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Citation

• Ray, I and Simpson A I F: “Shared Risk Formulation in Forensic Psychiatry”.
Shared Decision Making

What is it?

The patient is involved in defining problems and setting the targets that constitute the plan of care (Tiley et al, 1999)
Shared Decision Making

Why is it complex?
Can be seen as a “middle ground” between paternalism and autonomy

In forensic mental health care, a recovery framework involves a balance a patient’s own interests with public safety concerns
Shared Decision Making

Why is it important?

Brings together the patient and his or her treatment team in making health care decisions.

Involvement of patients in care may enhance their sense of self efficacy and responsibility for being a part of important decisions regarding their care.
Shared Risk Assessment

• involves a joint process of contributing to an understanding of key risk issues and effective ‘risk management’
• intermediate approach between the medical and traditional offender rehabilitation models
Study objective

• Exploratory study to find examples of SDM as it is applied to risk assessment and management of violence in forensic psychiatry:

• Literature review of quantitative studies of shared risk formulation using structured risk assessment tools in forensic mental health practice
Aims of the study

• Describe the methodologies employed
• Describe the settings they were applied in
• Examine their reliability, validity and feasibility
Methods

Original studies, systematic reviews and meta-analyses

**Focusing on:**

**WHAT:** shared risk assessment, formulation or decision making

**WHERE:** forensic psychiatric or correctional settings

**WHO:** for mentally disordered offenders with problems of violence were considered

Studies were all in English and had a published status
Search terms

• forensic or prisons or offend,

• share OR collaborate

AND

risk assessment

OR risk formulation

OR treatment plans

OR care plans

Databases searched

Ovid MEDLINE (R) 1946 to PRESENT,

Ovid MEDLINE ® In-Process and Other Non-Indexed Citations,

PsycINFO 1806 to PRESENT,

Embase Classic + Emblem 1947 to PRESENT databases
Search methodology

LITERATURE SEARCH
Databases: MEDLINE reviews, PsychINFO, EMBASE
Limits: English language articles and published articles only

Search results combined (n=245)

Articles screened on basis of title and abstract

Excluded (n=5)
Reason: Not related to forensic mental health

Excluded (n=235)
Reason: articles pertaining to other medical fields

Articles included (n=10)
Detailed review by both authors independently

Included (n=5)
After application of inclusion criteria
Results

<table>
<thead>
<tr>
<th>STUDY</th>
<th>LOCATION</th>
<th>SETTING</th>
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<tbody>
<tr>
<td>Bjorkly et al. [2004]</td>
<td>Norway</td>
<td>Medium Secure Forensic Unit</td>
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<td>Fluttert et al [2010]</td>
<td>Norway</td>
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<td>Rana Abou-Sinna and Leubers [2012]</td>
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<tr>
<td>Troquete et al. [2013]</td>
<td>Netherlands</td>
<td>Three outpatient Forensic Psychiatric Clinics</td>
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<td>van den Brink et al [2015]</td>
<td>Netherlands</td>
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<td>Daroven et al. [2015]</td>
<td>Ireland</td>
<td>Secure Forensic Psychiatry unit</td>
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Bjorkly et al. [2004]

SAMPLE:
Single case report

TOOLS:
Progression ladder; criterion based, stepwise intervention to reduce risk

STUDY DESIGN:
Literature review and a case illustration

OUTCOME/MAIN RESULTS
Case illustration of a successful progression towards self-management of violence and personal growth
Fluttert et al. (2010)

SAMPLE:
N= 189 eligible [males]; 168 were involved in the intervention

TOOLS:
• SOAS-R [Staff Observation Aggression Scale- Revised]
• Early Recognition Method evaluation

STUDY DESIGN:
Naturalistic one-way case-crossover design.
Cases were their own controls

OUTCOME/MAIN RESULTS:
SOAS-R scores
Severity of incidents from 1.38 to 0.50 (p<.001)

Seclusion events
219 to 104 in Intervention phase
Rate per patient/month mean of 0.13 to 0.05 (p<.001)
Early Recognition Method (ERM) Fluttert et al. (2010)

ERM is a guided process in which staff and patients develop shared understanding of early signs of aggression and implement plans to reduce violence.

1\textsuperscript{st} phase: intervention explained to patient

2\textsuperscript{nd} phase: list of early signs of aggression prepared by patient with help of nurse mentor

3\textsuperscript{rd} phase: patient and staff mentor together monitored patient’s behavior to detect early signs of aggression

4\textsuperscript{th} phase: preventive actions were listed in the early detection plan and implemented to help the patient de-escalate and regulate their behavior.
Early recognition method (ERM) method

Fluttert’s study showed **greatest effectiveness using ERM approach** which is notable to be both:

- a shared risk analysis, and
- a structured intervention

...to reduce violence in persons with serious mental illness
Rana Abou-Sinna and Leubbers (2012)

SAMPLE:
• N= 72, Males = 66 and Females = 6

TOOLS:
Camberwell Assessment of Needs – Forensic (CANFOR-S), HoNOS-S and HCR-20

OUTCOME/MAIN RESULTS:
CANFOR-S nurse and patient ratings of total needs positively correlated with staff completed HoNOS-S clinical and security scales, as well as HCR-20 clinical and risk scales
Troquete et al. (2013)
Risk Assessment and Care Evaluation (RACE) study

**SAMPLE:** N=310 (201 in intervention group), M=58 (case managers)

**TOOLS:**
Short-Term Assessment of Risk and Treatability (START)
Client version of the START called the Client Self Appraisal (CSA)

**STUDY DESIGN:**
Cluster randomized controlled trial

**OUTCOME/MAIN RESULTS:**
Primary outcome - one or more violent or criminal incidents in the 6 months before the end of follow up

No difference between “treatment as usual” staff-rated and the “START/CSA” person-rated groups
van den Brink et al. 2015
Risk Assessment and Care Evaluation (RACE) study

SAMPLE: N= 196 patients

TOOLS:
Short-Term Assessment of Risk and Treatability (START)
Client version of the START called the Client Self Appraisal (CSA)

STUDY DESIGN:
Naturalistic outcome study using the intervention group from Troquete et al.

OUTCOME/MAIN RESULTS:
Client ratings independently predicted violent or criminal behaviors at 6 month follow up

Best predictive model involved both the case managers’ rating from the START and patient rated CSA measure of risk and protective factors
What did the RACE study show?

• CSA was as good at the START at predicting outcomes
• But in the RCT, including the patient ratings did not alter outcomes suggesting implementation of patient based insights to risk management may not have been successfully achieved.
• Demonstrated the feasibility of including client ratings of their own risk and protective factors using an SPJ based tool
• Significant univariate association with adverse outcomes, with patient and staff ratings of similar efficacy
• Self-ratings contributed to the best fit for outcomes when a multivariate analysis was used
Daroven et al. 2015

SAMPLE: N=58, Males only
TOOLS:
DUNDRUM 3 and 4 completed separately by staff and patients
STUDY DESIGN:
- Prospective naturalistic observational cohort study, single blind design
- 14 month follow up period

HYPOTHESIS:
increased concordance between staff and patient ratings of risks and needs would predict clinical progress and conditional discharge over F/up period
Daroven et al. 2015

OUTCOME/MAIN RESULTS:

- Patients rated themselves more optimistically than the clinicians.
- Clinicians ratings predicted more accurately the move between levels of security.
- Higher concordance between staff and patient scores correlated with lower levels of security and clinical progress.
DUNDRUM 3 and 4

• At this point the only forensic recovery tool looking at staff and patient views of progress and needs

• But only one study showing:
  • Efficacy and feasibility (at least for 2/3 of forensic patients, and only male at this point),
  • raising the intriguing issue that agreement between staff and patients, as well as level of risk itself, may be of value as a measure of progress.
Limitations of the studies

Paucity of research
Studies need replication and expansion
Case-control and RCT designs are needed to evaluate the effectiveness of such interventions
What works as a clinician tool may not capture patient perspectives well
Most of the samples were of male forensic patients
Shared risk assessment: take home points

A small but significant literature of structured approaches to including patient voice into risk assessment and management in forensic mental health care

Consensus across the studies of the significance of user involvement and collaboration in risk assessment and management

Ample qualitative evidence for the desire for patient involvement in forensic recovery processes

Patient collaboration needs to be a defined ongoing clinical activity assisted by tools, but is unlikely to be achieved simply by completion of a tool as a one off exercise.
Thank you