

- Prior violence
  - Best predictor of chance of future violence
  - More episodes indicate higher chance in future
- Age at first offence
  - Especially if prior to age 12

Empirical Risk Factors for Violence

- History of abuse as child / domestic abuse
  - Likely due to modeling and reinforcement
- Low intelligence/neurological impairment
  - Impacts decision making, planning, and judgment
- Presence of substance use disorder
  - Second to past violence in predicting future risk

Empirical Risk Factors for Violence

- Psychotic disorders
  - Seems to be "threat/control override" symptoms rather than any psychosis
  - Perceptions of threat or that thoughts/actions are being controlled externally
- Bipolar disorder
  - When in manic phase only, likely due to impulsivity and impaired judgment

Empirical Risk Factors for Violence

- Personality disorders
  - Psychopathy and antisocial PD
  - Borderline and narcisstic PD
- Anger / impulsivity
  - Huge amounts of overlap; seen as predictors outside of only disorders that cause them

Empirical Risk Factors for Violence

- Environmental / contextual factors
- Stress and social support
  - High stress and low social contact are risks
- Weapon and substance availability
  - Access, interest, and past use

Empirical Risk Factors for Violence

- Victim availability
  - Family members are most often harmed group
- Setting
  - Males more likely to aggress in public, females in private/home

Empirical Risk Factors for Suicide

- Static and stable factors
  - History of self-harm
  - Seriousness of previous suicidality
  - Previous hospitalization
  - History of mental disorder
  - History of substance use disorder
  - Personality disorder/traits
  - Childhood adversity
  - Family history of suicide
  - Age, gender, and marital status

Empirical Risk Factors for Suicide

- Dynamic risk factors for suicide
  - Suicidal ideation, communication and intent
  - Hopelessness
  - Active psychological symptoms
  - Treatment adherence
  - Substance use
  - Psychiatric admission and discharge
  - Psychosocial stress
  - Problem-solving deficits

Empirical Risk Factors for Suicide

- Future risk factors for suicide
  - Access to preferred method of suicide
  - Future service contact
  - Future response to drug treatment
  - Future response to psychosocial intervention
  - Future stress

QUIZ TIME!

- **Static risk factors:**
  1) are of no importance in determining the level of risk of suicide or violence
  2) influence the type of treatment intervention chosen
  3) may change very slowly over time
  4) are always high in completed suicides
  5) may render a patient at high risk of suicide or violence throughout life

QUIZ TIME!

- **Static risk factors:**
  1) are of no importance in determining the level of risk of suicide or violence **F**
  2) influence the type of treatment intervention chosen **F**
  3) may change very slowly over time **F**
  4) are always high in completed suicides **F**
  5) may render a patient at high risk of suicide or violence throughout life **T**

QUIZ TIME!

- **Dynamic risk factors:**
  1) may change in response to treatment
  2) anticipate changes in the patient's circumstances
  3) change only very slowly over time
  4) may change suddenly, leading to unpredictable suicide
  5) will never change throughout a patient's lifetime

QUIZ TIME!

- **Dynamic risk factors:**
  1) may change in response to treatment **T**
  2) anticipate changes in the patient's circumstances **F**
  3) change only very slowly over time **F**
  4) may change suddenly, leading to unpredictable suicide or violence **T**
  5) will never change throughout a patient's lifetime **F**

Methods for Implementing SPJ

SPJ Tools

- Numerous tools have been developed to assist in and guide the SPJ process
- Some are for very specific types of risk, while others are more global in nature

Sex Offender Need Assessment Rating

- SONAR focuses exclusively on dynamic factors divided "stable" and "acute" categories
- Stable ("trait")
  - sexual self-regulation
  - general self-regulation
  - sexual deviant preference
  - Attitudes supportive of sexual offending
- Acute ("state")
  - Victim access
  - Anger and hostility
  - Substance abuse

Risk for Sexual Violence Protocol

- RSVP identifies static and dynamic risk factors based on literature review and consultation with clinicians and academics
- Mainly designed to be used with males over the age of eighteen with a known or suspected history of sexual violence.

Psychopathy Checklist - Revised

- PCL-R measures psychopathy among adults
- 20 items, each weighted on a scale of 0 (absent) to 2 (severe)
- Ideally requires records, files, reports, interviews and questionnaires from a variety of sources, such as police, courts, past parole officers and correctional staff

Level of Service Inventory-Revised

- LSI-R is the most comprehensive and popular instrument for assessing offender risk
- Assesses risk based on a broad array of eight different categories ("Big-8")
  - Antisocial attitudes
  - Antisocial thoughts, cognitions and ways of thinking
  - Antisocial personality
  - Antisocial history
  - Employment
  - Family
  - Leisure and recreational activities
  - Substance abuse problems
  - Antisocial peers or criminal associates

SAVRY

- The Structured Assessment for Violence Risk Among Youth is divided into four sections

1. Historical measures past history of violence, exposure to violence in the home, childhood maltreatment, and poor school achievement
2. Clinical measures attitudes, impulsivity, anger, empathy, compliance

SAVRY

3. Social-Contextual measures stress, coping, peer rejection, parental management
4. Protective includes prosocial activities, social support, attachments and bonds

Spousal Abuse Risk Assessment

- SARA includes 20 items – 10 general and 10 spousal violence factors
- General items measure past history of substance abuse, violence, and emotional problems
- Spousal items measure characteristics of recent spousal assaults, attitudes about spousal violence, and violations of no-contact orders

HCR-20

- One of the most widely used systems
- Includes three sub-scales: historical factors, clinical factors, and risk-management factors
- Intended to measure risk of violence among mentally-disordered, but works equally well with non-mentally-disordered

HCR-20 Areas

- Historical factors
  - Previous violence
  - Young age at first violent
  - Relationship instability
  - Employment problems
  - Substance use problems
  - Major mental illness
  - Psychopathy
  - Early maladjustment
  - Personality disorder
  - Prior supervision failure

HCR-20 Areas

- Clinical factors
  - Lack of insight (into mental disorder)
  - Negative attitudes toward others, institutions, social agencies, and the law
  - Active symptoms of major mental illness
  - Impulsivity
  - Unresponsive to treatment

HCR-20 Areas

- Risk Management factors
  - Plan feasibility
  - Exposure to destabilizers
  - Lack of personal support
  - Noncompliance with remediation attempts
  - Stress

Name: Walter

	Historical items	Code (0, 1, 2)
H 1	Previous violence	2
H 2	Young age at first violent incident	2
H 3	Relationship instability	2
H 4	Employment problems	1
H 5	Substance use problems	2
H 6	Major mental illness	0
H 7	Psychopathy	1
H 8	Early maladjustment	2
H 9	Personality disorder	2
H10	Prior supervision failure	2
	Total historical items:	16/20
	Clinical items	Code (0, 1, 2)
C1	Lack of insight	1
C2	Negative attitudes	1
C3	Active symptoms of major mental illness	0
C4	Impulsivity	1
C5	Unresponsive to treatment	1
	Total clinical items:	3/10
	Risk management items ☐ In ■ Out (transmural phase)	Code (0,1, 2)
R1	Plans lack feasibility	1
R2	Exposure to destabilizers	1
R3	Lack of personal support	1
R4	Noncompliance with remediation attempts	0
R5	Stress	1
	Total risk management items:	3/10
	HCR-20 total score:	21/40

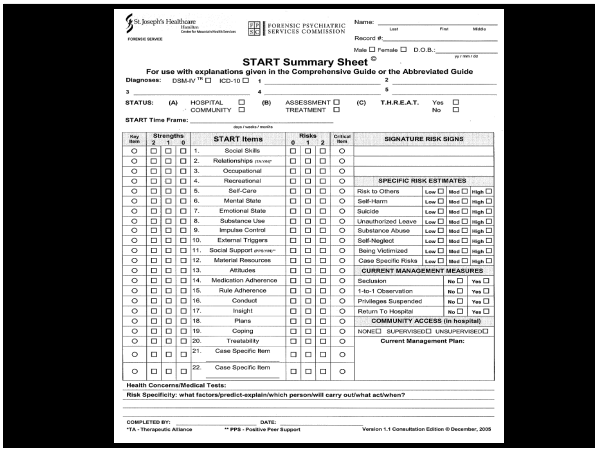
Final risk judgment ■ low ☐ moderate ☐ high

Suicide Risk Assessment and Management Manual

- Closely modeled on the HCR-20, the S-RAMM examines suicide rather than violence risk
- Looks at both background and dynamic factors, as well as helping to plan for risk management

START

- Short-Term Assessment of Risk and Treatability is a concise clinical guide for the dynamic assessment of short-term risk (weeks to months)
- Guides clinicians toward an integrated, balanced opinion to evaluate risk in seven domains
  - Violence
  - Suicide
  - self-harm
  - self-neglect
  - unauthorized absence
  - substance use
  - victimization



St. Joseph's Healthcare (Hamilton) — Centre for Advanced Mental Health Services — Forensic Service

FORENSIC PSYCHIATRIC SERVICES COMMISSION

Name: _____ (Last / First / Middle)

Record #: _____

Male ☐ Female ☐ D.O.B.: _____ (d / mm / yy)

START Summary Sheet ©

For use with explanations given in the Comprehensive Guide or the Abbreviated Guide

Diagnoses: DSM-IV [TR] ☐ ICD-10 ☐ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____

STATUS: (A) HOSPITAL ☐ COMMUNITY ☐ (B) ASSESSMENT ☐ TREATMENT ☐ (C) **T.H.R.E.A.T.** Yes ☐ No ☐

START Time Frame: _____ (days / weeks / months)

Key Item	Strengths 2	1	0	START Items	Risks 0	1	2	Critical Risk
○	☐	☐	☐	1. Social Skills	☐	☐	☐	○
○	☐	☐	☐	2. Relationships (PAIRS*)	☐	☐	☐	○
○	☐	☐	☐	3. Occupational	☐	☐	☐	○
○	☐	☐	☐	4. Recreational	☐	☐	☐	○
○	☐	☐	☐	5. Self-Care	☐	☐	☐	○
○	☐	☐	☐	6. Mental State	☐	☐	☐	○
○	☐	☐	☐	7. Emotional State	☐	☐	☐	○
○	☐	☐	☐	8. Substance Use	☐	☐	☐	○
○	☐	☐	☐	9. Impulse Control	☐	☐	☐	○
○	☐	☐	☐	10. External Triggers	☐	☐	☐	○
○	☐	☐	☐	11. Social Support (PEERS**)	☐	☐	☐	○
○	☐	☐	☐	12. Material Resources	☐	☐	☐	○
○	☐	☐	☐	13. Attitudes	☐	☐	☐	○
○	☐	☐	☐	14. Medication Adherence	☐	☐	☐	○
○	☐	☐	☐	15. Rule Adherence	☐	☐	☐	○
○	☐	☐	☐	16. Conduct	☐	☐	☐	○
○	☐	☐	☐	17. Insight	☐	☐	☐	○
○	☐	☐	☐	18. Plans	☐	☐	☐	○
○	☐	☐	☐	19. Coping	☐	☐	☐	○
○	☐	☐	☐	20. Treatability	☐	☐	☐	○
○	☐	☐	☐	21. Case Specific Item _____	☐	☐	☐	○
○	☐	☐	☐	22. Case Specific Item _____	☐	☐	☐	○

SIGNATURE RISK SIGNS

SPECIFIC RISK ESTIMATES

Risk to Others	Low ☐	Mod ☐	High ☐
Self-Harm	Low ☐	Mod ☐	High ☐
Suicide	Low ☐	Mod ☐	High ☐
Unauthorized Leave	Low ☐	Mod ☐	High ☐
Substance Abuse	Low ☐	Mod ☐	High ☐
Self-Neglect	Low ☐	Mod ☐	High ☐
Being Victimized	Low ☐	Mod ☐	High ☐
Case Specific Risks	Low ☐	Mod ☐	High ☐

CURRENT MANAGEMENT MEASURES

Seclusion	No ☐	Yes ☐
1-to-1 Observation	No ☐	Yes ☐
Privileges Suspended	No ☐	Yes ☐
Return To Hospital	No ☐	Yes ☐

COMMUNITY ACCESS (In hospital)

NONE☐ SUPERVISED☐ UNSUPERVISED☐

Current Management Plan:

Health Concerns/Medical Tests:

Risk Specificity: what factors/predict-explain/which person/will carry out/what act/when?

COMPLETED BY: _____ **DATE:** _____

*TA - Therapeutic Alliance ** PPS - Positive Peer Support

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Which One to Use?

- Depends on the population you are assessing
- START is the most flexible and widely applicable to all types of harm
- LIS-R and HCR-20 are both highly researched and used for violence
- S-RAMM is new but very promising

Which One to Use?

- Remember, you do not *have* to use any of them, but can instead use SPJ in a more informal way
- For example, agencies can construct a RA/RM measure in-house that assesses static and dynamic factors in a standard way that becomes mandatory to use

SPJ to RM

- Use of a SPJ can then move you directly into, and majorly inform, a risk management plan
- The areas assessed in a SPJ translate directly into making the most evidence-based, ethical RM plan

Applying SPJ to RM

- Assessing and planning the management of a patient at risk involves a number of stages:

1. Identifying whether the patient requires a full structured risk assessment
2. Detailing the risk factors present

Bouch & Marshall (2005)

Applying SPJ to RM

3. Considering the individual formulation of risk
4. Considering possible interventions and the level of support required
5. Anticipating the impact of possible interventions

Bouch & Marshall (2005)

Applying SPJ to RM

6. Developing the management plan
7. Reviewing and revising the management plan in the light of any changes to dynamic and future risk factors

Bouch & Marshall (2005)

Questions?

Resources

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