INPATIENT PRACTICE

Tools Assess Patients' Potential for Violence

Violent acts by psychiatric inpatients are distressingly common. In one survey of 330 people working in the department of psychiatry at Odense (Denmark) University Hospital, 90% of physicians, nurses, and nursing aides reported having been subjected to violence at least once during their careers.

In addition, 17% of medical residents reported experiencing violence directed toward themselves during a year, and one-third of the nurses and nursing aides said they had considered changing fields because they felt so threatened by the potential of being a victim of violence (Ugeskr. Laeger 1997;159:1768-73).

In response to this problem, several checklists and tools have been developed for assessing a patient's potential to be violent, for use in outpatient, inpatient, and hospital discharge situations.

Dr. John C. Kennedy, director of the University Institute for Psychiatry and Law at the University of Cincinnati, has reviewed three of these tools: the Bröset Violence Checklist, the Classification of Violence Risk (COVR), and the Historical Clinical Risk–20. After his review, Dr. Kennedy determined that the use of such instruments should be integrated into inpatient practice.

The Bröset Violence Checklist is the one of most interesting instruments for inpatient practice. It is a simple test in which six behaviors or emotional states are assessed to predict the likelihood that an inpatient will become violent within the next 24 hours. It was developed by Phil Woods, Ph.D., of the college of nursing at the University of Saskatchewan, Saskatoon, and Roger Almvik, Ph.D., of St. Olav's University Hospital, Trondheim, Norway.

The checklist, developed with data from a large inpatient study, assesses whether confusion, irritability, boisterousness, verbal threats, physical threats, and attacking objects are present. If two or more factors are present, the patient is considered to be potentially violent. (More information is available at http://home.no.net/bvc2.)

In one Swiss study of 219 consecutive patients assessed upon admission to a unit and at various points afterward, the checklist was found to have a sensitivity of 64%, a specificity of 94%, and a positive predictive value of 11% (J. Psychiatr. Ment. Health Nurs. 2004;11:422-7). However, the researchers noted that those values could be underestimates, because many patients deemed to be at risk had intense interventions imposed because of their checklist results.

The COVR is an actuarial tool designed to assess whether a psychiatric patient is a risk at discharge; it takes about 10 minutes of chart review and 10 minutes of patient interview to complete. The Historical Clinical Risk–20, the most complex instrument, is designed for use in many different settings.

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DR. KENNEDY

This month, CLINICAL PSYCHIATRY NEWS talks with Dr. Kennedy about these three tools specifically and the use of such tools generally.

CPN: Many such assessment tools are available. What made you focus on those three?

Dr. Kennedy: I wanted to give an example of a well-respected instrument for a variety of circumstances. None of the three really fully overlap. They target slightly different populations. The HCR–20 is a longer-term instrument that requires much more data gathering. You could use it in an acute civil hospital, but the data that you need for it might not be readily available, so it might not be as practical. It is better suited for a long-term civil or a forensic hospital.

The COVR is more nicely applied to acute civil hospital settings. And the Bröset targets violence while in the hospital.

CPN: Do you know how often hospitals use these types of tools now?

Dr. Kennedy: It has been my experience in speaking with clinicians that they are rarely used, actually, despite their having been available for awhile. I think that forensic and state hospitals are probably more ahead of the curve than [are] acute civil hospitals, in part because their patients stay longer, and they have more access to data. And the issue of dangerousness to others is a common issue for their patients, particularly in regard to releasing them to the community.

CPN: You have said that the use of these tools should become more common. What exactly is their advantage over clinical experience?

Dr. Kennedy: I think when researchers have, in a variety of experiments, compared man to machine, so to speak, the predictive accuracy of the tools has always come out on top. So, it is very hard in the face of the data to argue that we should continue to use unstructured clinical judgment. And, I think the thought leaders in the field are in virtually unanimous agreement.

CPN: Are there other instruments that might rival the Bröset?

Dr. Kennedy: Yes; there are a couple of competing models. One is the Dynamic Appraisal of Situational Aggression (DASA). It is very close to the Bröset. It has seven items, and you score each. Many of the items are identical to those on the Bröset. Another is called the Short-Term Assessment of Risk and Treatability (START), which is similar to the other two.

CPN: Are there any specific directions for what staff should do if a test predicts violence potential?

Dr. Kennedy: Interestingly, part of the value of these instruments is in formally requiring that the assessments be done. Doing them is half the battle. I think that the level of attention they require makes the clinicians focus on issues of violence. Much of why we have violence on inpatient units is because attention is not paid, and situations get out of hand. The theory is that use of these tools will lead to early, and earlier, interventions.

CPN: What about the false positives? Does this mean that in the end, assessment still comes down to clinical judgement?

Dr. Kennedy: The issue of false positives becomes important when something bad might happen to an individual because they are identified as positive.

If they are going to get sent to jail because of their score, then we want to be really sure we don't have any false positives. But if the response to a positive score is for a staff member to sit down and talk with a patient, a false positive is not a bad thing, the way it might be for something like a false positive on an HIV test. That would cause all kinds of undue emotional toll—to think you have HIV when you really don't. ■

By Timothy F. Kirn, Sacramento Bureau.
Share your thoughts and suggestions at cpnews@elsevier.com.

Informed Consent Important With Lamotrigine

MIAMI BEACH — Inadequate informed consent places physicians prescribing lamotrigine at increased risk of malpractice liability, Dr. Neelam Varshney suggested.

Given that, it is important to inform patients about the risk of a rare but life-threatening rash that can develop with lamotrigine, Dr. Varshney said in a poster presented at the annual meeting of the American Academy of Psychiatry and the Law.

In an interview, Dr. Varshney pointed out that although such cases are rare, these rashes can progress to Stevens-Johnson syndrome or to toxic epidermal necrolysis.

Severe rashes can result in hospitalization, permanent disability, or even death. "That is why it is so important to give adequate informed consent," said Dr. Varshney, a resident in the department of psychiatry at Elmhurst (N.Y.) Hospital.

It is a good idea to have solid therapeutic rapport for explaining everything to the patient, including risks and benefits. Also, it is important to remind patients of the risk throughout treatment. "Informed consent is not just given on the first visit," she said.

Some physicians have suggested showing pictures of the rash to patients, but Dr. Varshney said she thinks doing this is unnecessary.

When prescribed as adjunctive therapy for epilepsy, the incidence of severe rash is about 0.8% among patients younger than 16 years and 0.3% among adults, according to a black box warning on the product's label. In clinical trials of adults with bipolar and other mood disorders, the rate of serious rash was 0.08% with monotherapy and 0.13% when used as adjunctive therapy.

—Damian McNamara