Clinical Risk Management in Forensic Psychiatric Populations

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Forensic Psychiatric Services Commission
15th Biennial Symposium on Violence & Aggression

Saskatoon, June 2014
Valkenberg Hospital, Cape Town
South Africa
Canadian Royal College Examination Board
1992
Canada

- Correctional Services Canada
  Regional Psychiatric Centre - Pacific

- Forensic Psychiatric Services Commission
  - 190 bed Forensic Psychiatric Hospital
  - 6 Regional Forensic Clinics
The Setting

- 190-bed Forensic Psychiatric Hospital in Vancouver, BC
- 9 Secure, locked and open units with a secure perimeter
- 2012-013: 393 admissions and 384 discharges
- Six Regional Forensic Clinics
- Multidisciplinary treatment teams
- Patient-centred, trauma informed model of care
- Highest Accreditation award from Accreditation Canada
  - 402/403 standards met
The Challenge

- Governmental HR directives
- Negative impact on staff morale
- Critical Incidents
- Staff injuries
- Union concerns
- WorkSafe BC engagement
- Renewed focus on workplace safety and quality of care
The Response: Clinical risk management

- What is Clinical risk management?
- It is engaging patients in a pt centered model of care that:
  - Encompasses sound risk assessment and
  - Ensures effective communication of risk
  - It requires professional practice, and
  - It requires clear policy to ensure the above
Patient engagement

Thomas Szasz – “The Myth of Mental Illness”
Mental illness as a social construct
FPH Patient Engagement Project

- Patient Advisory Committee
- Member of Clinical Services Committee
- Meets with Director monthly
- Engaged in policy and QI
- Peer support worker
- Individual and group meetings, co-facilitator
- Peer Research group
  - Design, implementation, presentation of results

Supported by:

- Canadian Health Services Research Foundation
- Fonds Canadien des Services de Santé
- BC Mental Health & Addiction Services
PATIENT-CENTRED CARE IN THE BC FORENSIC PSYCHIATRIC HOSPITAL: AN EXPLORATORY STUDY

Canadian Health Services Research Foundation
BC Mental Health & Addiction Services (BCMHAS)
Johann Brink, Jamie Livingston, Colleen Calderwood, Marcel Hediger, Deborah Kinvig, Nancy Robinson, Nader Sharifi, Sara Lapsley
Possible? Paradigmatic tensions

- From a health perspective, forensic mental health service users are ‘patients’ and the purpose of the system is to provide treatment and support services in order to assist in their recovery.
- From a criminal justice perspective, forensic clients are ‘accused persons’ and the purpose of the system is to detain potentially dangerous individuals, and to reduce risk for violent and criminal recidivism.
Possible? Paradigmatic tensions

- Balance the interests of many parties, including the public, the state, the staff and their unions, as well as the patient.

- Reconciling these differences and balancing divergent needs is a daunting task — especially in the complex, dynamic environment of a forensic mental health hospital.
Michel Foucault 1926-1984
“Where power is exerted, resistance develops: this a productive relationship”
Staff perceived the hospital milieu as less safe than did the patients.

Table 3. Patient and provider ratings of therapeutic milieu

<table>
<thead>
<tr>
<th>EssenCES Scales (possible range)</th>
<th>Patients</th>
<th></th>
<th></th>
<th>Providers</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$n$</td>
<td>$M$</td>
<td>SD</td>
<td>$n$</td>
<td>$M$</td>
<td>SD</td>
<td>$t$</td>
</tr>
<tr>
<td>Patient cohesion (0-20)</td>
<td>29</td>
<td>9.86</td>
<td>3.85</td>
<td>28</td>
<td>8.32</td>
<td>4.03</td>
<td>1.47</td>
</tr>
<tr>
<td>Experienced safety (0-20)</td>
<td>28</td>
<td>9.11</td>
<td>3.21</td>
<td>28</td>
<td>4.18</td>
<td>3.33</td>
<td>5.63</td>
</tr>
<tr>
<td>Therapeutic hold (0-20)</td>
<td>29</td>
<td>10.86</td>
<td>4.03</td>
<td>28</td>
<td>11.46</td>
<td>4.19</td>
<td>-0.55</td>
</tr>
<tr>
<td>Total average (0-4)</td>
<td>29</td>
<td>2.01</td>
<td>0.49</td>
<td>28</td>
<td>1.61</td>
<td>0.51</td>
<td>2.99</td>
</tr>
</tbody>
</table>
### Table 1. Patient and provider ratings of recovery-oriented care

<table>
<thead>
<tr>
<th>RSA Scales (possible range)</th>
<th>Patients</th>
<th>Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$n$</td>
<td>$M$</td>
</tr>
<tr>
<td>Life goals (1-5)</td>
<td>29</td>
<td>3.30</td>
</tr>
<tr>
<td>Involvement (1-5)</td>
<td>29</td>
<td>2.77</td>
</tr>
<tr>
<td><strong>Treatment options (1-5)</strong></td>
<td><strong>29</strong></td>
<td><strong>2.76</strong></td>
</tr>
<tr>
<td>Choice (1-5)</td>
<td>29</td>
<td>3.11</td>
</tr>
<tr>
<td>Individualized services (1-5)</td>
<td>29</td>
<td>2.95</td>
</tr>
<tr>
<td>Inviting (1-5)</td>
<td>30</td>
<td>3.28</td>
</tr>
<tr>
<td>Total (1-5)</td>
<td>29</td>
<td>3.06</td>
</tr>
</tbody>
</table>

T1 results

Patients perceived fewer treatment options than did staff.
Table 2. Strengths and gaps of recovery-oriented care

<table>
<thead>
<tr>
<th>Patient Perspectives</th>
<th>Provider Perspectives</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strengths</strong></td>
<td><strong>Strengths</strong></td>
</tr>
</tbody>
</table>
| 1. Staff believe in patients’ recovery  
  \(n=29, M=3.93, SD=1.10\) | 1. Staff are diverse  
  \(n=27, M=4.63, SD=0.57\)* |
| 2. Staff are diverse  
  \(n=29, M=3.86, SD=1.33\)* | 2. Discharge criteria are discussed  
  \(n=27, M=3.96, SD=0.76\) |
| 3. Staff encourage hope and recovery  
  \(n=30, M=3.70, SD=1.12\) | 3. Spiritual needs are discussed  
  \(n=26, M=3.85, SD=0.97\) |
| 4. Staff believe in symptom self-management  
  \(n=29, M=3.66, SD=1.11\)† | 4. Plans are made for life goals  
  \(n=28, M=3.61, SD=0.99\) |
| 5. Staff are welcoming  
  \(n=30, M=3.63, SD=1.19\) | 5. Staff ask patients about their interests  
  \(n=27, M=3.59, SD=1.31\) |
| **Gaps**              | **Gaps**              |
| 1. Staff encourage positive risk-taking  
  \(n=29, M=2.14, SD=1.13\) | 1. Patients are involved in staff training  
  \(n=28, M=1.61, SD=0.96\)* |
| 2. Patient role models/mentors are used  
  \(n=29, M=2.31, SD=1.31\)* | 2. Patients can access their records  
  \(n=24, M=2.42, SD=1.06\) |
| 3. Staff help patients give back to the community  
  \(n=29, M=2.45, SD=1.40\) | 3. Staff believe in symptom self-management  
  \(n=28, M=2.43, SD=1.00\)† |
| 4. Sexual needs/interests discussed  
  \(n=28, M=2.46, SD=1.26\)* | 4. Sexual needs/interests discussed  
  \(n=25, M=2.44, SD=1.12\)* |
| 5. Patients are involved in staff training  
  \(n=29, M=2.48, SD=1.43\)* | 5. Patient role models/mentors are used  
  \(n=25, M=2.44, SD=1.00\)* |

* Indicates commonalities between patients and staff
† Indicates differences between patients and staff
The Response – Risk Assessment

- Focus on Clinical risk management
- Utilising core principles
- Evidence based risk assessment
- Structured professional judgment – SPJ
  - HCR-20 v3 Douglas et al 2013
  - Short Term Assessment of Risk and Treatability – START
    - Webster, Martin, Brink, Nicholls, & Desmarais, 2009
  - Short Nursing Assessment Protocol - SNAP
    - Brink, Greaves, & McNulty, 2011
- START-based Integrated Treatment Plan
  - Brink, 2011
- Nursing Management Model
  - Kinvig et al., 2011
What is sound Risk Assessment?

- Risk factors
- Strengths
- Risk Formulation
- Informs Risk Management Plan

Risk assessment
“FROM THE EXPERIENCES OF THE PAST, THE PRESENT ACTS PRUDENTLY, LEST IT SPOIL FUTURE ACTION.”
Structured Professional Judgement

- **HCR-20 v3**
  - Risk factors

- **START v 1.1 – Short Term Assessment of Risk & Treatability**
  - Webster, Martin, Brink, Nicholls, & Desmarais, 2009
  - Risks and Strengths

- **SAPROF 2\textsuperscript{nd} ed**
  - de Vogel, de Ruiter, Bouman, & de Vries Robbe, 2012
  - Protective factors
History of problems with...

Past

- Violence
- Antisocial behaviour
- Treatment or Supervision
- Violent attitudes
- Relationships
- Employment
- Traumatic experiences
- Substance use
- Personality disorder
- Mental disorder
Recent problems with...

- Insight
- Violent ideation
- Symptoms of major mental disorder
- Instability
- Treatment/supervision
Future problems with...

Future

Plans

Stress or Coping

Living situation

Treatment/Supervision

Support
What about strengths?

- Consideration of positive attributes:
- Ensures holistic appraisal of the person
- Avoids risk based bias
- Assists with treatment planning
- Adds incremental value to risk assessment and outcome

The Short-Term Assessment of Risk and Treatability (START)

• A concise clinical guide for the dynamic assessment of short-term risk (i.e., weeks to months)
• Individual clinician or team based assessment
• Historical and Dynamic factors
• Twenty dynamic Vulnerability and Strength factors
• Guides clinicians toward an integrated, balanced opinion to evaluate risk in seven domains
  - violence
  - suicide
  - self-harm
  - self-neglect
  - unauthorized absence
  - substance use
  - being victimized
• Intended to inform clinical interventions and assist in treatment and risk management plans
• Forensic and Civil and Correctional inpatient and community settings
Completing START involves integration of past and current evidence to estimate and manage future risks.
Grand Rounds - SMH\ITP FPS
Ecory V4_1_(3).pdf
The SNAP
Structured Nursing Assessment Protocol
Brink, Greaves, & McNulty, 2012

- One SNAP per patient per shift
- 4 Sections:
  - Clinical snapshot
  - Concern for this and the next shift
  - Suggested care strategies
  - Care notes

<table>
<thead>
<tr>
<th>SNAP - STRUCTURED NURSING ASSESSMENT PROTOCOL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Completed: ____ / ____ / ____</td>
</tr>
</tbody>
</table>

1. CLINICAL SNAPSHOT – THIS SHIFT
   **RATE EACH**
   - Supervision Challenge (Cooperation):
     - Low
     - Moderate
     - High
   - Hostility (Attitudes / Affective State):
     - Low
     - Moderate
     - High
   - Out of Control (Impulsivity):
     - Low
     - Moderate
     - High
   - Thought Disorganization (Mental State):
     - Low
     - Moderate
     - High

2. CONCERN FOR THIS AND THE NEXT SHIFT
   **RATE EACH**
   - Low
   - Moderate
   - High
   - Verbal Threats
   - Physical Assault
   - Sexual Aggression
   - Self-Harm / Suicidal Behaviours
   - Substance Use
   - Escape / UAL
   - Other:

3. SUGGESTED CARE STRATEGIES FOR THE NEXT SHIFT
   **TICK ALL THAT APPLY**
   - Follow ITP
   - 5/0
   - 1:1 / 2:1 / Constant observation
   - PRN Medication
   - Physical Intervention
   - Urgent psychiatric assessment
   - SAM protocol
   - Hold privileges
   - Other:

| Time completed: __________________________ |
| Health Care Worker’s Name: _______________ |
| Nurses’ Name: __________________________  |
| Nurses’ Signature: _______________________ |

**PATIENT CARE NOTES**

<table>
<thead>
<tr>
<th>Time</th>
<th>Patient Identification Area</th>
</tr>
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<tbody>
<tr>
<td></td>
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<tbody>
<tr>
<td>Low</td>
<td>Moderate</td>
</tr>
<tr>
<td>Uncooperative, Refuses / resists direction</td>
<td>Disobeys rules / ward or hospital regulations and expectations</td>
</tr>
<tr>
<td>Low</td>
<td>Moderate</td>
</tr>
<tr>
<td>Agitated, Irritable, Angry</td>
<td></td>
</tr>
<tr>
<td>Dysphoric, Depressed, Hopeless</td>
<td></td>
</tr>
<tr>
<td>Hostility (Attitudes / Affective State)</td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>Moderate</td>
</tr>
<tr>
<td>Impulsive, Reactive, Erratic</td>
<td></td>
</tr>
<tr>
<td>Risk-taking, Sensation-seeking</td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>Moderate</td>
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<tr>
<td>Thought Disorganization (Mental State)</td>
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<td>Disordered thinking, Delusions (persecutory, harm to self or others)</td>
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**2. CONCERN FOR THIS AND THE NEXT SHIFT**

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<tr>
<td>Substance Use</td>
</tr>
<tr>
<td>Escape / UAL</td>
</tr>
<tr>
<td>Other: ________ [e.g., firesetting, etc]</td>
</tr>
</tbody>
</table>

**3. SUGGESTED CARE STRATEGIES FOR THE NEXT SHIFT**

<table>
<thead>
<tr>
<th>Tick all that apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Follow ITP</td>
</tr>
<tr>
<td>O S/O</td>
</tr>
<tr>
<td>O Verbal intervention</td>
</tr>
<tr>
<td>O 1:1 / 2:1/ Constant observation</td>
</tr>
<tr>
<td>O PRN Medication</td>
</tr>
<tr>
<td>Time completed: __________________</td>
</tr>
<tr>
<td>Health Care Worker’s Name: __________________</td>
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### PATIENT CARE NOTES

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**BC Mental Health & Addiction Services**

**STRUCTURED NURSING ASSESSMENT PROTOCOL**

Feb 16, 2012
The SNAP
Structured Nursing Assessment Protocol

SNAP - STRUCTURED NURSING ASSESSMENT PROTOCOL

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<th>Hostility (Attitudes / Affective State)</th>
<th>Rate Each</th>
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<tbody>
<tr>
<td>Low</td>
<td>Moderate</td>
</tr>
<tr>
<td>Agitated, Irritable, Angry, Dysphoric, Depressed, Hopeless</td>
<td></td>
</tr>
<tr>
<td>Anxious, Fearful</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Out of Control (Impulsivity)</th>
<th>Rate Each</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
</tr>
<tr>
<td>Confusion, Disorientation</td>
<td></td>
</tr>
</tbody>
</table>

- **Low**: Exhibits no or low levels of the indicators
- **Mod**: Presents a few and/or limited levels of the relevant indicators
- **High**: Presents with many or a high level of relevant behavioural indicators

Greaves, McNulty, Kinvig, & Brink 2012
The SNAP
Structured Nursing Assessment Protocol

rate Concern section as ‘given the opportunity…’, not based on current circumstances/controls in their environment

- (e.g., patient in Seclusion could remain high risk for sexual assault)

Greaves, McNulty, Kinvig, & Brink 2012
The SNAP  
Structured Nursing Assessment Protocol

indicate any management strategy(s) during this, and over the next shift

<table>
<thead>
<tr>
<th>3. SUGGESTED CARE STRATEGIES FOR THE NEXT SHIFT</th>
<th>TICK ALL THAT APPLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>O Follow ITP</td>
<td>O S/I</td>
</tr>
<tr>
<td>O Verbal intervention</td>
<td>O 1:1 / 2:1 Constant observation</td>
</tr>
<tr>
<td>O PRN Medication</td>
<td>O Physical intervention</td>
</tr>
<tr>
<td>O Other: ____________________</td>
<td>O Other: ___________</td>
</tr>
</tbody>
</table>

Time: ____________  Patient Identification Area

Greaves, McNulty, Kinvig, & Brink 2012
Each Nursing shift

KARDEX

START

SNAP

ITP
Shift Assignment Sheet
- Pts assigned to staff this shift
  - Based on pt risk factors & staff

Patient milieu on unit today
- eg. any Review Boards pts upset, Anniversary of index offence? Contraband?

Review of roles if Code White needed this shift
- (e.g. who will take the lead role?)

Unit routine
- (e.g. security checks)

Staffing for our shift today
- Regular? New Hires? On-Call Staff?
- Take knowledge of pts for granted
- Don’t make assumptions, ask questions

Kinvig, McNulty, Greaves, & Brink 2012
Risk assessment of unit milieu

Know your patients

Know yourself

- What’s happening on the unit today that we need to know about? (E.g. drug dealing, conflict)

Admissions and transfers this shift

- Who will be coming or going?
- Who is going to be responsible for this new / transferring patient?

START Kardex - Signature risk signs? - Triggers? Before end of shift, beginning of shift standard work

Communication with Treatment team – Case Manager, Psychiatrist, Social Worker etc

Kinvig, McNulty, Greaves, & Brink 2012
Proposed Nursing Management Model (V.13 March 2013)

“Fostering a safer workplace through evidence-based nursing practice”

- Reinforce Use of These
- Shift Assignment Sheets (3)
- SNAP/Relational security workshop
- Nursing Supervisor Workshop
- Shift Safety Plan
- Review of Code White + NVCI
- ‘START’ Kardex & Shift handover used together at all shift changes
- Supporting Nursing Supervisors and Nurses in Charge on Units
- Encourage attendance of staff to Leaders Supporting Learning services + Coaching Out of the Box

Based on the Solution Focused Therapy model and 5-5-5 System of coaching practice

Kinvig, McNulty, Greaves, & Brink 2012
Professional treatment

- All professions
  - Clinical guidelines, ethical standards
  - Psychotic, Mood, Anxiety disorders
  - Trauma informed
  - Patient centred
  - Accreditation requirement

- Principles of effective programs
  - Andrews & Bonta, 2003

- Risk Needs Responsivity
Risk-Need-Responsivity


- **Risk principle:** Match the intensity of treatment to the offender's risk to re-offend.

- **Need principle:** Assess criminogenic, dynamic needs and target them in treatment.

- **Responsivity principle:** Provide cognitive behavioural treatment and tailor the intervention to the learning style, motivation, abilities and strengths of the offender.
Eight Principles of Effective Intervention

- Programs should be intensive and behavioural in design
- Target known criminogenic factors
- Standardised assessments of risk, need and responsivity characteristics
- Match the characteristics of offender, therapist and program
Eight Principles of Effective Intervention

- Firm but fair and equitable enforcement of contingencies and behavioural strategies
- Suitable, well qualified and well trained staff
- Relapse prevention component
- Networks and brokerage with other agencies, departments
Effective programs reduce reoffending
Andrews et al., 2004

- Adhering to all principles: 28% reduction
- Adhering to no principles: 5% reduction

- Note: High risk youth = US $1.7 – 2.5 million societal costs over criminal career – thus even 5-10% reduction = significant savings
Effective programs reduce reoffending  
Andrews & Bonta, 2003

Recidivism

Decase
Increase

# of Treatment Principles
From “Nothing Works” to Clinical Risk Management

- “Nothing Works”: 1975 to 1990
  - Lipton et al (1975)
  - ‘little reason to hope that we have found a sure way of reducing recidivism through rehabilitation”
If “Nothing Works” then try Deterrence

- “it is possible that something works...something that deters rather than cures”
Futility of punishment alone
Bonta 2011

- Punishment may deter – but does not teach new behaviour
- Few universal punishments
- Immediate
- Appropriate dosage or severity
- May be effective with:
  - Future and goal directed persons
  - Cautious, anxious
  - Average to above average intelligence
  - Minimal punishment history
## Risk level and Intensity of Treatment

<table>
<thead>
<tr>
<th>Risk Level</th>
<th>Low Tx</th>
<th>Intensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baird et al (1979)</td>
<td>Low</td>
<td>3</td>
</tr>
<tr>
<td>Andrews &amp; Kiessling</td>
<td>Low</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>High</td>
<td>51</td>
</tr>
<tr>
<td></td>
<td>High</td>
<td>78</td>
</tr>
<tr>
<td></td>
<td>High</td>
<td>37</td>
</tr>
<tr>
<td></td>
<td>High</td>
<td>58</td>
</tr>
</tbody>
</table>

Bonta, 2010
### Needs and Dynamic Risk

**Bonta 2010**

<table>
<thead>
<tr>
<th>Criminogenic</th>
<th>Non-criminogenic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procriminal attitudes</td>
<td>Self-esteem</td>
</tr>
<tr>
<td>Criminal associates</td>
<td>Vague emotional discomfort</td>
</tr>
<tr>
<td>Family affect</td>
<td>Physical training</td>
</tr>
<tr>
<td><strong>Antisocial personality</strong></td>
<td><strong>Group cohesion</strong></td>
</tr>
<tr>
<td>(Emotional dysregulation, impulsivity)</td>
<td></td>
</tr>
<tr>
<td>Vocational training</td>
<td>Foster ambition</td>
</tr>
<tr>
<td>Major risk/need factor</td>
<td>Indicators</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Antisocial personality pattern</td>
<td>Impulsive, adventurous pleasure seeking, restlessly aggressive and irritable</td>
</tr>
<tr>
<td></td>
<td><strong>Consider effect of BAD II? ADD?</strong></td>
</tr>
<tr>
<td>Procriminal attitudes</td>
<td>Rationalizations for crime, negative attitudes towards the law</td>
</tr>
<tr>
<td></td>
<td><strong>Consider psychotic/mood disorder</strong></td>
</tr>
<tr>
<td>Social supports for crime</td>
<td>Criminal friends, isolation from prosocial others Replace procriminal friends and associates with prosocial friends and associates</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>Abuse of alcohol and/or drugs Reduce substance abuse, enhance alternatives to substance use</td>
</tr>
</tbody>
</table>
| Family/marital relationships | Inappropriate parental monitoring and disciplining, poor family relationships  
Teaching parenting skills, enhance warmth and caring | Teaching parenting skills, enhance warmth and caring |
|-------------------------------|-------------------------------------------------|--------------------------------------------------|
| School/work                   | Poor performance, low levels of satisfactions  
Enhance work/study skills, nurture interpersonal relationships within the context of work and school | Enhance work/study skills, nurture interpersonal relationships within the context of work and school |
| Prosocial recreational activities | Lack of involvement in prosocial recreational/leisure activities | Encourage participation in prosocial recreational activities, teach prosocial hobbies and sports  
**What is suitable for impulsive, sensation seekers?**  
Skydiving? Rodeo? Car racing |
“Correctional Quackery’
Bonta 2010; Latessa, Cullen & Gendreau 2002

- Art/Horticulture/Music/Drama therapies
  - But note the value in inmates with severe mental illness as non-verbal modalities

- Pet therapy
- Transcendental Meditation
- Shaming exercises e.g. cross dressing
Does it work?
Results – START User satisfaction survey

- Desmarais, Nicholls, Brink & Read, (2010)

- User-Friendliness
  - Agreement rates >80%

- Clinical Utility Agreement rates high:
  - 71% signature risk signs
  - 88% critical items
  - 56% agreed it was easy to make finer scoring distinctions.
  - 81% dynamic items
  - 93% supported dual focus on strengths and vulnerabilities
  - 93% agreed that START is a clinically useful measure.
**Predictive Validity**


\( N = 120 \) forensic inpatients. START assessments 12 month follow up. M-OAS (Yudovisky, 1986)

<table>
<thead>
<tr>
<th>START Assessments (( N = 120 ))</th>
<th>Verbal</th>
<th>Physical – Objects</th>
<th>Physical – Others</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AUC (SE)</td>
<td>95% CI</td>
<td>AUC (SE)</td>
</tr>
<tr>
<td>Strength Total</td>
<td>.75 (.05)***</td>
<td>.66-.84</td>
<td>.77 (.06)***</td>
</tr>
<tr>
<td>Vulnerability Total</td>
<td>.79 (.04)***</td>
<td>.70-.87</td>
<td>.80 (.05)***</td>
</tr>
<tr>
<td>Risk Estimate</td>
<td>.78 (.04)***</td>
<td>.69-.86</td>
<td>.84 (.04)***</td>
</tr>
</tbody>
</table>
Distribution of Men’s Scores

Good dispersion across both strengths and vulnerabilities

Nicholls, 2010
$N = 291$ STARTS on 142 Forensic Psychiatric Inpatients.

Strengths: $F(2, 286) = 41.04, p < 0.001$

Vulnerabilities: $F(2, 286) = 31.38, p < 0.001$

Nicholls et al., 2009; Nicholls et al., 2006

- Scores change
- Item, total, and risk estimate scores are related to:
  - Internal aggression
  - External aggression
  - Security levels
Gender group Comparison

![Bar graph showing comparison between male and female strengths and vulnerabilities.](image)

Note. *** $p \leq 0.001$ level

Viljoen, Nicholls, Greaves, de Ruiter, & Brink 2010
Predictive Validity

Braithwaite, Charette, Crocker & Reyes (2011)

- Forensic inpatient sample in Quebec

<table>
<thead>
<tr>
<th>Original START Scales</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Vulnerabilities</td>
<td>AUC .66</td>
<td>p &lt; .001</td>
</tr>
<tr>
<td>Strengths</td>
<td>AUC .65</td>
<td>p &lt; .05</td>
</tr>
<tr>
<td>Risk Estimates</td>
<td>AUC .52</td>
<td>ns</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Optimised Scales</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Vulnerabilities</td>
<td>AUC .77</td>
<td>p &lt; .001</td>
</tr>
<tr>
<td>Strengths</td>
<td>AUC .65</td>
<td>p &lt; .001</td>
</tr>
</tbody>
</table>
Predictive Validity

Haque & Cree, 2009

46 English male consecutive admissions to medium security

<table>
<thead>
<tr>
<th></th>
<th>AUC</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strength</td>
<td>.76</td>
<td>&lt; .001</td>
</tr>
<tr>
<td>Vulnerability</td>
<td>.82</td>
<td>&lt; .001</td>
</tr>
</tbody>
</table>
## START Predictive Validity

*Wilson, Desmarais, Nicholls & Brink 2011*

Predictive validity of Vulnerability and Strength scores over next three months using M-OAS

<table>
<thead>
<tr>
<th>Category</th>
<th>AUC</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strength</td>
<td>.73</td>
<td>&lt; .001</td>
</tr>
<tr>
<td>Vulnerability</td>
<td>.74</td>
<td>&lt; .001</td>
</tr>
<tr>
<td>Specific Risk Estimates</td>
<td>.82</td>
<td>&lt; .001</td>
</tr>
</tbody>
</table>
Norwegian forensic inpatient sample
Nonstad et al 2011

<table>
<thead>
<tr>
<th>Predictive validity over 90 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vulnerability score:</td>
</tr>
<tr>
<td>Strength score:</td>
</tr>
<tr>
<td>Strength score &gt; vulnerability</td>
</tr>
<tr>
<td>score</td>
</tr>
</tbody>
</table>
**Predictive Validity – START, PCL:SV, HCR-20**


<table>
<thead>
<tr>
<th>Assessment</th>
<th>Physical Aggression Against Others</th>
<th>AUC(SE)</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>START</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N=120</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strength Total Score</td>
<td>.80 (.05)***</td>
<td>.70-.89</td>
<td></td>
</tr>
<tr>
<td>Vulnerability Total</td>
<td>.77(.05)***</td>
<td>.66-.88</td>
<td></td>
</tr>
<tr>
<td>Violence Risk Estimate</td>
<td>.85(.04)***</td>
<td>.77-.93</td>
<td></td>
</tr>
<tr>
<td><strong>HCR-20</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Historical subscale score</td>
<td>.69(.06)**</td>
<td>.58-.81</td>
<td></td>
</tr>
<tr>
<td>Clinical subscale score</td>
<td>.71(.06)***</td>
<td>.58-.83</td>
<td></td>
</tr>
<tr>
<td>Risk Mx subscale score</td>
<td>.75(.05)***</td>
<td>.65-.85</td>
<td></td>
</tr>
<tr>
<td>Total score</td>
<td>.75(.05)***</td>
<td>.65-.86</td>
<td></td>
</tr>
<tr>
<td>Violence Risk Estimate</td>
<td>.77(.07)***</td>
<td>.64-.90</td>
<td></td>
</tr>
<tr>
<td><strong>PCL:SV</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total score</td>
<td>.74(.06)***</td>
<td>.63-.85</td>
<td></td>
</tr>
</tbody>
</table>
FPH Patient Aggression Rate

Data Source: Patient Safety Learning System (PSLS)

Includes verbal & physical aggression, directed at co-patients, staff, visitors or property
Staff Injury Reports

Employee Injury Reports Due to Aggression

- # of employee injury reports due to aggression
- # of EE injuries due to aggression resulting in time loss
Patient Aggression

FPH Patient Aggression - Event Rate per 1000 Patient Days

# aggressive events per 1000 patient days

Patient Aggression

FPH Patient Aggression - Physical & Sexual Aggression Towards Staff:
Event Rate per 1000 Patient Days

# aggressive events per 1000 patient days

Support from senior leadership in the organisation is essential

To ensure
- Treatment and programs recognised as essential components of crime prevention
- Space
- Budget
- Staffing
- Program Fidelity and after care/follow up
- Program Evaluation
- Academic linkages and the value of research
- Therapeutic autonomy
Direct care staff should not have to fight battles that need not be battles in the first place.
Quality people
• Respected
• Skilled
• Engaged
• Professional satisfaction

Clinical Excellence
• Therapeutic skills
• Treatment models
  • CBT/DBT/Individual
  • Medical
• Risk assessment
• Clinical Risk Management
• Quality of care & Pt safety

Organisational Excellence
• Receptive, Innovative
• Supportive
• Flexible
• Responsive
• Relevant
• Learning organisation

Evaluation & Research
• Principles of Effective Intervention - PEI
• Program Evaluation
• Resilience and Protective factors
• Knowledge transfer

 Networks
• Knowledge exchange
• Stakeholders, Partners
• Consultation/Shared care models

Partners
• Judiciary
• Review tribunals
• Internal/External
• Community Housing
Philippe Pinel unchaining mentally ill patients in 1794 in La Salpêtrière
Thank you!

Johann Brink
2014
jbrink@forensic.bc.ca